CHAPTER 550. GENERAL INSURANCE LAWS

EMERGENCY INSURANCE LEGISLATION
Act 66 of 1933

AN ACT to regulate insurance corporations, fraternal benefit and other societies and associations doing an insurance business in Michigan during and under certain emergencies, to extend the powers of the commissioner of insurance over such companies and business in such emergencies; to prevent preferences among policyholders and creditors of such companies in the payment of debts and claims and withdrawals of cash; to preserve the solvency and integrity of such companies during such emergencies for the benefit of all policyholders and other obligees of such companies and societies; and to limit certain legal process and proceedings for the period prescribed herein.

History: 1933, Act 66, Imd. Eff. Apr. 28, 1933.

Compiler's note: For transfer of the Department of Insurance and Office of the Commissioner on Insurance from the Department of Licensing and Regulation to the Department of Commerce, see E.R.O. No. 1991-9, compiled at MCL 338.3501 of the Michigan Compiled Laws.

The People of the State of Michigan enact:

550.1 Declaration of emergency.

Sec. 1. That an emergency exists in the United States of America and the state of Michigan with respect to its financial and investment institutions and the financial condition of its people generally, such emergency affecting the business of insurance. The provisions of this act are, therefore, deemed to be for the protection of the public as a whole; to preserve the stability of insurance companies; to prevent undue preference among the policyholders of such companies; and to conserve the income and assets of such companies for the benefit of their policyholders and creditors.

History: 1933, Act 66, Imd. Eff. Apr. 28, 1933;—CL 1948, 550.1.

Compiler's note: For transfer of the Department of Insurance and Office of the Commissioner on Insurance from the Department of Licensing and Regulation to the Department of Commerce, see E.R.O. No. 1991-9, compiled at MCL 338.3501 of the Michigan Compiled Laws.

For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.2 Insurance company disbursement limitations.

Sec. 2. The provisions of any law of this state to the contrary notwithstanding, during any period of public calamity resulting in abnormal financial losses to and unforeseen and excessive disbursements by any insurance company, fraternal benefit society or association (herein referred to as "company" or "companies") doing business in this state, and during any financial emergency, including the emergency referred to in the governor's proclamation of February 14, 1933, and the president's proclamation of March 6, 1933, and other similar emergencies, occurring as the result of financial disturbances in business generally, threatened or actual disaster to the banking and other financial institutions of the United States or of this state, and disruption of business and orderly business process resulting in such unusual demands upon the cash or other assets of insurance companies doing business in this state as to endanger the solvency of or threaten insolvency to any such companies and the consequences thereof, the commissioner of insurance may, by general regulations applicable to all such companies, or by special regulations applicable to any class of insurance companies, prescribe such limits or restrictions upon the disbursements, loans, investment of funds or other disposition of assets of any such companies as in his judgment is or may be necessary for the preservation of the rights of all of the policy-holders, beneficiaries or assignees, or other claimants or creditors of such companies, for the purpose of preventing such undue preferential payments to certain policyholders, beneficiaries, claimants and creditors as may or will imperil or prejudice the rights of other policyholders, beneficiaries, claimants and creditors, and for the promotion and maintenance of sound insurance practices. Provided, That no such rules or regulations shall be made in any case to relieve the company from making any loan applied for by the policyholder against the legal reserves on his or her policy for the purpose of paying his or her premium on his or her policy of insurance in such company.

History: 1933, Act 66, Imd. Eff. Apr. 28, 1933;—CL 1948, 550.2.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.3 Insurance commissioner regulatory powers.

Sec. 3. The rules and regulations made by the commissioner of insurance pursuant to this act, when filed with the secretary of the state of Michigan, shall have the force and effect of law; and the said commissioner is hereby granted the power and authority to alter, amend and promulgate all such rules and regulations.

History: 1933, Act 66, Imd. Eff. Apr. 28, 1933;—CL 1948, 550.3.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.4 Foreign insurance companies; other states' regulations, application.

Sec. 4. The said commissioner is hereby authorized and empowered to put into effect, and to enforce as against any foreign insurance company doing business in this state, any rule or regulation made applicable to any Michigan corporation or society doing an insurance business in the domestic state of such foreign company, during the period of any emergency covered by the provisions of this act. This section shall be in addition to, and not in limitation of, any law of this state requiring or permitting reciprocal application of the laws of this state to foreign insurance companies doing business in Michigan or requiring equal privileges to be extended to Michigan companies operating in other states.

History: 1933, Act 66, Imd. Eff. Apr. 28, 1933;—CL 1948, 550.4.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.5 Purposes of act.

Sec. 5. The purposes of the provisions of this act, among other things, are to preserve as far as possible the solvency of such insurance companies as are qualified and authorized to carry on business in this state, and to prevent the impairment of the obligations of the contracts of such companies as a whole.

History: 1933, Act 66, Imd. Eff. Apr. 28, 1933;—CL 1948, 550.5.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.6 Suits against insurance companies; statute of limitations, extension.

Sec. 6. During the period of any such calamity or emergency no suit at law or in equity shall be commenced or brought on for hearing, in any court of this state, for the enforcement of demands upon or against any insurance company when the payment thereof has been prohibited, suspended, or otherwise regulated by the commissioner of insurance pursuant to this act, nor shall proceedings be taken in any such court or by the state treasurer to satisfy any judgment obtained by any policyholder, or his assignee in any proceeding had or taken to enforce said demands. The commissioner of insurance may intervene in any such suit or proceeding by virtue of his office, and he or the defendant company may plead this statute and any regulation or order made pursuant thereto, in temporary bar or stay of any such action or proceeding. The period of such emergency shall be added to any statute limiting the time for commencement of any action to enforce such policy rights, or the issuance of the writ of execution or other mandatory writ enforcing such rights.

History: 1933, Act 66, Imd. Eff. Apr. 28, 1933;—CL 1948, 550.6.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.7 Duration of emergency; proclamations.

Sec. 7. The emergency referred to in section 1 hereof shall be deemed to continue until March 30, 1935, unless the legislature of this state, if in session, or the governor of this state, if the legislature be not in session, shall by resolution or proclamation officially declare such emergency to have sooner terminated; and as to any other such emergency hereafter occurring, the provisions of this act shall not be effective unless and until the governor of the state shall by proclamation have declared the same to exist and invoke therein the provisions of this act. In any such case, the governor by proclamation shall have the power to declare such emergency terminated at such date certain as he may determine.

History: 1933, Act 66, Imd. Eff. Apr. 28, 1933;—CL 1948, 550.7.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the

commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.8 Violation of act; misdemeanor; license revocation, grounds.

Sec. 8. Any person or corporation violating any of the provisions hereof, or any regulation or proclamation made pursuant hereto, shall be deemed guilty of a misdemeanor, and of violating the insurance law of this state; and any such violation by any insurance company or its agent shall be deemed cause for revoking the license of such company or agent, as the case may be, to do an insurance business in this state.

History: 1933, Act 66, Imd. Eff. Apr. 28, 1933;—CL 1948, 550.8.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

INTERSTATE INSURANCE RECEIVERSHIP COMPACT
Act 385 of 1996

550.11-550.13 Repealed. 1996, Act 385, Eff. June 1, 2006.

PRUDENT PURCHASER ACT
Act 233 of 1984

AN ACT to authorize certain organizations to enter into prudent purchaser agreements with health care providers; to control health care costs, assure appropriate utilization of health care services, and maintain quality of health care; to provide for the regulation of certain organizations, health care providers, health care facilities, and prudent purchaser arrangements; to establish a joint legislative committee to investigate the degree of competition in the health care coverage market in this state; and to provide for the powers and duties of certain state officers and agencies.

History: 1984, Act 233, Eff. Dec. 20, 1984.

The People of the State of Michigan enact:

550.51 Short title.

Sec. 1. This act shall be known and may be cited as the "prudent purchaser act".

History: 1984, Act 233, Eff. Dec. 20, 1984.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.52 Definitions.

Sec. 2. As used in this act:

(a) "Commissioner" means the commissioner of insurance.

(b) "Dental care corporation" means a dental care corporation incorporated under 1963 PA 125, MCL 550.351 to 550.373.

(c) "Health care corporation" means a health care corporation incorporated under the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1101 to 550.1704.

(d) "Health care provider" means a health facility or a person licensed, certified, or registered under part 62 or parts 161 to 182 of the public health code, 1978 PA 368, MCL 333.6230 to 333.6251 and 333.16101 to 333.18237, and chapter 2A of the mental health code, 1974 PA 258, MCL 330.1260 to 330.1287. Health care provider does not include a pharmacist or pharmacy engaged in the retail sale of drugs, until January 1, 1987.

(e) "Health facility" means:

(*i*) A facility or agency licensed or authorized under parts 201 to 217 of the public health code, 1978 PA 368, MCL 333.20101 to 333.21799e, or a licensed part of that facility or agency. Health facility does not include an ambulance operation, aircraft transport operation, nontransport prehospital life support operation, or medical first response service.

(*ii*) A mental hospital, psychiatric hospital, psychiatric unit, or other facility defined in 42 USC 1396d(d) operated by the department of community health or certified or licensed under the mental health code, 1974 PA 258, MCL 330.1001 to 330.2106.

(*iii*) A facility providing outpatient physical therapy services, including speech pathology services.

(*iv*) A kidney disease treatment center, including a freestanding hemodialysis unit.

(*v*) An organized ambulatory health care facility.

(*vi*) A tertiary health care service facility.

(*vii*) A substance abuse treatment program licensed under part 62 of the public health code, 1978 PA 368, MCL 333.6230 to 333.6251, or chapter 2A of the mental health code, 1974 PA 258, MCL 330.1260 to 330.1287.

(*viii*) An outpatient psychiatric clinic.

(*ix*) A home health agency.

(f) "Health maintenance organization" means that term as defined in section 3501 of the insurance code of 1956, 1956 PA 218, MCL 500.3501.

(g) "Hospital service corporation" means a hospital service corporation incorporated under former 1939 PA 109.

(h) "Insurer" means an insurer as defined in section 106 of the insurance code of 1956, 1956 PA 218, MCL 500.106.

(i) "Medical care corporation" means a medical care corporation incorporated under former 1939 PA 108.

(j) "Organization" means an insurer, a dental care corporation, hospital service corporation, medical care corporation, health care corporation, or third party administrator.

(k) "Provider panel" means a panel of health care providers providing health care services under a prudent

purchaser agreement.

(*l*) "Prudent purchaser agreement" means an agreement between an organization and a health care provider under section 3.

(m) "Third party administrator" means an administrator operating under a certificate of authority issued by the commissioner pursuant to the third party administrator act.

History: 1984, Act 233, Eff. Dec. 20, 1984;—Am. 2014, Act 74, Imd. Eff. Mar. 28, 2014.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.53 Prudent purchaser agreement; number; location of health care provider; membership on provider panel; written standards; notice procedures; provider application period; providing standards on request; notice of acceptance or rejection; reasons for termination; professional review program; evaluation; 2 or more classes of health care providers providing same health care service; removal from provider panel; membership in more than 1 provider panel; provider panel including health care providers and facilities outside state; required information; emergency episode of illness or injury; limiting number of prudent purchaser agreements; benefits for services within scope of practice of optometry, chiropractic, or physical therapy.

Sec. 3. (1) An organization may enter into a prudent purchaser agreement with 1 or more health care providers of a specific service to control health care costs, assure appropriate utilization of health care services, and maintain quality of health care. The organization may limit the number of prudent purchaser agreements entered into under this section if the number of agreements is sufficient to assure reasonable levels of access to health care services for recipients of those services. The number of prudent purchaser agreements authorized by this section that are necessary to assure reasonable levels of access to health care services for recipients shall be determined by the organization. However, the organization shall offer a prudent purchaser agreement, comparable to those agreements with other members of the provider panel, to at least 1 health care provider that provides the applicable health care services and is located within a reasonable distance from the recipients of those health care services, if a health care provider that provides the applicable health care services is located within that reasonable distance.

(2) An organization shall give all health care providers that provide the applicable health care services and are located in the geographic area served by the organization an opportunity to apply to the organization for membership on the provider panel.

(3) A prudent purchaser agreement shall be based upon the following written standards, which shall be filed by the organization with the commissioner on a form and in a manner that is uniformly developed and applied by the commissioner before the initial provider panel is formed:

(a) Standards for maintaining quality health care.

(b) Standards for controlling health care costs.

(c) Standards for assuring appropriate utilization of health care services.

(d) Standards for assuring reasonable levels of access to health care services.

(e) Other standards considered appropriate by the organization.

(4) An organization shall develop and institute procedures that are designed to notify health care providers located in the geographic area served by the organization of the acceptance of applications for a provider panel. The procedures shall include the giving of notice to providers of the service upon request and shall include publication in a newspaper with general circulation in the geographic area served by the organization at least 30 days before the initial provider application period. An organization shall provide for an initial 60-day provider application period during which providers of the service may apply to the organization for membership on the provider panel. An organization that has entered into a prudent purchaser agreement concerning a particular health care service shall provide, at least once every 4 years, for a 60-day provider application period during which providers of that service may apply to the organization for membership on the provider panel. Notice of this provider application period shall be given to providers of the service upon request and shall be published in a newspaper with general circulation in the geographic area served by the organization at least 30 days before the commencement of the provider application period. The initial 60-day provider application period and procedures and the 4-year 60-day provider application periods and procedures required under this subsection do not apply to organizations whose provider panels are open to application for membership at any time. Upon receipt of a request by a health care provider, the organization shall provide the written standards described in subsection (3) to the health care provider. Within 90 days after the close of

a provider application period, or within 30 days following the completion of the applicable physician credentialing process, whichever is later, an organization shall notify an applicant in writing as to whether the applicant has been accepted or rejected for membership on the provider panel. If an applicant has been rejected, the organization shall state in writing the reasons for rejection, citing 1 or more of the standards.

(5) A health care provider whose membership on an organization's provider panel is terminated shall be provided upon request with a written explanation by the organization of the reasons for the termination.

(6) An organization that enters into a prudent purchaser agreement shall institute a program for the professional review of the quality of health care, performance of health care personnel, and utilization of services and facilities under the prudent purchaser agreement. At least every 2 years, the organization shall provide for an evaluation of its professional review program by a professionally recognized independent third party.

(7) If 2 or more classes of health care providers may legally provide the same health care service, the organization shall offer each class of health care providers the opportunity to apply to the organization for membership on the provider panel.

(8) Each prudent purchaser agreement shall state that the health care provider may be removed from the provider panel before the expiration of the agreement if the provider does not comply with the requirements of the contract.

(9) This act does not preclude a health care provider or health care facility from being a member of more than 1 provider panel.

(10) A provider panel may include health care providers and facilities outside this state if necessary to assure reasonable levels of access to health care services under coverage authorized by this act.

(11) When coverage authorized by this act is offered to a person, the organization shall give or cause to be given to the person the following information:

(a) The identity of the organization contracting with the provider panel.

(b) The identity of the party sponsoring the coverage including, but not limited to, the employer.

(c) The identity of the collective bargaining agent if the coverage is offered pursuant to a collective bargaining agreement.

(12) If a person who has coverage authorized by this act is entitled to receive a health care service when rendered by a health care provider who is a member of the provider panel, the person is entitled to receive the health care service from a health care provider who is not a member of the provider panel for an emergency episode of illness or injury that requires immediate treatment before it can be obtained from a health care provider who is on the provider panel.

(13) Subsections (2) to (12) do not limit the authority of organizations to limit the number of prudent purchaser agreements.

(14) If coverage under a prudent purchaser agreement provides for benefits for services that are within the scope of practice of optometry, this act does not require that coverage or reimbursement be provided for a practice of optometry service unless that service was included in the definition of practice of optometry under section 17401 of the public health code, 1978 PA 368, MCL 333.17401, as of May 20, 1992.

(15) If coverage under a prudent purchaser agreement provides for benefits for services that are within the scope of practice of chiropractic, this act does not require that coverage or reimbursement be provided for a practice of chiropractic service unless that service was included in the definition of practice of chiropractic under section 16401 of the public health code, 1978 PA 368, MCL 333.16401, as of January 1, 2009.

(16) If coverage under a prudent purchaser agreement provides for benefits for services that are provided by a licensed physical therapist or physical therapist assistant under the supervision of a licensed physical therapist, this act does not require that coverage or reimbursement be provided for services provided by a physical therapist or a physical therapist assistant unless that service was provided by a licensed physical therapist or physical therapist assistant under the supervision of a licensed physical therapist pursuant to a prescription from a health care professional who holds a license issued under part 166, 170, 175, or 180 of the public health code, 1978 PA 368, MCL 333.16601 to 333.16648, 333.17001 to 333.17084, 333.17501 to 333.17556, and 333.18001 to 333.18058, or the equivalent license issued by another state.

History: 1984, Act 233, Eff. Dec. 20, 1984;—Am. 1994, Act 439, Eff. Mar 30, 1995;—Am. 1996, Act 518, Eff. Oct. 1, 1997;—Am. 2009, Act 224, Imd. Eff. Jan. 5, 2010;—Am. 2014, Act 262, Imd. Eff. July 1, 2014.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.53a Disclosure of financial relationships between organization and participating health care providers, health care facilities, or other entities.

Sec. 3a. An organization that establishes a prudent purchaser agreement shall disclose in writing to all purchasers of its coverage and to all covered members of its plans upon request the financial relationships between the organization and its participating health care providers, health care facilities, or other similar entities, including all of the following as applicable:

(a) Whether a fee-for-service arrangement exists, under which the provider is paid a specified fee for each particular covered service rendered to each covered individual.

(b) Whether a capitation arrangement exists, under which a fixed amount is paid to the provider for all covered services rendered to each covered individual.

(c) Whether payments to providers are made according to how well the provider meets criteria regarding costs, quality, patient satisfaction, or other criteria.

History: Add. 1996, Act 518, Eff. Oct. 1, 1997.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.53b Prudent purchaser agreement services; providing requested information to insurer.

Sec. 3b. An organization that is providing prudent purchaser agreement services to an insurer shall provide the insurer on a timely basis with information requested by the insurer that the organization has and that the insurer needs to comply with section 2212 of the insurance code of 1956, Act No. 218 of the Public Acts of 1956, being section 500.2212 of the Michigan Compiled Laws.

History: Add. 1996, Act 518, Eff. Oct. 1, 1997.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.54 Discrimination prohibited; complaint of violation; hearing; penalty.

Sec. 4. An organization shall not refuse to enter into a prudent purchaser agreement with a health care provider on the basis of religion, race, color, national origin, age, sex, or marital status. Upon receipt of a complaint of a violation of this section, in a form satisfactory to the commissioner, and if the commissioner has probable cause to believe that such a violation has occurred, the commissioner shall conduct a hearing pursuant to the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, being sections 24.201 to 24.315 of the Michigan Compiled Laws. If after such hearing the commissioner determines the organization has violated this section, the commissioner may do 1 or more of the following:

(a) Issue a cease and desist order requiring the organization to cease and desist from engaging in the conduct prohibited by this section.

(b) Issue a cease and desist order requiring the organization to enter into a prudent purchaser agreement with a health care provider.

(c) Impose a fine of not more than $500.00 for each violation, but not to exceed an aggregate fine of $5,000.00, unless the organization knew or reasonably should have known it was violating this section, in which case the fine shall not be more than $2,500.00 for each violation and shall not exceed an aggregate fine of $25,000.00 for all violations committed in a 6-month period.

(d) Suspend, limit, or revoke the organization's license or certificate of authority.

History: 1984, Act 233, Eff. Dec. 20, 1984.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.55 Notice of membership in provider panels; display.

Sec. 5. A health care provider which is a member of a provider panel shall display a notice in a conspicuous place at the entrance of the health care provider's facility indicating those provider panels to which the health care provider is a member.

History: 1984, Act 233, Eff. Dec. 20, 1984.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.56 Reporting certain information on standard forms required; availability of information to appropriate state agencies; confidentiality.

Sec. 6. (1) An organization which enters into prudent purchaser agreements with health care providers under this act shall report with its annual statement, or on a date set by the commissioner, on standard forms

prescribed by the commissioner the following information:

(a) The number of natural persons receiving health care benefits under prudent purchaser agreements.

(b) The number of individual and group contracts providing health care services pursuant to prudent purchaser agreements.

(c) The dollar volume of business conducted under prudent purchaser agreements.

(2) Information received by the commissioner pursuant to this section shall be made available to appropriate state agencies for purposes of reviewing and evaluating this act.

(3) The commissioner and state agencies shall ensure the confidentiality of information containing data which may be associated with a particular organization. Information pertaining to the diagnosis, treatment, or health of any person receiving health care benefits under prudent purchaser agreements shall be confidential and shall not be disclosed to any person, except to the extent that it may be necessary to carry out the purposes of this act; upon the express consent of the person; pursuant to statute or court order for the production of evidence or the discovery thereof; or in the event of claim examination or litigation between the person and the organization, to the extent that the data or information is pertinent.

History: 1984, Act 233, Eff. Dec. 20, 1984;—Am. 1988, Act 282, Imd. Eff. July 27, 1988.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.57 Agreements between health care providers and purchasers of health care services.

Sec. 7. Nothing in this act shall preclude 1 or more health care providers from entering into agreements with purchasers of health care services for the provision of health care services. Such agreements between 1 or more health care providers and purchasers of health care services shall not be considered to be per se violations of Michigan law prohibiting unreasonable restraint of trade. However, such agreements shall be fully subject to Michigan law regarding monopolization or attempted monopolization.

History: 1984, Act 233, Eff. Dec. 20, 1984.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.58 Organization subject to enabling act; financial records.

Sec. 8. (1) An organization which provides or administers health care benefits or coverage under a prudent purchaser agreement shall remain subject to all of the provisions of its enabling act.

(2) An organization shall maintain financial records for its prudent purchaser agreements and activities in a form separate or separable from the financial records of other operations and activities carried on by the organization.

History: 1984, Act 233, Eff. Dec. 20, 1984.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.59 Report on competition in retail pharmacy industry.

Sec. 9. The department of management and budget shall contract with an independent third party for a report which shall determine the extent of competition in the retail pharmacy industry, whether such competition results in maximum economic efficiency and the lowest possible costs for consumers, and the potential effects of this act on the retail pharmacy industry. Such report shall be submitted to the legislature before June 1, 1986.

History: 1984, Act 233, Eff, Dec. 20, 1984.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.60 Repealed. 2005, Act 203, Imd. Eff. Nov. 10, 2005.

Compiler's note: The repealed section pertained to creation of a joint committee to investigate competition in the health care coverage market.

550.61 Repealed. 1988, Act 282, Imd. Eff. July 27, 1988.

Compiler's note: The repealed section pertained to applicability of act.

550.62 Provisions inapplicable to certain contracts and renewal thereof.

Sec. 12. Nothing in this act shall apply to any contract which is in existence before the effective date of this act, or the renewal of such contract.

History: 1984, Act 233, Eff. Dec. 20, 1984.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.63 Conditional effective date.

Sec. 13. This act shall not take effect unless all of the following bills of the 82nd Legislature are enacted into law:

(a) Senate Bill No. 714.
(b) House Bill No. 4799.
(c) House Bill No. 4800.
(d) House Bill No. 4801.
(e) House Bill No. 5067.
(f) House Bill No. 5068.
(g) House Bill No. 5141.

History: 1984, Act 233, Eff. Dec. 20, 1984.

Compiler's note: The bills referred to in this section were enacted into law as follows:
Senate Bill No. 714, filed with the Secretary of State December 20, 1984, became P.A. 1984, No. 280, Imd. Eff. Dec. 20, 1984;
House Bill No. 4799, filed with the Secretary of State July 30, 1984, became P.A. 1984, No. 230, Imd. Eff. July 30, 1984;
House Bill No. 4800, filed with the Secretary of State July 30, 1984, became P.A. 1984, No. 231, Imd. Eff. July 30, 1984;
House Bill No. 4801, filed with the Secretary of State July 30, 1984, became P.A. 1984, No. 232, Imd. Eff. July 30, 1984;
House Bill No. 5067, filed with the Secretary of State July 30, 1984, became P.A. 1984, No. 235, Imd. Eff. July 30, 1984;
House Bill No. 5068, filed with the Secretary of State July 30, 1984, became P.A. 1984, No. 234, Imd. Eff. July 30, 1984; and
House Bill No. 5141, filed with the Secretary of State July 13, 1984, became P.A. 1984, No. 218, Imd. Eff. July 13, 1984.
For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

SURETY COMPANIES
Act 266 of 1895

550.101-550.111 Repealed. 1964, Act 256, Eff. Aug. 28, 1964;—2001, Act 183, Imd. Eff. Dec. 21, 2001.

MUTUAL INSURANCE COMPANIES; APPROVAL FEE
Act 151 of 1893

550.151,550.152 Repealed. 1956, Act 218, Eff. Jan. 1, 1957.

UNIFORM INSURERS LIQUIDATION ACT
Act 158 of 1943

550.201-550.213 Repealed. 1956, Act 218, Eff. Jan. 1, 1957.

OFFICE AGENT; SET-OFF FOR DAMAGES
Act 143 of 1935

AN ACT relative to the payment of the unpaid balance owed by an insurance agent to an insurance company taken over by the commissioner of insurance or in the hands of a receiver; to authorize as a set-off thereof damages incurred to the business of any such agent on account of the taking over by the commissioner of insurance of such insurance company, or of the placing of same into the hands of a receiver; and to declare the effect of this act.

History: 1935, Act 143, Imd. Eff. June 4, 1935.

Compiler's note: For transfer of the Department of Insurance and Office of the Commissioner on Insurance from the Department of Licensing and Regulation to the Department of Commerce, see E.R.O. No. 1991-9, compiled at MCL 338.3501 of the Michigan Compiled Laws.

The People of the State of Michigan enact:

550.231 Office agent of insurance company taken over by insurance commissioner or receiver; off-set for damages.

Sec. 1. Any insurance agent, who has been the office agent of an insurance company taken over by the commissioner of insurance or an insurance company in the hands of a receiver, may off-set against any balance unpaid and owing such insurance company the damages resulting to such agent, and his insurance business, due to the taking over of such company by the commissioner of insurance or the placing of such company in the hands of a receiver.

History: 1935, Act 143, Imd. Eff. June 4, 1935;—CL 1948, 550.231.

Compiler's note: For transfer of the Department of Insurance and Office of the Commissioner on Insurance from the Department of Licensing and Regulation to the Department of Commerce, see E.R.O. No. 1991-9, compiled at MCL 338.3501 of the Michigan Compiled Laws.

For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.232 Applicability of act.

Sec. 2. The provisions of this act shall apply to any balances unpaid and owing any such insurance companies at the time this act shall take effect, as represented in moneys uncollected by the agent and moneys collected by the agent and deposited in banks now closed, and shall apply to all actions at law or in equity to recover said unpaid balances which are pending in the courts of this state at the time this act shall take effect.

History: 1935, Act 143, Imd. Eff. June 4, 1935;—CL 1948, 550.232.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.233 Construction of act.

Sec. 3. This act shall be construed as supplemental to the existing laws of this state governing insurance companies and insurance agents, and insofar as inconsistent shall supersede said laws.

History: 1935, Act 143, Imd. Eff. June 4, 1935;—CL 1948, 550.233.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

THE COORDINATION OF BENEFITS ACT
Act 64 of 1984

AN ACT to provide for a uniform order of benefits determination under which plans pay claims; to prescribe the powers and duties of certain state governmental officers and entities; and to require the promulgation of rules.

History: 1984, Act 64, Imd. Eff. Apr. 18, 1984;—Am. 2016, Act 275, Imd. Eff. July 1, 2016.

Compiler's note: For transfer of the Department of Insurance and Office of the Commissioner on Insurance from the Department of Licensing and Regulation to the Department of Commerce, see E.R.O. No. 1991-9, compiled at MCL 338.3501 of the Michigan Compiled Laws.

The People of the State of Michigan enact:

550.251 Short title.

Sec. 1. This act shall be known and may be cited as "the coordination of benefits act".

History: 1984, Act 64, Imd. Eff. Apr. 18, 1984.

Compiler's note: For transfer of the Department of Insurance and Office of the Commissioner on Insurance from the Department of Licensing and Regulation to the Department of Commerce, see E.R.O. No. 1991-9, compiled at MCL 338.3501 of the Michigan Compiled Laws.

For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.252 Definitions.

Sec. 2. (1) As used in this act:

(a) "Allowable expense" means a health care expense, including coinsurance or copayments and without reduction for any applicable deductible, that is covered in full or in part by any of the plans covering the individual. The amount of a reduction may be excluded from allowable expense if a covered person's benefits are reduced under a primary plan for either of the following reasons:

(*i*) Because the covered person does not comply with the plan provisions concerning second surgical opinions or precertification of admissions or services.

(*ii*) Because the covered person has a lower benefit because the covered person did not use a preferred provider.

(b) "Claim" means a request that benefits of a plan be provided or paid. The benefits claimed may be in the form of any of the following:

(*i*) Services including supplies.

(*ii*) Payment for all or a portion of the expenses incurred.

(*iii*) A combination of subparagraphs (*i*) and (*ii*).

(*iv*) An indemnification.

(c) "Closed panel plan" means a plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the insurer that issues the plan and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

(d) "Coordination of benefits" or "COB" means a provision that establishes an order in which insurers pay claims, and that permits benefits paid under secondary plans to be reduced so that the combined benefits paid under all plans do not exceed 100% of the total allowable expenses of the claims.

(e) "Custodial parent" means any of the following:

(*i*) The parent awarded custody of a child by a court order or judgment.

(*ii*) In the absence of a court order or judgment, the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

(f) "Dental care corporation" means a nonprofit dental care corporation incorporated under 1963 PA 125, MCL 550.351 to 550.373.

(g) "Group-type contract" means a contract that is not available to the general public and is obtained and maintained only because of membership in or a connection with a particular organization or group, including blanket coverage. Group-type contract does not include an individually underwritten and issued guaranteed renewable policy even if the policy is purchased through payroll deduction at a premium savings to the insured, because the insured would have the right to maintain or renew the policy independently of continued employment with the employer.

(h) "Health maintenance organization" means that term as defined in section 3501 of the insurance code of

1956, 1956 PA 218, MCL 500.3501.

(i) "Insurer" means that term as defined in section 106 of the insurance code of 1956, 1956 PA 218, MCL 500.106.

(j) Subject to subsections (2) and (3), "plan" means a form of health care coverage with which coordination is allowed. Separate parts of a plan for members of a group that are provided through alternative contracts and that are intended to be part of a coordinated package of benefits are considered 1 plan and there is not COB among the separate parts of the plan. If benefits are coordinated under a plan, the contract must state the types of coverage that will be considered in applying the COB provision of the contract. Whether the contract uses the term "plan" or some other term such as "program", the contractual definition must not be broader than the definition of "plan" in this subdivision. Plan includes any of the following:

(*i*) Group and nongroup insurance contracts and subscriber contracts.

(*ii*) Uninsured arrangements of group or group-type coverage.

(*iii*) Group and nongroup coverage through closed panel plans.

(*iv*) Group-type contracts.

(*v*) The medical care components of long-term care contracts, including skilled nursing care.

(*vi*) Medicare or other governmental benefits, as permitted by law, except as provided in subsection (2)(g). Plan under this subdivision may be limited to the hospital, medical, and surgical benefits of the governmental program.

(*vii*) Group and nongroup insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care.

(*viii*) Group and nongroup dental insurance contracts and subscriber contracts issued by a dental care corporation.

(k) "Primary plan" means a plan under which benefits for an individual's health care coverage are determined without taking into consideration the existence of any other plan. A plan is a primary plan under either of the following circumstances:

(*i*) The plan either has no order of benefit determination rules or its rules differ from those authorized under this act.

(*ii*) All plans that cover the individual use the order of benefit determination rules required under this act and, under those rules, the benefits payable under the plan are determined to be payable first.

(*l*) "Secondary plan" means a plan that is not a primary plan.

(2) For purposes of this act, plan does not include any of the following:

(a) Hospital indemnity coverage benefits or other fixed indemnity coverage.

(b) Accident-only coverage or disability income insurance.

(c) Specified disease or specified accident coverage.

(d) School-accident-type coverages that cover students for accidents only, including athletic injuries, either on a 24-hour basis or on a to-and-from-school basis.

(e) Benefits provided in long-term care insurance policies for nonmedical services, including personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care, or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services.

(f) Medicare supplement plans.

(g) A state plan under Medicaid.

(h) A governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.

(3) For purposes of this act, plans are issued by any of the following:

(a) A health maintenance organization under which health services are provided, either directly or through contracts with affiliated providers, to individual or group enrollees.

(b) A dental care corporation under which dental benefits are provided to individual or group enrollees.

(c) An insurer that provides for hospital, medical, surgical, dental, or sick care benefits.

History: 1984, Act 64, Imd. Eff. Apr. 18, 1984;—Am. 2016, Act 275, Imd. Eff. July 1, 2016.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.253 Coverage by 2 or more plans; order of benefit payments; length of time covered under plan; inability to agree on order of benefits; amount to be paid by insurer issuing secondary plan; amount to be paid by insurer issuing secondary dental plan; payment of claims or coordination of benefits not provided or authorized by health maintenance organization.

Sec. 3. (1) If an individual is covered by 2 or more plans, the rules for determining the order of benefit payments are as follows:

(a) The insurer that issues the primary plan shall pay or provide benefits as if a secondary plan does not exist.

(b) If the individual is covered by more than 1 secondary plan, the order of benefit determination rules under this act determine the order under which secondary plan benefits are determined in relation to each other. An insurer that issues a secondary plan shall take into consideration the benefits of the primary plan and the benefits of any other plan that are, under this act, determined to be payable before those of the secondary plan.

(c) Subject to subdivision (d), a plan that does not contain order of benefit determination provisions that are consistent with this act is always the primary plan unless the provisions of both plans, regardless of this subdivision, state that the complying plan is primary.

(d) If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the insurer that issues the secondary plan shall pay or provide benefits as if it were the primary plan if a covered person uses a nonpanel provider, except for emergency services or authorized referrals that are paid or provided by the insurer that issued the primary plan.

(2) The order in which benefits are payable by insurers that issue plans are determined by using the first of the following rules that applies:

(a) The nondependent/dependent rule. If the individual is not a dependent but is an employee, member, subscriber, policyholder, or retiree under 1 plan and is a dependent under another plan, the order of payment of benefits under the plans is determined as follows:

(*i*) Except as otherwise provided in subparagraph (*ii*), the plan that covers the individual other than as a dependent is the primary plan and the plan that covers the individual as a dependent is the secondary plan.

(*ii*) If the individual is a Medicare beneficiary and, as a result of the provisions of title XVIII of the social security act, 42 USC 1395 to 1395*lll*, Medicare is secondary to the plan covering the individual as a dependent and primary to the plan covering the individual as other than a dependent, then the order of benefits is reversed and the plan covering the individual as other than a dependent is the secondary plan and the plan covering the individual as a dependent is the primary plan.

(b) The dependent covered under more than 1 plan rule. If the individual is a dependent child, unless there is a court order or judgment stating otherwise, the order of payment of benefits under the plans covering the dependent child is determined as follows:

(*i*) If the child's parents are married or are living together, whether or not they have ever been married, as follows:

(A) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan.

(B) If both parents have the same birthday, the plan that has covered the parent longest is the primary plan.

(*ii*) If the child's parents are divorced, separated, or not living together, whether or not they have ever been married, as follows:

(A) If a court order or judgment states that 1 of the parents is responsible for the dependent child's health care expenses or health care coverage and the insurer that issued the plan of the parent with responsibility has actual knowledge of the terms of the order or judgment, that plan is the primary plan. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This sub-subparagraph does not apply with respect to a plan year during which benefits are paid or provided before the insurer has actual knowledge of the terms of the court order or judgment.

(B) If a court order or judgment states that both parents are responsible for the dependent child's health care expenses or health care coverage, the order of benefits is determined in the manner prescribed in subparagraph (*i*).

(C) If a court order or judgment states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the order of benefits is determined in the manner prescribed in subparagraph (*i*).

(D) If there is no court order or judgment allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows, in the following order of priority:

(I) The plan covering the custodial parent.

(II) The plan covering the custodial parent's spouse.

(III) The plan covering the noncustodial parent.

(IV) The plan covering the noncustodial parent's spouse.

(*iii*) If the child is covered under more than 1 plan of individuals who are not the parents of the child, the order of benefits is determined in the manner prescribed in subparagraph (*i*) or (*ii*), as applicable, as if those

individuals were parents of the child.

(*iv*) If the child is covered under either or both parents' plans and is also covered as a dependent under his or her spouse's plan, the order of benefits is determined in the manner prescribed in subdivision (e). If the dependent child's coverage under his or her spouse's plan began on the same date as his or her coverage under either or both parents' plans, the order of benefits is determined by applying the birthday rule prescribed in subparagraph (*i*) to the dependent child's parents, as applicable, and his or her spouse.

(c) The active, retired, or laid-off employee rule. If the individual is an active employee, laid-off employee, or retired employee, or is a dependent of an active employee, laid-off employee, or retired employee, the order of payment of benefits under the plans covering the individual is determined as follows:

(*i*) The plan that covers the individual as an active employee or as a dependent of an active employee is the primary plan. The plan that covers the individual as a laid-off employee or retired employee or as a dependent of a laid-off employee or retired employee is the secondary plan.

(*ii*) Subparagraph (*i*) does not apply if the other plan that covers the individual does not have the rule described in subparagraph (*i*) and, as a result, the plans do not agree on the order of benefits.

(*iii*) This rule does not apply if the plan that covers the member, subscriber, enrollee, or retiree or the individual as a dependent of an employee, member, subscriber, enrollee, or retiree is the primary plan.

(d) The continuation coverage rule. If the individual has coverage under a right of continuation pursuant to federal or state law, the order of payment of benefits under the plans covering the individual is determined as follows:

(*i*) The plan that covers the individual as an employee, member, subscriber, enrollee, or retiree or as a dependent of an employee, member, subscriber, enrollee, or retiree is the primary plan. The plan that covers the individual under the continuation coverage is the secondary plan.

(*ii*) Subparagraph (*i*) does not apply if the other plan that covers the individual does not have the rule described in subparagraph (*i*) and, as a result, the plans do not agree on the order of benefits.

(*iii*) This rule does not apply if the order of benefits can be determined by the rule in subdivision (a).

(e) The longer or shorter length of coverage rule. If the rules in subdivisions (a) to (d) do not determine the order of benefits, the plan that has covered the individual for the longer period of time is the primary plan and the plan that has covered the individual for the shorter period of time is the secondary plan. To determine the length of time an individual has been covered under a plan, 2 successive plans are treated as 1 if the covered individual was eligible under the second plan within 24 hours after coverage under the first plan ended. Any of the following changes do not constitute the start of a new plan:

(*i*) A change in the amount or scope of a plan's benefits.

(*ii*) A change in the entity that pays, provides, or administers the plan's benefits.

(*iii*) A change from 1 type of plan to another, such as from a single-employer plan to a multiple-employer plan.

(3) A person's length of time covered under a plan is measured from the person's first date of coverage under the plan. If that date is not readily available for a group plan, the date the person first became a member of the group must be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

(4) If the insurers that issued plans cannot agree on the order of benefits within 30 calendar days after the insurers have received all of the information needed to pay the claim, the insurers shall immediately pay the claim in equal shares and determine their relative liabilities following payment. An insurer is not required to pay more than it would have paid had the plan it issued been the primary plan.

(5) Except as provided in subsection (6), in determining the amount to be paid on a claim by the insurer that issued a secondary plan, if the insurer wishes to coordinate benefits, the insurer shall calculate the benefits it would have paid on the claim in the absence of other health care coverage and apply the calculated amount to any allowable expense under its plan that is unpaid under the primary plan. The insurer that issued a secondary plan may reduce its payment by the calculated amount so that, when combined with the amount paid under the primary plan, the total benefits paid or provided under all plans for the claim do not exceed 100% of the total allowable expense for the claim.

(6) In determining the amount to be paid on a dental plan claim by the insurer that issued a secondary plan, if the insurer wishes to coordinate benefits, it may do so in accordance with subsection (5) or, for not more than 2 years after the effective date of the amendatory act that added this subsection, it may do so under a nonduplication of benefits method. Under a nonduplication of benefits method, the primary plan payment is subtracted from the secondary plan's allowable benefit amount. If there is a positive balance, the insurer that issued the secondary plan shall make a payment equal to the difference. If there is a negative or zero balance, the insurer that issued the secondary plan shall make no payment. If an insurer that issues a plan is advised by a covered person that all plans covering the person are high-deductible health plans and the person intends to

contribute to a health savings account established in accordance with section 223 of the internal revenue code of 1986, 26 USC 223, the primary high-deductible health plan's deductible is not an allowable expense, except for any health care expense incurred that may not be subject to the deductible as described in section 223(c)(2)(C) of the internal revenue code of 1986, 26 USC 223.

(7) A health maintenance organization is not required to pay claims or coordinate benefits for services that are not provided or authorized by the health maintenance organization and that are not benefits under the health maintenance contract.

History: 1984, Act 64, Imd. Eff. Apr. 18, 1984;—Am. 1996, Act 325, Imd. Eff. June 26, 1996;—Am. 2016, Act 275, Imd. Eff. July 1, 2016.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.253a Contract issued before effective date of amendatory act; compliance with changes; transition period.

Sec. 3a. (1) An insurer that, before the effective date of the amendatory act that added this section, issued a contract that provides health care benefits shall bring the contract into compliance with the changes made to this act by the amendatory act that added this section by either of the following dates:

(a) Whichever of the following dates is later:

(*i*) The next anniversary date or renewal date of the contract.

(*ii*) Twelve months after the effective date of the amendatory act that added this section.

(b) If the contract was written pursuant to a collectively bargained contract, the expiration date of the collectively bargained contract.

(2) For the transition period between the effective date of the amendatory act that added this section and the time within which contracts are to be in compliance under subsection (1), a plan that is subject to the prior coordination of benefits requirements shall not be considered a noncomplying plan by a plan subject to the new coordination of benefits requirements and if there is a conflict between the prior coordination of benefits requirements under the prior regulation and the new coordination of benefits requirements under the amended regulation, the prior coordination of benefits requirements apply.

History: Add. 2016, Act 275, Imd. Eff. July 1, 2016.

550.254 Rules.

Sec. 4. The director of the department of insurance and financial services may promulgate rules to implement and supervise this act pursuant to the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328.

History: 1984, Act 64, Imd. Eff. Apr. 18, 1984;—Am. 2016, Act 275, Imd. Eff. July 1, 2016.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.255 Repealed. 2016, Act 275, Imd. Eff. July 1, 2016.

Compiler's note: The repealed section pertained to conditional effective date.

SHARING HEALTH CARE INFORMATION
Act 593 of 2006

AN ACT to provide for the sharing of certain health care coverage information; to provide for the powers and duties of certain departments and agencies; and to provide penalties and fines.

History: 2006, Act 593, Imd. Eff. Jan. 3, 2007.

The People of the State of Michigan enact:

550.281 Definitions.

Sec. 1. As used in this act:

(a) "Department" means the department of community health.

(b) "Entity" means a health insurer; a health maintenance organization; a nonprofit health care corporation; a managed care corporation; a preferred provider organization; an organization operating pursuant to the prudent purchaser act, 1984 PA 233, MCL 550.51 to 550.63; a self-funded health plan; a professional association, trust, pool, union, or fraternal group, offering health coverage; a system of health care delivery and financing operating pursuant to section 3573 of the insurance code of 1956, 1956 PA 218, MCL 500.3573; and a third party administrator.

(c) "Medical assistance" means the medical assistance program administered by the state under the social welfare act, 1939 PA 280, MCL 400.1 to 400.119b.

(d) "Qualified health plan" means that term as defined in section 111i of the social welfare act, 1939 PA 280, MCL 400.111i.

History: 2006, Act 593, Imd. Eff. Jan. 3, 2007.

550.283 Determination that health coverage recipient is also medical assistance recipient; information to be provided by health insurer.

Sec. 3. (1) An entity shall provide on a monthly basis to the department, in a format determined by the department, information necessary to enable the department or entity to determine whether a health coverage recipient of the entity is also a medical assistance recipient.

(2) If a health coverage recipient of the entity is also a medical assistance recipient, the entity shall do all of the following by not later than 180 days after the department's request:

(a) Pay the department for, or assign to the department any right of recovery owed to the entity for, a covered health claim for which medical assistance payment has been made.

(b) Respond to any inquiry by the department concerning a claim for payment for any health care item or service that is submitted not later than 3 years after the date the health care item or service was provided.

(3) An entity shall not deny a claim submitted by the department solely on the basis of the date of submission of the claim, the type or format of the claim form, or a failure to present proper documentation at the time the health care item or service that is the basis of the claim was provided so long as both of the following apply:

(a) The claim is submitted to the entity within 3 years of the date that the health care item or service that is the subject of the claim was provided.

(b) Any action by the state to enforce its rights under this subdivision is commenced within 6 years of the date that the health care item or service that is the subject of the claim was provided.

History: 2006, Act 593, Imd. Eff. Jan. 3, 2007.

550.285 Determination that health coverage recipient is also medical assistance recipient; actions by department.

Sec. 5. If the department determines that a health coverage recipient is also a medical assistance recipient:

(a) The department may use information received under section 3 to update the medical assistance database maintained by the department.

(b) If the medical assistance recipient is covered by a qualified health plan, the department shall share with that qualified health plan all information received under this act by the department for that medical assistance recipient.

History: 2006, Act 593, Imd. Eff. Jan. 3, 2007.

550.287 Violation of act; administrative fine; notice; right to hearing.

Sec. 7. An entity that violates this act is subject to an administrative fine of not more than $500.00 for each day the entity does not comply with section 3(1) or with a request for information made pursuant to section

3(2). Upon the department's determination that a violation of this act has occurred, the entity has a right to notice of the alleged violation and an opportunity for a hearing under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328.

History: 2006, Act 593, Imd. Eff. Jan. 3, 2007.

550.289 Rules.

Sec. 9. The department may promulgate rules pursuant to the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, necessary to implement this act. Rules governing the exchange of information under this act shall be consistent with all laws, regulations, and rules relating to the confidentiality or privacy of personal information or medical records, including, but not limited to, the health insurance portability and accountability act of 1996, Public Law 104-191, and regulations promulgated under that act, 45 CFR parts 160 to 164.

History: 2006, Act 593, Imd. Eff. Jan. 3, 2007.

NONPROFIT MEDICAL CARE CORPORATIONS
Act 108 of 1939

550.301-550.316 Repealed. 1980, Act 350, Eff. Apr. 3, 1981.

Compiler's note: Prior to April 3, 1981, the effective date of Act 350 of 1980, Blue Cross & Blue Shield of Michigan brought a complaint for declaratory judgment challenging the constitutionality of the act and sought an injunction against the act's enforcement in the Ingham County Circuit Court. On April 2, 1981, the Ingham County Circuit Court enjoined the enforcement of the act and further ordered the parties to comply with the existing enabling acts, Acts 108 and 109 of 1939. Blue Cross & Blue Shield of Michigan v Governor, 422 Mich 1; 367 NW2d 1, appdis, 474 US 805, 106 S Ct 40; 88 L Ed 2d 33 (1985).

During the period when enforcement of Act 350 of 1980 was enjoined by the Ingham County Circuit Court, Act 108 was amended by Acts 142, 199, and 232 of 1982 and by Acts 67, 180, 194, 231, and 370 of 1984 and Act 109 was amended by Acts 198 and 233 of 1982 and by Acts 68, 182, 195, 232, and 371 of 1984.

The Michigan Supreme Court in Blue Cross & Blue Shield of Michigan v Governor, 422 Mich at 97, ordered the Ingham County Circuit Court to dissolve the injunction against the enforcement of Acts 108 and 109 of 1939. An order dissolving the injunction was entered on August 28, 1985.

NONPROFIT DENTAL CARE CORPORATIONS
Act 125 of 1963

AN ACT to provide for the incorporation, supervision, and regulation of nonprofit dental care corporations; to prescribe the functions of the commissioner of insurance as to such corporations; to provide for the imposition of a regulatory fee; and to prescribe penalties for violations of this act.

History: 1963, Act 125, Eff. Sept. 6, 1963;—Am. 1994, Act 168, Imd. Eff. June 17, 1994.

Compiler's note: For transfer of the Department of Insurance and Office of the Commissioner on Insurance from the Department of Licensing and Regulation to the Department of Commerce, see E.R.O. No. 1991-9, compiled at MCL 338.3501 of the Michigan Compiled Laws.

The People of the State of Michigan enact:

550.351 Nonprofit dental care corporation; formation; purpose; types of dental care plans; services in other states; corporation subject to nonprofit corporation act.

Sec. 1. (1) Three or more residents of this state may form a nonprofit corporation under the provisions of this act for the purpose of establishing, maintaining, and operating nonprofit dental care plans by which professional licensed dental services are provided at the expense of the corporation to persons who become subscribers to the plans.

(2) The dental care plans may be a fee for service plan, administrative service contract, cost-plus arrangement, or a capitation plan.

(3) The corporation may establish, maintain, and operate dental care plans to furnish, deliver, indemnify, or finance professional dental services in other states, directly or through affiliate corporations.

(4) Except as otherwise provided in this act, a corporation formed under this act is subject to the nonprofit corporation act, Act No. 162 of the Public Acts of 1982, being sections 450.2101 to 450.3192 of the Michigan Compiled Laws.

History: 1963, Act 125, Eff. Sept. 6, 1963;—Am. 1990, Act 129, Imd. Eff. June 26, 1990.

Compiler's note: For transfer of the Department of Insurance and Office of the Commissioner on Insurance from the Department of Licensing and Regulation to the Department of Commerce, see E.R.O. No. 1991-9, compiled at MCL 338.3501 of the Michigan Compiled Laws.

For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.352 Subscriber contract payment regulations; prohibited provisions.

Sec. 2. No contract shall provide for the payment of any cash or other material benefits to a subscriber or to his estate on account of death, illness or injury, or be in any way related to the payment of any such benefit by any other agency.

History: 1963, Act 125, Eff. Sept. 6, 1963.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.353 Supervision by insurance commissioner; incorporation procedures.

Sec. 3. A nonprofit dental care corporation is subject to regulation and supervision by the commissioner of insurance as hereinafter provided. Any law of this state now or hereafter in force relating to insurance or corporations engaged in the business of insurance shall not apply unless such law specifically, in exact terms, applies to nonprofit dental care corporations. A nonprofit dental care corporation may not be incorporated in this state except under the provisions of this act, but nothing herein contained limits the corporations formed under Act No. 108 of the Public Acts of 1939, being sections 550.301 to 550.316 of the Compiled Laws of 1948, in providing care to subscribers.

History: 1963, Act 125, Eff. Sept. 6, 1963.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.354 Articles of incorporation; contents.

Sec. 4. Any persons associating as a nonprofit dental care corporation shall qualify under this act by subscribing to and filing articles of incorporation as provided in section 5. The articles shall contain:

(a) The names of the incorporators and their places of residence.

(b) The location of the principal office of the corporation for the transaction of business in this state.

(c) The name by which the corporation shall be known, which shall not include the words insurance, casualty, surety, health and accident, mutual or other words descriptive of the insurance or surety business. The corporation shall not assume any name likely to mislead the public, or any name already in use by another existing corporation of this state, or corporation lawfully carrying on business in this state, or so nearly similar thereto as to lead to confusion or deception.

(d) The purposes of the corporation.

(e) The term of existence of the corporation, which shall be for not more than 30 years.

(f) The time for holding the annual meeting of members of the corporation.

(g) Any terms and conditions of membership in the corporation which the incorporators wish set forth in the articles.

(h) Any other terms and conditions, not inconsistent with the provisions of this act, necessary for the conduct of the affairs of the corporation.

History: 1963, Act 125, Eff. Sept. 6, 1963.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.355 Articles of incorporation; execution, filing, fee, approval, amendment.

Sec. 5. The articles shall be acknowledged before a notary public of this state by at least 1 of the persons signing them. The articles shall be filed in triplicate in the form prescribed by the commissioner of insurance. A corporation shall pay to the commissioner a $10.00 fee for filing its articles or any amendments. The fees shall be paid into the state treasury to the credit of the general fund.

If the commissioner approves the corporation, he shall return to the incorporators 1 copy of the articles certified for filing with the county clerk of the county in which the corporation proposes to maintain its principal business office, and 1 copy certified by the commissioner for the records of the corporation, and he shall retain 1 copy for his office files.

A corporation, with the approval of the commissioner and in the manner provided in its articles, may amend its articles in any manner not inconsistent with this act.

History: 1963, Act 125, Eff. Sept. 6, 1963.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.356 Contracts; statement to insurance commissioner; contents, examination.

Sec. 6. Before a corporation shall enter into or solicit contracts to provide dental services at the expense of such corporation to persons who shall become subscribers, it shall file a statement with the commissioner of insurance showing in full detail:

(a) The plan on which it proposes to transact business.

(b) A copy of its bylaws.

(c) A copy of the contract to be issued to subscribers.

(d) A copy of its prospectus and advertising proposed to be used in the solicitation of contracts and subscribers.

The commissioner shall examine the statements and the documents so filed with him, and may conduct any investigation he deems necessary, and examine under oath any persons interested in or connected with the proposed corporation. If in the opinion of the commissioner the incorporation or solicitation of contracts would work a fraud upon the persons so solicited, he may refuse to license the corporation.

History: 1963, Act 125, Eff. Sept. 6, 1963.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.357 Certificate of authority to commence business and issue contracts; requirements.

Sec. 7. If the commissioner is satisfied that:

(a) The solicitation of subscriptions would not work a fraud upon the persons so solicited,

(b) The rates to be charged and the benefits to be provided are fair and reasonable,

(c) The amount of money available for working capital is not less than $5,000.00,

(d) The amounts contributed as the working capital of the corporation are repayable only out of surplus earnings of such corporation,

(e) Adequate and reasonable reserves to insure the maturity of the contracts are provided,

he shall issue and deliver to the corporation a certificate of authority to commence business and issue contracts under this act.

History: 1963, Act 125, Eff. Sept. 6, 1963.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.358 Certificate of authority; revocation; liquidation.

Sec. 8. The commissioner of insurance, after reasonable notice and hearing, may revoke a certificate, order or consent, made by him and forbid applications for membership, upon being satisfied that further solicitation of subscribers would work a fraud upon the persons so solicited. He may make such investigations from time to time as he deems best and grant hearings to the incorporators. He shall have the same authority in respect to taking over or liquidating a corporation formed or doing business under this act as is provided by chapter 78 of Act No. 218 of the Public Acts of 1956, as amended, being sections 500.7800 to 500.7868 of the Compiled Laws of 1948.

A dissolution or liquidation of a corporation shall be conducted under the supervision of the commissioner, who shall have the same power with respect thereto as granted to him under provisions of the law for the dissolution and liquidation of insurance companies.

History: 1963, Act 125, Eff. Sept. 6, 1963.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.359 Corporation examination by insurance commissioner; expenses.

Sec. 9. The commissioner of insurance, or any deputy, examiner, or other person whom the commissioner appoints, may visit and examine into the affairs of a corporation, have free access to all of the books, papers, and documents that relate to the business of the corporation, may summon and qualify witnesses under oath, and examine corporation officers, agents, employees, or other persons having knowledge of the corporation's affairs, transactions, and conditions. Except as provided in section 9a, per diem, travel, and other necessary expenses in connection with an examination under this section shall be paid by the corporation.

History: 1963, Act 125, Eff. Sept. 6, 1963;—Am. 1994, Act 168, Imd. Eff. June 17, 1994.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.359a Nonprofit dental care corporation subject to MCL 500.224 and 500.225; costs and expenses.

Sec. 9a. A nonprofit dental care corporation is subject to sections 224(4) through (13) and 225 of the insurance code of 1956, Act No. 218 of the Public Acts of 1956, being sections 500.224 and 500.225 of the Michigan Compiled Laws, instead of the costs and expenses that may be imposed by the commissioner pursuant to section 9.

History: Add. 1994, Act 168, Imd. Eff. June 17, 1994.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.360 Annual statement; filing.

Sec. 10. A corporation, annually on or before March 1 of each year, shall file in the office of the commissioner of insurance a sworn statement verified by at least 2 of its principal officers showing its condition on the preceding December 31, which shall be in such form and contain such matters as the commissioner shall prescribe. If a corporation fails to file such annual statement, the commissioner may suspend the certificate of authority issued to the corporation until such statement shall be properly filed.

History: 1963, Act 125, Eff. Sept. 6, 1963.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.361 Providing dental services outside state.

Sec. 11. A dental care corporation may provide dental services to persons outside the state who are eligible

under contracts entered into under section 19.

History: 1963, Act 125, Eff. Sept. 6, 1963;—Am. 1990, Act 129, Imd. Eff. June 26, 1990.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.362 Dental care service contracts; preliminary requirements; payments.

Sec. 12. A dental care corporation before entering into a contract with an applicant or group of applicants for dental services may require:

(a) A physical examination of the applicant and each of his dependents and proof of their substantial freedom from any disease or condition requiring immediate dental service.

(b) A reasonable waiting period after a contract is entered into before the subscriber is entitled to dental service.

(c) Payment by or for the subscriber of the stated fee for dental services for the care of any given illness, injury or other condition requiring dental service.

History: 1963, Act 125, Eff. Sept. 6, 1963.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.363 Dental care corporation; board of directors; membership, consideration of candidates recommended by Michigan Dental Association; composition of board; hearing to determine compliance; findings; order; failure to comply with order; civil fine; information to be provided by dental care corporation.

Sec. 13. (1) The board of directors of a dental care corporation must have not more than 25 members. The board must have representation from the general public, from licensed dentists, and from among the various classes of subscribers identified in section 19. The Michigan Dental Association, or its successor, may submit to a dental care corporation a list of candidates recommended for appointment to the board. A dental care corporation may consider those recommended candidates, but is not required to appoint any recommended candidate to the board.

(2) Subject to subsection (3), not less than 40% of the directors of a dental care corporation must be licensed dentists who are not active employees of the dental care corporation.

(3) Of the not less than 40% of the board who are licensed dentists and who are not active employees of the dental care corporation under subsection (2), a minimum portion must be members of the Michigan Dental Association at the time of appointment or reappointment to the board. At a minimum, the proportion must equal the percentage of licensed dentists who are also members of the Michigan Dental Association.

(4) The board of directors of a dental care corporation must consist of not more than 60% licensed dentist directors.

(5) If the director of the department of insurance and financial services believes that the composition of the board of a dental care corporation is not in compliance with this section, the director of the department of insurance and financial services shall hold a hearing. After the hearing and after written findings that the board composition does not comply with this section, the director of the department of insurance and financial services shall issue and cause to be served on the dental care corporation a copy of the findings and an order requiring the dental care corporation to comply with this section. In addition, if the dental care corporation does not comply with the order within 30 days, the director of the department of insurance and financial services may order the payment of a civil fine of not more than $10,000.00.

(6) Not more frequently than annually, on the Michigan Dental Association's request, a dental care corporation shall provide all of the following information:

(a) The names of the dentist directors.

(b) The terms of service of the dentist directors.

(c) The date on which new dentist directors are elected.

History: 1963, Act 125, Eff. Sept. 6, 1963;—Am. 2017, Act 222, Imd. Eff. Dec. 20, 2017.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.364 Contract limitations; service classes; county residents.

Sec. 14. A dental care corporation, by its articles of incorporation or bylaws, may limit the care that it will furnish, and may divide such care as it elects to furnish into classes or kinds. A corporation by its bylaws may

limit the issuance of contracts to residents of certain counties.

History: 1963, Act 125, Eff. Sept. 6, 1963.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.365 Dentists; eligibility; agreements with corporation.

Sec. 15. A licensed dentist is eligible to render professional services to subscribers upon compliance with uniform requirements prescribed by the dental care corporation. At least 1/4 of the resident licensed dentists practicing in this state shall execute and maintain agreements with the corporation to render dental care to the subscribers of the corporation in order for the corporation to qualify and continue operating under this act.

History: 1963, Act 125, Eff. Sept. 6, 1963;—Am. 1990, Act 129, Imd. Eff. June 26, 1990.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.366 Subscriber-dentist relationship; choice of dentist; refusal to place name of dentist on register; removal of name from register.

Sec. 16. The relation between a subscriber or any of his or her dependents and a dentist shall be identical with the relation that ordinarily exists in the community between a dentist and his or her patient. Except as otherwise provided in section 16a, a dental care corporation, its officers, agents, or employees shall not interfere with or influence a patient's choice of his or her dentist, but a corporation may refuse to place the name of a dentist upon its register or remove the name of a dentist from its register, after due notice and hearing for cause satisfactory to the corporation.

History: 1963, Act 125, Eff. Sept. 6, 1963;—Am. 1984, Act 234, Eff. Dec. 20, 1984.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.366a Prudent purchaser agreements; rates; provisions inapplicable to certain contracts and renewal thereof.

Sec. 16a. (1) A dental care corporation may enter into prudent purchaser agreements with dentists pursuant to the prudent purchaser act.

(2) The rates charged by a corporation for coverage under contracts issued under this section shall not be unreasonably lower than what is necessary to meet the expenses of the corporation for providing this coverage and shall not have an anticompetitive effect or result in predatory pricing in relation to prudent purchaser agreement coverages offered by other organizations.

(3) Nothing in the 1984 amendatory act that added this section shall apply to any contract which was in existence before December 20, 1984, or the renewal of such contract.

History: Add. 1984, Act 234, Eff. Dec. 20, 1984;—Am. 1988, Act 281, Imd. Eff. July 27, 1988.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.367 Reserve funds; maintenance; investment.

Sec. 17. A dental care corporation, before beginning business and at all times while engaged in business, shall maintain reserves in such form and amount as the commissioner of insurance may determine. Reserve funds shall be invested only in securities permitted by the laws of this state for the investment of assets of life insurance companies.

History: 1963, Act 125, Eff. Sept. 6, 1963.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.368 Dental care to be in accordance with accepted dental practice.

Sec. 18. Dental care rendered by a dental care corporation shall at all times be in accordance with the accepted dental practice in the community in which the care was rendered. A corporation shall furnish dental care only through licensed dentists.

History: 1963, Act 125, Eff. Sept. 6, 1963;—Am. 1990, Act 129, Imd. Eff. June 26, 1990.

Compiler's note: For provisions of Act 122 of 1939, referred to in this section, see MCL 338.201 et seq.

For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.369 Dental care for needy and other persons; payments; contracts.

Sec. 19. A dental care corporation may receive from governmental or private agencies, corporations, associations, groups, or individuals, within or outside the state, payments covering all or part of the costs of subscriptions to provide dental care for needy and other persons. Contracts for dental care shall be between the corporation and the person to receive the care.

History: 1963, Act 125, Eff. Sept. 6, 1963;—Am. 1990, Act 129, Imd. Eff. June 26, 1990.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.369a Coordination of benefits.

Sec. 19a. If a group contract issued by a corporation contains a coordination of benefits provision, the benefits shall be payable pursuant to the coordination of benefits act.

History: Add. 1984, Act 70, Imd. Eff. Apr. 18, 1984.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.370 Dentist-patient relationship; civil actions.

Sec. 20. A civil action based upon or arising out of the dentist-patient relationship shall not be maintained against a dental care corporation.

History: 1963, Act 125, Eff. Sept. 6, 1963.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.371 Previously existing corporations merger; agreement, approval.

Sec. 21. A nonprofit corporation heretofore incorporated under Act No. 327 of the Public Acts of 1931, as amended, engaged in operations prior to the effective date of this act and offering dental care contracts to persons or groups by the terms of which contracts dental services by licensed dentists are made available to such persons or groups at the expense of such persons or groups, or at the expense of others on their behalf, under an agreed-upon fee schedule, may be merged into a dental care corporation organized under this act under such terms as shall be specified in an agreement of merger. The corporation organized under this act is the surviving corporation. A majority of directors or trustees of each corporation desiring to merge, may enter into and sign the agreement, under the corporate seals of the corporations, prescribing the terms and conditions of merger and the mode of carrying the same into effect. The agreement shall also state such other facts required or permitted by Act No. 327 of the Public Acts of 1931, as amended, as it applies to nonprofit corporation articles in the case of a merger, stated in such altered form as the circumstances of the case required. It shall also state the manner of converting the shares or memberships of each of the constituent corporations into shares or memberships of the surviving corporation, with such other details and provisions as are deemed necessary, including provisions as to conversion of contracts with subscribers. No vote or consent shall be required of the members or shareholders of either of the corporations and no notice need be given or published as otherwise required by the laws of this state relating to merger of corporations. The agreement shall be effective upon the date of its approval by and filing with the commissioner of insurance and filing by the Michigan corporation and securities commission, whichever is later.

History: 1963, Act 125, Eff. Sept. 6, 1963.

Compiler's note: For provisions of Act 327 of 1931, referred to in this section, see MCL 450.1 et seq.

For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.372 Dental care corporations; tax exemption.

Sec. 22. A corporation subject to the provisions of this act is declared to be a charitable and benevolent institution, and its funds and property shall be exempt from taxation by the state, or any political subdivision.

History: 1963, Act 125, Eff. Sept. 6, 1963.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the

commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.373 False statement; penalty.

Sec. 23. Any person, or any agent or officer of a corporation, who violates any of the provisions of this act or who makes a false statement with respect to any report or statement required by this act is guilty of a misdemeanor.

History: 1963, Act 125, Eff. Sept. 6, 1963.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

NONPROFIT HOSPITAL SERVICE CORPORATIONS
Act 109 of 1939

550.501-550.517 Repealed. 1980, Act 350, Eff. Apr. 3, 1981.

Compiler's note: Prior to April 3, 1981, the effective date of Act 350 of 1980, Blue Cross & Blue Shield of Michigan brought a complaint for declaratory judgment challenging the constitutionality of the act and sought an injunction against the act's enforcement in the Ingham County Circuit Court. On April 2, 1981, the Ingham County Circuit Court enjoined the enforcement of the act and further ordered the parties to comply with the existing enabling acts, Acts 108 and 109 of 1939. Blue Cross & Blue Shield of Michigan v Governor, 422 Mich 1; 367 NW2d 1, appdis, 474 US 805, 106 S Ct 40; 88 L Ed 2d 33 (1985).

During the period when enforcement of Act 350 of 1980 was enjoined by the Ingham County Circuit Court, Act 108 was amended by Acts 142, 199, and 232 of 1982 and by Acts 67, 180, 194, 231, and 370 of 1984 and Act 109 was amended by Acts 198 and 233 of 1982 and by Acts 68, 182, 195, 232, and 371 of 1984.

The Michigan Supreme Court in Blue Cross & Blue Shield of Michigan v Governor, 422 Mich at 97, ordered the Ingham County Circuit Court to dissolve the injunction against the enforcement of Acts 108 and 109 of 1939. An order dissolving the injunction was entered on August 28, 1985.

VIATICAL SETTLEMENT CONTRACTS
Act 386 of 1996

AN ACT to regulate the sale and purchase of viatical settlement contracts; to prescribe the powers and duties of certain state agencies and officials; and to prescribe penalties.

History: 1996, Act 386, Eff. Mar. 31, 1997.

The People of the State of Michigan enact:

550.521 Definitions.

Sec. 1. As used in this act:

(a) "Commissioner" means the commissioner of insurance.

(b) "Life insurance" means that term as defined in section 602 of the insurance code of 1956, Act No. 218 of the Public Acts of 1956, being section 500.602 of the Michigan Compiled Laws.

(c) "Physician" means a person licensed in this or another state to practice medicine or osteopathic medicine.

(d) "Policy" means an individual life insurance policy or a certificate under a group life insurance policy.

(e) "Provider" means a person who enters into a viatical settlement contract with a viator. Provider does not mean any of the following:

(*i*) A financial lending institution that takes a policy as collateral for a loan.

(*ii*) The issuer of a policy providing accelerated benefits under section 602 of Act No. 218 of the Public Acts of 1956.

(*iii*) An individual who enters into no more than 1 viatical settlement contract in a calendar year for the transfer of a policy for any value less than the expected death benefit.

(f) "Viatical settlement contract" or "contract" means a written agreement entered into between a provider and a viator in which the provider will pay consideration that is less than the expected death benefit of the viator's policy in return for the viator's assignment, transfer, sale, devise, or bequest of the death benefit or ownership of the policy to the provider.

(g) "Viator" means the owner or holder of a policy who has a terminal illness or condition and who enters into a viatical settlement contract.

History: 1996, Act 386, Eff. Mar. 31, 1997.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.522 Records; production; maintenance; availability for inspection; payment of expenses.

Sec. 2. (1) The commissioner may order a provider to produce records, books, files, or other information that is necessary to determine the qualifications of the provider or whether the provider is or has acted in violation of this act.

(2) The provider shall maintain records of all transactions of contracts and make the records available to the commissioner for inspection during reasonable business hours.

(3) The provider shall pay the expenses incurred in conducting an examination under this section.

History: 1996, Act 386, Eff. Mar. 31, 1997.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.523 Disclosure of information.

Sec. 3. A provider shall disclose all of the following information to the viator no later than the date the contract is signed by the viator:

(a) Options other than the contract for a person with a terminal illness or condition, including accelerated benefits offered by the issuer of the policy.

(b) That some or all of the contract consideration may be taxable, and that assistance should be sought from a personal tax advisor.

(c) That the contract consideration could be subject to the claims of creditors.

(d) That receipt of the contract consideration may adversely affect the viator's eligibility for government benefits or entitlements.

(e) The viator's right to rescind the contract within 30 days after the date the contract is executed or within 15 days after the receipt of the contract consideration by the viator, whichever is less.

(f) The date by which the contract consideration will be available to the viator and the source of the consideration.

History: 1996, Act 386, Eff. Mar. 31, 1997.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.524 Documents to be obtained by provider; right to avoid or rescind contract.

Sec. 4. (1) A provider entering into a contract with a viator shall obtain both of the following:

(a) A written statement from a physician that the viator is of sound mind and under no constraint or undue influence.

(b) A signed document by the viator stating:

(*i*) Consent to the contract.

(*ii*) Acknowledgment of the terminal illness or condition.

(*iii*) Representation that the viator has a full and complete understanding of the contract.

(*iv*) Representation that the viator has a full and complete understanding of the benefits of the policy.

(*v*) A release of the medical records and acknowledgment that the contract has been entered into freely and voluntarily. The provider shall keep all medical records received under this subparagraph confidential.

(2) A viatical settlement contract entered into in this state shall contain a provision giving the viator the right to void the contract for at least 30 days after the date the contract is signed, or 15 days after the receipt of the viatical settlement contract consideration, whichever is less. The provider shall notify the insurer of the policy of a rescission within 30 days of the date that a contract is rescinded under this subsection.

History: 1996, Act 386, Eff. Mar. 31, 1997.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.524a Agreement to commit suicide; payment prohibited.

Sec. 4a. A provider shall not offer to provide or provide any payment to a viator that is conditioned on the viator's agreement to commit suicide.

History: Add. 1999, Act 163, Imd. Eff. Nov. 4, 1999.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.525 Disposition of contract consideration.

Sec. 5. (1) Upon receipt from the viator of the documents to effect the transfer of the policy, the provider shall deposit the contract consideration in an escrow or trust account managed by a state or federal chartered financial institution, pending acknowledgment of the transfer by the issuer of the policy. The financial institution shall transfer the contract consideration to the viator immediately upon receipt of acknowledgment of the transfer from the insurer.

(2) Failure by the provider to tender the contract consideration as required by this act renders the contract void.

History: 1996, Act 386, Eff. Mar. 31, 1997.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.526 Double or additional indemnity.

Sec. 6. If a policy provides for double or additional indemnity in case of accidental death and accidental death occurs, the provider shall be entitled only to the face amount of the policy. Any amounts payable under the policy that exceed the face amount shall be paid to the beneficiary designated by the viator or, if no beneficiary has been designated, to the viator's estate.

History: 1996, Act 386, Eff. Mar. 31, 1997.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.527 Offer to purchase policy or certificate; notice to insurer.

Sec. 7. An offer to purchase a life insurance policy or certificate from the viator shall be transmitted to the

insurer providing the life insurance policy, who may advise the viator of other alternatives which may be available under the policy. The notice required by this section shall be transmitted by the provider of the viatical settlement contract.

History: 1996, Act 386, Eff. Mar. 31, 1997.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.528 Order prohibiting provider from entering viatical settlement contract; additional orders.

Sec. 8. (1) The commissioner may issue an order prohibiting the provider from entering into a viatical settlement contract in this state if the commissioner finds any of the following:

(a) The provider has been fraudulent or engaged in dishonest practices.

(b) The provider demonstrates a pattern of unreasonable payments to policy owners.

(c) The provider has been convicted of a felony or any misdemeanor that involved criminal fraud.

(d) The provider has violated a provision of this act.

(2) In addition to the order under subsection (1), the commissioner may order any of the following:

(a) Payment of a civil fine of not more than $500.00 for each violation.

(b) If the provider knew or reasonably should have known that the provider was in violation of this act, the repayment of all consideration paid by or on behalf of a viator for a viatical settlement contract affected by the violation and a civil fine of not more than $2,500.00 for each violation.

(c) A cease and desist order.

History: 1996, Act 386, Eff. Mar. 31, 1997;—Am. 1997, Act 189, Imd. Eff. Dec. 30, 1997.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

ABORTION INSURANCE OPT-OUT ACT
Act 182 of 2013

550.541-550.551 Repealed. 2023, Act 286, Eff. Feb. 13. 2024.

Compiler's note: Enacting section 1 of Act 182 of 2013 provides:

"Enacting Section 1. If any part or parts of this act are found to be in conflict with the state constitution of 1963, the United States constitution, or federal law, this act shall be implemented to the maximum extent that the state constitution of 1963, the United States constitution, and federal law permit. Any provision held invalid or inoperative shall be severable from the remaining portions of this act."

Public Act 182 of 2013 was proposed by initiative petition pursuant to Const 1963, art II, § 9. On December 11, 2013, the initiative petition was approved by an affirmative vote of the majority of the Senate and the House of Representatives, and filed with the Secretary of State on December 12, 2013.

CREDIT INSURANCE ACT
Act 173 of 1958

AN ACT to provide for the regulation of credit life insurance and credit accident and health insurance; to define the powers and duties of the state commissioner of insurance; and to provide penalties for violations of this act.

History: 1958, Act 173, Eff. Sept. 13, 1958.

Compiler's note: For transfer of the Department of Insurance and Office of the Commissioner on Insurance from the Department of Licensing and Regulation to the Department of Commerce, see E.R.O. No. 1991-9, compiled at MCL 338.3501 of the Michigan Compiled Laws.

The People of the State of Michigan enact:

550.601 Credit insurance act; short title.

Sec. 1. This act shall be known and may be cited as "credit insurance act".

History: 1958, Act 173, Eff. Sept. 13, 1958.

Compiler's note: For transfer of the Department of Insurance and Office of the Commissioner on Insurance from the Department of Licensing and Regulation to the Department of Commerce, see E.R.O. No. 1991-9, compiled at MCL 338.3501 of the Michigan Compiled Laws.

For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.602 Scope of act.

Sec. 2. All life insurance and all accident and health insurance sold in connection with loans or other credit transactions shall be subject to the provisions of this act except such insurance sold in connection with loans on dwellings or mobile homes where the term of the loan is in excess of 5 years.

History: 1958, Act 173, Eff. Sept. 13, 1958;—Am. 1968, Act 97, Imd. Eff. June 7, 1968.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.603 Credit insurance act; definitions.

Sec. 3. As used in this act:

(1) "Credit life insurance" means insurance on the life of a debtor pursuant to or in connection with a specific loan or other credit transaction.

(2) "Credit accident and health insurance" means insurance on a debtor to provide indemnity for payments becoming due on a specific loan or other credit transaction while the debtor is disabled as defined in the policy.

(3) "Creditor" means the lender of money or vendor or lessor of goods, services, property, rights or privileges, for which payment is arranged through a credit transaction or any successor to the right, title or interest of any such lender, vendor or lessor.

(4) "Debtor" means a borrower of money or a purchaser or lessee of goods, services, property, rights or privileges for which payment is arranged through a credit transaction.

(5) "Indebtedness" means the total amount payable by a debtor to a creditor in connection with a loan or other credit transaction.

(6) "Commissioner" means state insurance commissioner.

History: 1958, Act 173, Eff. Sept. 13, 1958.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.604 Credit life insurance, credit accident and health insurance; forms.

Sec. 4. Credit life insurance and credit accident and health insurance shall be issued only in the following forms:

(a) Individual policies of life insurance issued to debtors on the term plan;

(b) Individual policies of accident and health insurance issued to debtors on a term plan or disability provisions in individual policies of credit life insurance;

(c) Group policies of life insurance issued to creditors providing insurance upon the lives of debtors on the term plan;

(d) Group policies of accident and health insurance issued to creditors on a term plan insuring debtors or disability provisions in group life policies to provide such coverage.

History: 1958, Act 173, Eff. Sept. 13, 1958.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.605 Credit life insurance; amount.

Sec. 5. The amount of credit life insurance shall not exceed the indebtedness. Where indebtedness repayable in substantially equal installments is secured by an individual policy of credit life insurance the amount of insurance shall not exceed the approximate unpaid indebtedness on the date of death and, where secured by a group policy of credit life insurance shall not exceed the exact amount of unpaid indebtedness on such date.

History: 1958, Act 173, Eff. Sept. 13, 1958.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.606 Periodic indemnity payable.

Sec. 6. The amount of periodic indemnity payable by credit accident and health insurance in the event of disability, as defined in the policy, shall not exceed the aggregate of the periodic scheduled unpaid installments of indebtedness and shall not exceed the original indebtedness divided by the number of periodic installments.

History: 1958, Act 173, Eff. Sept. 13, 1958.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.607 Term; refund on termination prior to expiration.

Sec. 7. The term of any credit life insurance or credit accident and health insurance shall commence, subject to acceptance by the insurer, on the date when the debtor becomes obligated to the creditor, except that, where a group policy provides coverage with respect to existing obligations, the insurance on a debtor with respect to such indebtedness shall commence on the effective date of the policy. The term of such insurance shall not extend more than 15 days beyond the scheduled maturity date of the indebtedness except when extended without additional cost to the debtor. If the indebtedness is discharged due to renewal or refinancing prior to the scheduled maturity date, the insurance in force shall be terminated before any new insurance may be issued in connection with the renewed or refinanced indebtedness. In all cases of termination prior to scheduled maturity, a refund shall be paid or credited as provided in section 18.

History: 1958, Act 173, Eff. Sept. 13, 1958.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.608 Evidence of insurance; policy or certificate delivery.

Sec. 8. All credit life insurance and credit accident and health insurance sold shall be evidenced by an individual policy, or in the case of group insurance by a certificate of insurance, which individual policy or group certificate of insurance shall be delivered to the debtor.

History: 1958, Act 173, Eff. Sept. 13, 1958.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.609 Policy or certificate; contents.

Sec. 9. Each individual policy or group certificate of credit life insurance, and credit accident and health insurance in addition to other requirements of law, shall set forth the name and home office address of the insurer, and the identity by name or otherwise of the person or persons insured, the amount of payment separately in connection with credit life insurance and credit accident and health insurance if an identifiable charge is made to the debtor, a description of the coverage including any exceptions, limitations or restrictions, and shall state that the benefits shall be paid to the creditor to reduce or extinguish the unpaid indebtedness and, wherever the amount of insurance may exceed the unpaid indebtedness, that any such

excess shall be payable to a beneficiary, other than the creditor, named by the debtor or to his estate.

History: 1958, Act 173, Eff. Sept. 13, 1958.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.610 Policy or certificate; delivery to debtor.

Sec. 10. The individual policy or group certificate of insurance shall be delivered to the insured debtor at the time the indebtedness is incurred except as hereinafter provided.

History: 1958, Act 173, Eff. Sept. 13, 1958.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.611 Policy or certificate; application, contents.

Sec. 11. If the individual policy or group certificate of insurance is not delivered to the debtor at the time the indebtedness is incurred, a copy of the application for such policy or a notice of proposed insurance, signed by the debtor and setting forth the name and home office address of the insurer, the name or names of the debtor, the rate of premium, or at the option of the creditor or debtor, the amount of payment separately in connection with credit life insurance and credit accident and health insurance coverage, and a brief description of the coverage provided, shall be delivered to the debtor at the time such indebtedness is incurred. The copy of the application for, or notice of proposed insurance shall refer exclusively to insurance coverage, and shall be separate and apart from the loan, sale or other credit statement of account, instrument or agreement unless the information required by this section is set forth therein. Upon acceptance of the insurance and within 30 days of the date upon which the indebtedness is incurred, the insurer shall cause the individual policy or group certificate of insurance to be delivered to the debtor. Said application or notice of proposed insurance shall state that, upon acceptance by the insurer, the insurance shall become effective as of the date the indebtedness is incurred.

History: 1958, Act 173, Eff. Sept. 13, 1958.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled MCL 445.2003 of the Michigan compiled laws.

550.612 Papers filed with commissioner of issuing state.

Sec. 12. All policies, certificates of insurance, notices of proposed insurance, applications for insurance, binder, endorsements and riders shall be filed with the commissioner of the state in which the policy is issued.

History: 1958, Act 173, Eff. Sept. 13, 1958.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.613 Papers filed with commissioner of issuing state; disapproval.

Sec. 13. The commissioner within 30 days after the filing of all policies, certificates of insurance, notices of proposed insurance, applications for insurance, binders, endorsements and riders, in addition to other requirements of law, may disapprove any such form if the benefits provided therein are not reasonable in relation to the premium charge or if it contains provisions which are unjust, unfair, inequitable, misleading, deceptive or encourage misrepresentation of such policy.

History: 1958, Act 173, Eff. Sept. 13, 1958.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.614 Papers filed with commissioner of issuing state; use, hearing, prior written approval.

Sec. 14. If the commissioner notifies the insurer that the form does not comply with this subsection, it is unlawful thereafter for such insurer to issue or use such form. In such notice, the commissioner shall specify the reason for his disapproval and state that a hearing will be granted within 20 days after request in writing by the insurer. No such policy, certificate of insurance, notice of proposed insurance, nor any application, binder, endorsement or rider, shall be issued or used until the expiration of 30 days after it has been so filed, unless the commissioner shall give his prior written approval thereto.

History: 1958, Act 173, Eff. Sept. 13, 1958.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.615 Papers filed with commissioner of issuing state; withdrawal of approval.

Sec. 15. The commissioner, at any time after a hearing, of not less than 20 days written notice to the insurer, may withdraw his approval of any such form on any of such grounds.

History: 1958, Act 173, Eff. Sept. 13, 1958.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.616 Papers filed with commissioner of issuing state; use after withdrawal of approval.

Sec. 16. It is not lawful for the insurer to issue such forms or use them after the effective date of such withdrawal of approval.

History: 1958, Act 173, Eff. Sept. 13, 1958.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.617 Papers filed with commissioner of issuing state; judicial review.

Sec. 17. Any order or final determination of the commissioner under the provisions of this section shall be subject to judicial review.

History: 1958, Act 173, Eff. Sept. 13, 1958.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.618 Schedule of premium rates; refunds; nonissuance credit.

Sec. 18. Each insurer issuing credit life insurance or credit accident and health insurance shall file with the commissioner its schedules of premium rates for use in connection with such insurance. Any insurer may revise such schedules from time to time, and shall file such revised schedules with the commissioner. No insurer shall issue any credit life insurance policy or credit accident and health insurance policy for which the premium rate exceeds that determined by the schedules of such insurer as then on file with the commissioner. The commissioner may require the filing of the schedule of premium rates for use in connection with and as a part of the specific policy filings as provided by sections 12 to 17. Each individual policy, group certificate or notice of proposed insurance of credit life insurance and credit accident and health insurance shall provide that in the event of termination of the insurance prior to the scheduled maturity date of the indebtedness, any refund of premium due shall be paid or credited promptly to the person entitled thereto: Provided, however, That the commissioner shall prescribe a minimum refund and no refund which would be less than such minimum need be made. The formula to be used in computing such refund shall be filed with the commissioner. If a creditor requires a debtor to make a payment in connection with credit life insurance and credit accident and health insurance and an individual policy or group certificate of insurance is not issued, the creditor shall immediately give written notice to such debtor and shall promptly make an appropriate credit to the account.

History: 1958, Act 173, Eff. Sept. 13, 1958.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.619 Policies issuable only by authorized insurers.

Sec. 19. All policies of credit life insurance and credit accident and health insurance shall be delivered or issued for delivery in this state only by an insurer authorized to do an insurance business therein, and shall be issued only through holders of licenses or authorizations issued by the commissioner.

History: 1958, Act 173, Eff. Sept. 13, 1958.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.620 Payment of claims; claim files; group insurance claims.

Sec. 20. All claims shall be promptly reported to the insurer or its designated claim representative, and the

insurer shall maintain adequate claim files. All claims shall be settled as soon as possible and in accordance with the terms of the insurance contract. All claims shall be paid either by draft drawn upon the insurer or by check of the insurer to the order of the claimant to whom payment of the claim is due pursuant to the policy provisions, or upon direction of such claimant to one specified. No plan or arrangement shall be used whereby any person, firm or corporation other than the insurer or its designated claim representative shall be authorized to settle or adjust claims. The creditor shall not be designated as claim representative for the insurer in adjusting claims; but a group policyholder, by arrangement with the group insurer, may draw drafts or checks in payment of claims due to the group policyholder subject to audit and review by the insurer.

History: 1958, Act 173, Eff. Sept. 13, 1958.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.621 Procurement of insurance by debtor.

Sec. 21. When credit life insurance or credit accident and health insurance is required as additional security for any indebtedness, the debtor, upon request to the creditor, shall have the option of furnishing the required amount of insurance through existing policies of insurance owned or controlled by him or of procuring and furnishing the required coverage through any insurer authorized to transact an insurance business within this state.

History: 1958, Act 173, Eff. Sept. 13, 1958.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.622 Rules; violation, notice of hearing, finding, order.

Sec. 22. The commissioner, after notice and hearing, may issue such rules and regulations in accordance with Act No. 88 of the Public Acts of 1943, as amended, being sections 24.71 to 24.82 of the Compiled Laws of 1948, and subject to Act No. 197 of the Public Acts of 1952, as amended, being sections 24.101 to 24.110 of the Compiled Laws of 1948, as he deems appropriate for the supervision of this act. Whenever the commissioner finds that there has been a violation of this act or any rules or regulations issued pursuant thereto, and after written notice thereof and hearing given to the insurer or other person authorized or licensed by the commissioner, he shall set forth the details of his findings together with an order for compliance by a specified date. The order shall be binding on the insurer and other person authorized or licensed by the commissioner on the date specified unless sooner withdrawn by the commissioner or a stay thereof has been ordered by a court of competent jurisdiction.

History: 1958, Act 173, Eff. Sept. 13, 1958.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

Administrative rules: R 500.2031 et seq. of the Michigan Administrative Code.

550.623 Violation; penalty; license or authority, suspension or revocation.

Sec. 23. In addition to any other penalty provided by law, any person who violates an order of the commissioner after it has become final, and while such order is in effect, shall, upon proof thereof to the satisfaction of the court, forfeit and pay to the state a sum not to exceed the $250.00 which may be recovered in a civil action, except that if such violation is found to be willful, the amount of such penalty shall be a sum not to exceed the $1,000.00. The commissioner, in his discretion, may revoke or suspend the license or certificate of authority of the person guilty of such violation.

History: 1958, Act 173, Eff. Sept. 13, 1958.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.624 Effect of act; scope of act.

Sec. 24. This act shall not alter or amend any provision of Act No. 21 of the Public Acts of 1939, as amended, being sections 493.1 to 493.26 of the Compiled Laws of 1948, or permit any premium, contribution or other charge to be collected for credit life or health and accident insurance in connection with loans made by licensees under said act: Provided, however, That if section 13 of said Act No. 21 of the Public Acts of 1939, as amended, is amended to permit licensees to collect premiums from borrowers for credit life insurance or credit health and accident insurance in addition to the maximum rate of charge authorized by said

section 13, this act shall apply to licensees as provided by such amendment to section 13.

History: 1958, Act 173, Eff. Sept. 13, 1958.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

STATE INSURANCE
Act 388 of 1913

AN ACT to provide for state insurance on state property and against liability arising or that may arise under certain laws.

History: 1913, Act 388, Eff. Aug. 14, 1913;—Am. 1980, Act 94, Imd. Eff. Apr. 16, 1980.

Compiler's note: For transfer of the Department of Insurance and Office of the Commissioner on Insurance from the Department of Licensing and Regulation to the Department of Commerce, see E.R.O. No. 1991-9, compiled at MCL 338.3501 of the Michigan Compiled Laws.

The People of the State of Michigan enact:

550.701 Insurance of state property; determination; approval; bids; purchase of deductible or catastrophe insurance; payment of premiums.

Sec. 1. (1) An officer or agent of this state or a person or persons having charge of a state owned and state used building or property of the state shall not pay out any public moneys or funds on account of an insurance against loss by fire, lightning, windstorm, explosion, riot, riot attending a strike, civil commotion, falling aircraft, hail, except this does not apply to growing crops, and smoke, caused from faulty operation of a heating plant using oil or gas fuel, or shall not in any manner contract for or incur an indebtedness against the state on account of an insurance upon any of the buildings, furniture, fixtures, or property of any kind belonging to the state, or against liability arising or that may arise under Act No. 317 of the Public Acts of 1969, as amended, being sections 418.101 to 418.941 of the Michigan Compiled Laws, except in a manner provided in this act. If a state agency which has charge of the property determines that state owned properties in a single building represent an abnormal concentration of values, or are without adequate fire protection, or are highly combustible or highly inflammable, the director of the department of management and budget, after review, approval, or modification of the determination by the state agency, and after approval by the state administrative board, shall arrange for the insurance of the property against the perils named in this section in companies authorized to operate in the state.

(2) The state administrative board, after an investigation as it considers necessary, may direct the director of the department of management and budget to call for bids and purchase deductible or catastrophe fire, lightning, windstorm, explosion, riot, riot attending a strike, civil commotion, falling aircraft, hail, and smoke insurance, covering any or all state property, with insurance companies duly authorized to do business in this state. An amount sufficient to pay the premiums on all insurance authorized to be purchased from private companies under this section is appropriated from the applicable fund.

History: 1913, Act 388, Eff. Aug. 14, 1913;—CL 1915, 9268;—CL 1929, 12680;—Am. 1945, Act 314, Imd. Eff. May 25, 1945;—Am. 1946, 1st Ex. Sess., Act 28, Imd. Eff. Feb. 26, 1946;—Am. 1947, Act 173, Eff. Oct. 11, 1947;—Am. 1948, 1st Ex. Sess., Act 40, Imd. Eff. May 10, 1948;—CL 1948, 550.701;—Am. 1951, Act 197, Imd. Eff. June 8, 1951;—Am. 1965, Act 365, Imd. Eff. July 23, 1965;—Am. 1980, Act 94, Imd. Eff. Apr. 16, 1980.

Compiler's note: For transfer of the Department of Insurance and Office of the Commissioner on Insurance from the Department of Licensing and Regulation to the Department of Commerce, see E.R.O. No. 1991-9, compiled at MCL 338.3501 of the Michigan Compiled Laws.

For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.702, 550.703 Repealed. 1965, Act 365, Imd. Eff. July 23, 1965.

Compiler's note: The repealed sections provided for state insurance fund and for investment of moneys therein.

550.704 Loss in case of damage; fixing amount.

Sec. 4. In case any buildings or property of the state other than those insured under the provisions of section 1 shall be damaged by fire, lightning, windstorm, explosion, riot, riot attending a strike, civil commotion, falling aircraft, hail (except growing crops) and smoke, caused from faulty operation of a heating plant using oil or gas fuel the controller, within 30 days or as soon as possible thereafter, shall ascertain and fix the amount of such damage. The ascertained amount of such damage shall in no case be less than the amount necessary to rebuild, repair or replace the property so damaged.

History: 1913, Act 388, Eff. Aug. 14, 1913;—CL 1915, 9271;—CL 1929, 12683;—Am. 1945, Act 314, Imd. Eff. May 25, 1945;—CL 1948, 550.704;—Am. 1965, Act 365, Imd. Eff. July 23, 1965.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance

services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.705 Loss in case of damage; payment, release of additional amounts necessary to rebuild or restore.

Sec. 5. When the amount of loss has been fixed and determined to be $50,000.00 or less by the controller, the amount so determined is appropriated in the applicable fund to be used by the state administrative board, for the rebuilding or restoring of the property damaged, and to be disbursed in such manner as other state funds are paid out. If during the rebuilding or restoring of such property damaged it shall be necessary in the opinion of the state administrative board to expend any additional amounts over and above the amounts certified by the controller, an additional amount equal to 10% of such previously determined amount is appropriated, but in no case to exceed $50,000.00 to be paid out in the same manner as provided for the payments made from the original appropriation. When the amount of loss has been fixed and determined to be more than $50,000.00, not to exceed a total of $5,000.00 is appropriated to be used under the supervision of the state administrative board for preliminary expenses connected with the loss, to be disbursed in such manner as other state funds are paid out. No payment in excess of $5,000.00 for any such loss shall be made until authorized and provided for by either the legislature or the special commission on appropriations created under the provisions of Act No. 120 of the Public Acts of 1937, as amended, being sections 5.1 to 5.5 of the Compiled Laws of 1948.

History: 1913, Act 388, Eff. Aug. 14, 1913;—CL 1915, 9272;—CL 1929, 12684;—Am. 1945, Act 314, Imd. Eff. May 25, 1945;—CL 1948, 550.705;—Am. 1955, Act 203, Imd. Eff. June 17, 1955;—Am. 1965, Act 365, Imd. Eff. July 23, 1965.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.706 Repealed. 1993, Act 199, Eff. Dec. 28, 1994.

Compiler's note: The repealed section pertained to determination of assessments by state accident fund.

550.707, 550.708 Repealed. 1965, Act 365, Imd. Eff. July 23, 1965.

Compiler's note: The repealed sections pertained to duties of commissioner of insurance in administering state insurance act.

550.709 Self-liquidation projects exempted; applicability of act.

Sec. 9. The provisions of this act shall not have application to any structure, building, or the contents thereof, acquired, purchased or erected as self-liquidating projects pursuant to the terms of Act No. 15 of the Public Acts of 1937, as amended, being sections 390.451 to 390.456, inclusive, of the Compiled Laws of 1948, or Act No. 9 of the Public Acts of the Extra Session of 1938, as amended, being sections 390.371 to 390.375, inclusive, of the Compiled Laws of 1948, where the state board of education or the board of control of Michigan college of mining and technology has arranged for insuring such property against the perils designated in section 1 hereof in companies authorized to operate in the state of Michigan, in such amounts as such board shall deem adequate.

History: Add. 1949, Act 100, Eff. Sept. 23, 1949.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.710 Election of coverage.

Sec. 10. An institution, agency, authority or instrumentality of the state which, under the constitution or laws of the state, has control and direction of the expenditures of its funds may elect to be covered under the provisions of this act.

History: Add. 1965, Act 365, Imd. Eff. July 23, 1965.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.711 State insurance fund abolished; reversion of funds.

Sec. 11. The state insurance fund is abolished on June 30, 1965, and any unencumbered balance in the fund at that time shall revert to the several state funds in the same proportion as the last previous premium assessments against such funds.

History: Add. 1965, Act 365, Imd. Eff. July 23, 1965.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance

services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

REPAIR OF DESTROYED STATE PROPERTY
Act 176 of 1895

550.801-550.805 Repealed. 1965, Act 318, Imd. Eff. July 22, 1965.

PHARMACY BENEFIT MANAGER LICENSURE AND REGULATION ACT
Act 11 of 2022

AN ACT to license and regulate pharmacy benefit managers; to require reporting of certain data; to provide for the powers and duties of certain state governmental officers and entities; to provide remedies; to require the promulgation of rules; and to require and to provide sanctions for violation of this act.

History: 2022, Act 11, Eff. Jan. 1, 2024.

The People of the State of Michigan enact:

550.811 Short title.

Sec. 1. This act may be cited as the "pharmacy benefit manager licensure and regulation act".

History: 2022, Act 11, Eff. Jan. 1, 2024.

550.815 Definitions; A to I.

Sec. 5. As used in this act:

(a) "Affiliated pharmacy" means, except as otherwise provided in this subdivision, a network pharmacy that directly, or indirectly through 1 or more intermediaries, controls, is controlled by, or is under common control with, a pharmacy benefit manager. As used in section 19, affiliated pharmacy does not include a pharmacy that controls, is controlled by, or is under common control with, a hospital as that term is defined in section 20106 of the public health code, 1978 PA 368, MCL 333.20106.

(b) "Aggregate retained rebate percentage" means the percentage of all rebates received by a pharmacy benefit manager from all manufacturers, that is not passed on to the pharmacy benefit manager's Michigan health plan or insurer clients. Aggregate retained rebate percentage must be expressed without disclosing any identifying information regarding any health plan, drug, or therapeutic class, and must be calculated as follows:

(*i*) Calculate the aggregate dollar amount of all rebates that the pharmacy benefit manager received during the prior calendar year from all manufacturers and did not pass through to the pharmacy benefit manager's Michigan health plan or insurer clients.

(*ii*) Divide the result of the calculation under subparagraph (*i*) by the aggregate dollar amount of all rebates that the pharmacy benefit manager received during the prior calendar year from all manufacturers.

(c) "Carrier" means that term as defined in section 3701 of the insurance code of 1956, 1956 PA 218, MCL 500.3701.

(d) "Claim" means a request for payment for administering, filling, or refilling a drug or for providing a pharmacy service or a medical supply or device to an enrollee.

(e) "Claims processing services" means the administrative services performed in connection with the processing and adjudicating of claims relating to pharmacist services that include any of the following:

(*i*) Receiving payments for pharmacist services.

(*ii*) Making payments to pharmacists or pharmacies for pharmacist services.

(*iii*) Receiving and making the payments described in subparagraphs (*i*) and (*ii*).

(f) "Covered person" means a person that is insured in a health plan.

(g) "Department" means the department of insurance and financial services.

(h) "Director" means the director of the department.

(i) "Enrollee" means that term as defined in section 116 of the insurance code of 1956, 1956 PA 218, MCL 500.116.

(j) "Financially viable" means that 1 of the following conditions is met:

(*i*) The pharmacy benefit manager has received an unqualified opinion from an independent public accountant showing it is solvent based on generally accepted accounting principles.

(*ii*) If no independent public accountant opinion is obtained, the pharmacy benefit manager remains solvent after adjusting for goodwill and intangible assets.

(k) "Health plan" means a qualified health plan as that term is defined in section 1261 of the insurance code of 1956, 1956 PA 218, MCL 500.1261.

(*l*) "Individual responsible for the conduct of affairs of the pharmacy benefit manager" means any of the following:

(*i*) A member of the board of directors, board of trustees, executive committee, or other governing board or committee.

(*ii*) A principal officer for a corporation or a partner or member for a partnership, association, or limited liability company.

(*iii*) A shareholder or member holding directly or indirectly 10% or more of the voting stock, voting securities, or voting interest of the pharmacy benefit manager.

(*iv*) Any person who exercises control over the affairs of the pharmacy benefit manager.

(m) "Insurer" means an insurer that delivers, issues for delivery, or renews in this state a health plan that provides drug coverage under the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302.

History: 2022, Act 11, Eff. Jan. 1, 2024.

550.817 Definitions; M to P.

Sec. 7. As used in this act:

(a) "Mail-order pharmacy" means a pharmacy whose primary business is to receive prescriptions by mail, fax, or through electronic submissions, dispense drugs to enrollees through the use of the United States Postal Service or other common carrier services, and provide consultation with patients electronically rather than face-to-face.

(b) "Manufacturer" means that term as defined in section 17706 of the public health code, 1978 PA 368, MCL 333.17706.

(c) "Maximum allowable cost" means the maximum amount that a pharmacy benefit manager will reimburse a network pharmacy for the ingredient cost for a generic drug.

(d) "Maximum allowable cost list" means a listing of drugs used by a pharmacy benefit manager, directly or indirectly, to set the maximum allowable cost.

(e) "Multiple source drug" means a therapeutically equivalent drug that is available from 1 or more of the following:

(*i*) At least 1 brand-named manufacturer and at least 1 generic manufacturer.

(*ii*) Two or more generic manufacturers.

(f) "Network pharmacy" means a retail pharmacy or other pharmacy that contracts directly or through a pharmacy services administration organization with a pharmacy benefit manager.

(g) "Nonaffiliated pharmacy" means a network pharmacy that directly, or indirectly through 1 or more intermediaries, does not control, is not controlled by, and is not under common control with, a pharmacy benefit manager.

(h) "Person" means an individual, partnership, corporation, association, governmental entity, or any other legal entity.

(i) "Pharmacist" means that term as defined in section 17707 of the public health code, 1978 PA 368, MCL 333.17707.

(j) "Pharmacist services" means products, goods, and services, or any combination of products, goods, and services, provided as a part of the practice of pharmacy.

(k) "Pharmacy" means that term as defined in section 17707 of the public health code, 1978 PA 368, MCL 333.17707.

(*l*) Except as otherwise provided in subdivision (m), "pharmacy benefit manager" means an entity that contracts with a pharmacy or a pharmacy services administration organization on behalf of a health plan or carrier to provide pharmacy health services to individuals covered by the health plan or carrier or administration that includes, but is not limited to, any of the following:

(*i*) Contracting directly or indirectly with pharmacies to provide drugs to enrollees or other covered persons.

(*ii*) Administering a drug benefit.

(*iii*) Processing or paying pharmacy claims.

(*iv*) Creating or updating drug formularies.

(*v*) Making or assisting in making prior authorization determinations on drugs.

(*vi*) Administering rebates on drugs.

(*vii*) Establishing a pharmacy network.

(m) "Pharmacy benefit manager" does not include the department of health and human services, a carrier, or an insurer.

(n) "Pharmacy benefit manager network" means a network of pharmacists or pharmacies that are offered by an agreement or contract to provide pharmacist services.

(o) "Pharmacy services administration organization" means an entity that provides contracting and other administrative services relating to prescription drug benefits to pharmacies.

(p) "Plan sponsor" means that term as defined in section 7705 of the insurance code of 1956, 1956 PA 218, MCL 500.7705.

(q) "Practice of pharmacy" means that term as defined in section 17707 of the public health code, 1978 PA 368, MCL 333.17707.

(r) "Preferred pharmacy" means a network pharmacy that offers covered drugs to health plan members at lower out-of-pocket costs than what the member would pay at a nonpreferred network pharmacy.

History: 2022, Act 11, Eff. Jan. 1, 2024.

550.819 Definitions; R to W.

Sec. 9. As used in this act:

(a) "Rebate" means a formulary discount or remuneration attributable to the use of prescription drugs that is paid by a manufacturer or third party, directly or indirectly, to a pharmacy benefit manager after a claim has been adjudicated at a pharmacy. Rebate does not include a fee, including, but not limited to, a bona fide service fee or administrative fee, that is not a formulary discount or remuneration described in this subdivision.

(b) "Retail pharmacy" means a pharmacy that dispenses prescription drugs to the public at retail primarily to individuals that reside in close proximity to the pharmacy, typically by face-to-face interaction with the individual or the individual's caregiver.

(c) "Rule" means a rule promulgated under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328.

(d) "Specialty drug" means a drug that provides treatment for serious, chronic, or life-threatening diseases that is covered under a patient's health plan or by a patient's carrier to which any of the following apply:

(*i*) The cost of the drug exceeds the drug cost threshold established by the Centers for Medicare and Medicaid Services under the Medicare Part D program.

(*ii*) The drug requires special administration, including, but not limited to, injection, infusion, or inhalation.

(*iii*) The drug requires unique storage, handling, or distribution.

(*iv*) The drug requires special oversight, intensive monitoring, complex education and support, or care coordination with a person licensed under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838.

(e) "Specialty pharmacy" means a pharmacy that dispenses specialty drugs to patients and that is nationally accredited by an independent third party.

(f) "Spread pricing" means the model of prescription drug pricing in which a pharmacy benefit manager charges a health plan a contracted price for prescription drugs, and the contracted price for the prescription drugs differs from the amount the pharmacy benefit manager directly or indirectly pays the pharmacist or pharmacy for pharmacist services.

(g) Except as otherwise provided in subdivision (h), "third party" means a person that is not an enrollee or insured in a health plan.

(h) "Third party" does not include a pharmacy benefit manager.

(i) "Wholesale distributor" means that term as defined in section 17709 of the public health code, 1978 PA 368, MCL 333.17709.

History: 2022, Act 11, Eff. Jan. 1, 2024.

550.821 Pharmacy benefit manager; licensure; application requirements; modification notice; grounds for refusal, revocation, denial, or suspension; fines; notice and hearings; investigation of officers, directors and owners; renewal.

Sec. 11. (1) A pharmacy benefit manager that provides services to residents of this state shall apply for, obtain, and maintain a license to operate as a pharmacy benefit manager from the director. A license under this act is renewable biennially and is nontransferable.

(2) Subject to this section, an applicant for a license to operate in this state as a pharmacy benefit manager shall submit to the director both of the following:

(a) An application in a form and manner prescribed by the director that is signed by an officer or individual responsible for the conduct or affairs of the pharmacy benefit manager verifying that the contents of the application form and any attachments are correct. The application form must include, but is not limited to, all of the following:

(*i*) A copy of all basic organizational documents of the pharmacy benefit manager, including, but not limited to, the articles of incorporation, bylaws, articles of association, trade name certificate, and other similar documents and all amendments to those documents.

(*ii*) A copy of a power of attorney duly executed by the pharmacy benefit manager if not domiciled in this state, appointing the director, the director's successors in office, and the director's authorized deputies as the attorney of the pharmacy benefit manager in and for this state, on whom process in any legal action or proceeding against the pharmacy benefit manager on a cause of action arising in this state may be served.

(*iii*) The names, addresses, official positions, and professional qualifications of each individual who is

responsible for the conduct of the affairs of the pharmacy benefit manager.

(*iv*) A copy of recent financial statements showing the pharmacy benefit manager's assets, liabilities, and sources of financial support that the director determines are sufficient to show that the pharmacy benefit manager is financially viable. If the pharmacy benefit manager's financial statements are prepared by an independent public accountant, a copy of the most recent regular financial statement satisfies the requirement to show financial viability unless the director determines that additional or more recent financial information is required for the proper administration of this act.

(*v*) A description of the pharmacy benefit manager, its services, facilities, and personnel.

(*vi*) A document in which the pharmacy benefit manager confirms that its business practices and each ongoing contract comply with this act.

(b) An application fee as provided by the director by rule.

(3) Within 30 days after any significant modification of information submitted with the application for a license under subsection (2), a pharmacy benefit manager shall file a notice of the modification with the director.

(4) The director may refuse to issue a license under this act if the director determines that the pharmacy benefit manager is not financially viable or that the pharmacy benefit manager or any individual responsible for the conduct of the affairs of the pharmacy benefit manager has had a pharmacy benefit manager certificate of authority or license denied or revoked for cause in another state.

(5) The director may deny, suspend, or revoke the license of a pharmacy benefit manager, or may issue a cease and desist order if the pharmacy benefit manager is not licensed, if the director finds, after notice and opportunity for hearing, any of the following:

(a) That the pharmacy benefit manager has violated any lawful rule or order of the director or any law of this state applicable to the pharmacy benefit manager.

(b) That the pharmacy benefit manager has refused to be examined or to produce its accounts, records, and files for examination, or if any individual responsible for the conduct of affairs of the pharmacy benefit manager has refused to give information with respect to its affairs or has refused to perform any other legal obligation as to an examination when required by the director.

(c) That the pharmacy benefit manager has, without just cause, refused to pay proper claims or perform services arising under its contracts or has, without just cause, caused covered persons or enrollees to accept less than the amount due them or caused covered persons or enrollees to employ attorneys or bring suit against the pharmacy benefit manager or a payor that it represents to secure full payment or settlement of the claims.

(d) That the pharmacy benefit manager is required under this act to have a license and fails at any time to meet any qualification for which issuance of a license could have been refused had the failure then existed and been known to the director, unless the director issued a license with knowledge of the ground for disqualification and had the authority to waive it.

(e) That any individual responsible for the conduct of affairs of the pharmacy benefit manager has been convicted of, or has entered a plea of guilty or nolo contendere to, a felony without regard to whether adjudication was withheld.

(f) That the pharmacy benefit manager's license has been suspended or revoked in another state.

(g) That a pharmacy benefit manager has failed to file a timely transparency report required under section 23.

(6) If a pharmacy benefit manager's license is suspended or restricted, the director may permit the operation of the pharmacy benefit manager for a limited time not to exceed 60 days. However, the director may permit a pharmacy benefit manager whose license has been suspended or restricted to operate for a period that exceeds 60 days if the director determines that the continued operation of the pharmacy benefit manager is in the beneficial interests of covered persons by ensuring minimal disruptions to the continuity of care. A pharmacy benefit manager whose license has been suspended or restricted is subject to a fine each month, as determined by the director, not to exceed $20,000.00 per month, until the pharmacy benefit manager has remedied the violation leading to the suspension or restriction.

(7) The director may revoke the license of a pharmacy benefit manager if the pharmacy benefit manager has been operating under a suspended license for a period of more than 60 days.

(8) For purposes of this section, a pharmacy benefit manager has the same rights to notice and hearings that are provided to an insurer under the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302.

(9) The director may investigate officers, directors, and owners of a pharmacy benefit manager in the same manner as officers, directors, and owners of a business entity licensed under the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302.

(10) To renew a license as a pharmacy benefit manager, an applicant shall submit to the director all of the

following:

(a) A renewal application in a form and manner prescribed by the director that is signed by an officer or authorized representative of the pharmacy benefit manager verifying that the contents of the renewal form are correct.

(b) A renewal schedule and fee as provided by the director by rule.

(c) A retail pharmacy benefit manager network adequacy report required under section 17.

(11) A pharmacy benefit manager license expires if a complete renewal filing and fee is not received by the due date as established in rule by the director.

History: 2022, Act 11, Eff. Jan. 1, 2024.

550.823 Promulgation of rules.

Sec. 13. (1) The director shall promulgate rules that are necessary or required to implement this act.

(2) The rules promulgated by the director under subsection (1) must include fines, suspension of licensure, restriction of licensure, and revocation of licensure in accordance with this act.

History: 2022, Act 11, Eff. Jan. 1, 2024.

550.825 Contractual responsibilities; conflict of interest; exception for certain audits.

Sec. 15. (1) A pharmacy benefit manager shall exercise good faith and fair dealing in the performance of its contractual duties to a health plan or network pharmacy. A provision in a contract that attempts to waive or limit the obligation under this subsection is void.

(2) A pharmacy benefit manager shall notify a health plan in writing of any activity, policy, or practice of the pharmacy benefit manager that directly or indirectly presents a conflict of interest with the duties imposed in this section.

(3) A pharmacy benefit manager shall not directly or indirectly, including indirectly through a pharmacy services administrative organization, charge or hold a pharmacist or pharmacy responsible for a fee related to a claim or reduce the amount of the claim at the time of the claim's adjudication or after the claim is adjudicated.

(4) This section does not apply to an audit under section 28 of a pharmacy's records if either of the following applies:

(a) The review of claims data or statements indicates fraud, abuse, other intentional misconduct, or waste.

(b) An investigative method, other than a review described in subdivision (a), indicates that the pharmacy is or has committed fraud or other intentional misrepresentation.

(5) Except for the recoupment of money under an audit conducted under section 28, a pharmacy benefit manager shall not recoup money from a pharmacist or pharmacy in connection with a claim for which the pharmacist or pharmacy has been paid unless the recoupment is required by law.

History: 2022, Act 11, Eff. Jan. 1, 2024.

550.827 Pharmacy benefit manager network; report; waiver; prohibition on spread pricing and fees for electronic processing.

Sec. 17. (1) A pharmacy benefit manager shall provide a reasonably adequate and accessible retail pharmacy benefit manager network for the provision of drugs for a health plan that must provide for convenient enrollee access to pharmacies within a reasonable distance from an enrollee's residence, as determined by the director. For purposes of this subsection, retail pharmacy benefit manager network does not include a mail-order pharmacy or specialty pharmacy.

(2) A pharmacy benefit manager shall submit to the director a retail pharmacy benefit manager network adequacy report that describes the retail pharmacy benefit manager network and the retail pharmacy benefit manager network's accessibility in this state. The report must categorize the network by urban, suburban, and rural geography and must include the applicable zip codes.

(3) A pharmacy benefit manager may apply for a waiver from the director if the pharmacy benefit manager is unable to meet the network adequacy requirements under subsection (1).

(4) To apply for a waiver under subsection (3), a pharmacy benefit manager must submit to the director an application in a form and manner prescribed by the director that does both of the following:

(a) Demonstrates with specific data why the pharmacy benefit manager is not able to meet the network adequacy requirements under subsection (1).

(b) Includes information as to the steps that the pharmacy benefit manager has taken and will take to address network adequacy.

(5) If the director grants a waiver under subsection (3), the waiver expires after 2 years. If a pharmacy benefit manager seeks a renewal of the waiver, the director must consider the steps that the pharmacy benefit

manager has taken over the 2-year period covered by the waiver to address network adequacy.

(6) A pharmacy benefit manager shall not conduct spread pricing in this state. However, if a contract between a plan sponsor and a health plan is in effect on the effective date of this act and the contract conflicts with this subsection, for that contract, this subsection applies to the pharmacy benefit manager beginning on the date the contract is amended, extended, or renewed, or before January 1, 2028, whichever is earlier.

(7) A pharmacy benefit manager shall not charge a pharmacy or pharmacist a fee to process a claim electronically.

History: 2022, Act 11, Eff. Jan. 1, 2024.

550.829 Prohibited conduct.

Sec. 19. (1) A pharmacy benefit manager shall not discriminate against a nonaffiliated pharmacy that is a retail pharmacy.

(2) A pharmacy benefit manager shall not impose limits, including quantity limits or refill frequency limits, on an enrollee's access to retail prescription drugs that differ based solely on whether the pharmacy benefit manager has an ownership interest in a pharmacy or the pharmacy has an ownership interest in the pharmacy benefit manager.

(3) A pharmacy benefit manager or carrier shall not prohibit a 340B Program entity or a pharmacy that has a license in good standing in this state under contract with a 340B Program entity from participating in the pharmacy benefit manager's or carrier's provider network solely because it is a 340B Program entity or a pharmacy under contract with a 340B Program entity. A pharmacy benefit manager or carrier shall not reimburse a 340B Program entity or a pharmacy under contract with a 340B Program entity differently than other similarly situated pharmacies. As used in this subsection, "340B Program entity" means an entity authorized to participate in the federal 340B Program under section 340B of the public health service act, 42 USC 256b.

(4) Unless required by applicable law or as required under Medicaid by the department of health and human services, a carrier, health plan, or pharmacy benefit manager shall not require an enrollee or covered person to use only an affiliated pharmacy that is a retail pharmacy.

(5) A carrier, health plan, pharmacy, or pharmacy benefit manager shall not financially induce an enrollee or covered person or prescriber to transfer an enrollee or covered person prescription to a retail affiliated pharmacy. As used in this subsection, "prescriber" means that term as defined in section 17708 of the public health code, 1978 PA 368, MCL 333.17708.

(6) A carrier, health plan, or pharmacy benefit manager shall not require a retail nonaffiliated pharmacy to transfer an enrollee's or covered person's retail prescription to a retail affiliated pharmacy without the prior consent of the enrollee or patient.

(7) A pharmacy benefit manager shall not unreasonably restrict an enrollee or covered person from using a particular network retail pharmacy for the purposes of receiving pharmacist services covered by the enrollee's or covered person's health plan.

(8) Before a prescription is dispensed, an affiliated pharmacy shall disclose to an enrollee or covered person that the affiliated pharmacy is an affiliated pharmacy and that the enrollee or covered person is not obligated to use the affiliated pharmacy.

(9) This section does not prohibit a health plan or carrier from doing any of the following:

(a) Offering customized pharmacy network options to its clients.

(b) Offering mail order of specialty treatments.

(c) Establishing a tiered network.

History: 2022, Act 11, Eff. Jan. 1, 2024.

550.831 Contractual restrictions and limitations with pharmacists or pharmacies; disclosure of costs; payment at point of sale.

Sec. 21. (1) A contract between a pharmacy benefit manager and a pharmacist or a pharmacy that provides drug coverage for health plans must not prohibit or restrict a pharmacy or pharmacist from, or penalize a pharmacy or pharmacist for, disclosing to a covered person or enrollee health care information that the pharmacy or pharmacist considers appropriate regarding any of the following:

(a) The nature of the treatment or the risks or the alternatives to the treatment.

(b) The availability of alternate therapies, consultations, or tests.

(2) A pharmacy benefit manager shall not prohibit a pharmacy or pharmacist from discussing information regarding the total cost for pharmacist services for a drug or from selling a more affordable alternative to the covered person or enrollee if a more affordable alternative is available.

(3) A carrier, health plan, or pharmacy benefit manager shall not require a covered person or enrollee to

make a payment for a prescription drug at the point of sale in an amount greater than the lesser of the following:

(a) The applicable copayment, coinsurance, and deductible.

(b) The final reimbursement amount to the network pharmacy.

History: 2022, Act 11, Eff. Jan. 1, 2024.

550.833 Transparency report; requirements; exempt from freedom of information act; report to legislature; inapplicable to Medicaid contracts.

Sec. 23. (1) Unless otherwise required more frequently by the director, by April 1, 2025 and each April 1 after that date, except as otherwise provided in subsection (5), a pharmacy benefit manager shall file a transparency report with the director that contains the information required under subsection (2) from the preceding calendar year. The transparency report must not disclose any of the following information:

(a) The identity of a specific health plan or enrollee.

(b) The price the pharmacy benefit manager charged a pharmacy for a specific drug or class of prescription drugs.

(c) The amount of any rebate or fee provided to the pharmacy benefit manager for a prescription drug or class of prescription drugs.

(2) The transparency report required under subsection (1) must include all of the following information:

(a) The aggregate wholesale acquisition costs from a manufacturer or wholesale distributor for each therapeutic category of drugs for the pharmacy benefit manager's Michigan plan sponsors, net of rebates and other fees and payments, direct or indirect, from all sources.

(b) The aggregate amount of rebates that the pharmacy benefit manager received from all manufacturers for the pharmacy benefit manager's Michigan plan sponsors. The aggregate amount of rebates must include any utilization discounts the pharmacy benefit manager receives from a manufacturer or wholesale distributor.

(c) The aggregate amount of all fees that the pharmacy benefit manager received.

(d) The aggregate amount of rebates that the pharmacy benefit manager received from all manufacturers that were not passed through to Michigan health plans or insurers.

(e) The aggregate amount of fees that the pharmacy benefit manager received from all manufacturers that were not passed through to Michigan health plans, carriers, or insurers.

(f) The aggregate retained rebate percentage from business conducted in this state.

(g) All of the following information attributable to patient use of prescription drugs covered by Michigan health plans:

(*i*) The aggregate amount of rebates and fees that the pharmacy benefit manager received from manufacturers.

(*ii*) The aggregate amount of rebates and fees that the pharmacy benefit manager received from manufacturers that were either of the following:

(A) Passed through to Michigan health plans or enrollees at the point of sale of a prescription drug.

(B) Retained by the pharmacy benefit manager.

(3) Except to the extent to prepare the report under subsection (4), all information submitted to the director in a transparency report under this section is exempt from disclosure under section 13 of the freedom of information act, 1976 PA 442, MCL 15.243.

(4) By August 1, 2025 and each August 1 after that date, the director shall prepare a report based on the information received by the director under this act and submit the report to the legislature. The report must contain aggregate data and must not contain any information that the director determines would cause financial, competitive, or proprietary harm to a pharmacy benefit manager or carrier that the pharmacy benefit manager services. The department shall post the report required under this subsection on the department's website.

(5) This section does not apply to a contract between a pharmacy benefit manager and the department of health and human services under Medicaid. As used in this subsection, "Medicaid" means benefits under the program of medical assistance established under title XIX of the social security act, 42 USC 1396 to 1396w-6, and administered by the department of health and human services under the social welfare act, 1939 PA 280, MCL 400.1 to 400.119b.

History: 2022, Act 11, Eff. Jan. 1, 2024.

550.837 Maximum allowable costs; pharmacy benefit manager duties.

Sec. 27. (1) For each drug that a pharmacy benefit manager establishes a maximum allowable cost, the pharmacy benefit manager shall do all of the following:

(a) Provide each pharmacy subject to a maximum allowable cost list with access to the maximum

allowable cost list and the source used to determine the maximum allowable cost for each drug.

(b) Update its maximum allowable cost list at least once every 7 calendar days.

(c) Provide a process for each pharmacy subject to the maximum allowable cost list to receive prompt notification of an update to the maximum allowable cost list.

(d) Establish and maintain a reasonable administrative appeals process to allow a pharmacy subject to the maximum allowable cost list or an agent of a pharmacy subject to the maximum allowable cost list to challenge the adjudication of a pharmacy's claim.

(e) Investigate and resolve an appeal under this subsection within 14 calendar days after the pharmacy benefit manager receives the appeal. An appeal under this subsection must be submitted to the pharmacy benefit manager not later than 45 calendar days after the date the pharmacy's claim for reimbursement has been adjudicated.

(f) Respond in writing to any appealing pharmacy or an appealing pharmacy's agent not later than 30 calendar days after receipt of an appeal if the pharmacy filed the appeal more than 10 calendar days after the date the pharmacy's claim for reimbursement is adjudicated.

(g) If an appeal is denied, provide the appealing pharmacy or the appealing pharmacy's agent the national drug code number available for purchase in this state at or below the appealed maximum allowable cost.

(h) If an appeal is granted, permit the pharmacy to reverse and rebill the claim and all claims for the drug.

(2) Before a pharmacy benefit manager places or continues a drug on a maximum allowable cost list, all of the following conditions must be met:

(a) The drug is available for purchase by pharmacies in this state from wholesale distributors operating in this state.

(b) The drug is not obsolete.

(c) The drug is a multiple source drug.

(3) All benefits payable by a carrier, health plan, or pharmacy benefit manager to a pharmacy must be paid within 14 days after adjudication of a claim if claims are submitted electronically.

History: 2022, Act 11, Eff. Jan. 1, 2024.

550.838 Authorization to conduct audit; process and duties; written report; extrapolation audit prohibition; inapplicable to certain investigations; carrier pharmacy audits not impaired or superseded.

Sec. 28. (1) Subject to this section, a carrier or a pharmacy benefit manager may conduct an audit of a pharmacy in this state. A carrier or a pharmacy benefit manager that conducts an audit of a pharmacy in this state shall do all of the following:

(a) In its pharmacy contract, identify and describe in detail the audit procedures, including the appeals process described in subdivision (m). A carrier or pharmacy benefit manager shall update its pharmacy contract and communicate any changes to the pharmacy as changes to the contract occur.

(b) Provide written notice to the pharmacy at least 2 weeks before initiating and scheduling the initial on-site audit for each audit cycle. If the pharmacy on average dispenses more than 600 prescriptions per week, a carrier or pharmacy benefit manager shall not initiate or schedule an audit under this subsection during the first 5 business days of a month without the express consent of the pharmacy. A carrier or pharmacy benefit manager shall be flexible in initiating and scheduling an audit at a time that is reasonably convenient to the pharmacy. Within 3 business days after the pharmacy receives notice of an on-site audit, the pharmacy may reschedule the audit to a date not more than 10 business days after the date proposed by the carrier or pharmacy benefit manager.

(c) Utilize every effort to minimize inconvenience and disruption to pharmacy operations during the audit process. A carrier or pharmacy benefit manager that conducts an audit of a pharmacy in this state shall not interfere with the delivery of pharmacy services to a patient.

(d) Conduct an audit that involves clinical or professional judgment by or in consultation with a pharmacist.

(e) Subject to the requirements of article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838, for the purpose of validating a pharmacy record with respect to orders, refills, or changes in prescriptions, allow the use of either of the following:

(*i*) Hospital or physician records that are written or that are transmitted or stored electronically, including file annotations, document images, and other supporting documentation that is date- and time-stamped.

(*ii*) A prescription that complies with the requirements of the Michigan board of pharmacy created under section 17721 of the public health code, 1978 PA 368, MCL 333.17721, and federal law.

(f) Base any finding of an overpayment or underpayment on the actual overpayment or underpayment of claims.

(g) Subject to subsection (4), base any recoupment or payment adjustments of claims on a calculation that is reasonable and proportional in relation to the type of error detected.

(h) If there is a finding of an underpayment, reimburse the pharmacy as soon as possible after detection.

(i) Conduct its audit of the pharmacy under the same standards and parameters that the carrier or pharmacy benefit manager uses when auditing other similarly situated pharmacies.

(j) Audit only claims submitted or adjudicated within the 1-year period preceding the initiation of the audit unless a longer period is permitted under federal or state law.

(k) Not receive payment and not compensate the auditor based on the amount recovered.

(*l*) Not include the dispensing fee amount in a finding of an overpayment unless any of the following apply:

(*i*) The prescription was not dispensed. As used in this subparagraph, "dispense" means that term as defined in section 17703 of the public health code, 1978 PA 368, MCL 333.17703.

(*ii*) The prescription was not delivered to the patient. As used in this subparagraph, "deliver" means that term as defined in section 17703 of the public health code, 1978 PA 368, MCL 333.17703.

(*iii*) The prescriber denied prior authorization.

(*iv*) The prescription was a medication error by the pharmacy.

(*v*) The overpayment is solely based on an extra dispensing fee.

(m) Establish a written appeals process that includes a process to appeal preliminary audit reports and final audit reports prepared under this section. A pharmacy has 30 days after the pharmacy receives the final audit report to file an appeal under this section.

(n) Not limit the days' supply for unit-of-use items, such as topicals, drops, vials, and inhalants, beyond manufacturer recommendations.

(o) If the only commercially available package size exceeds the maximum days' supply, not use the dispensing of the package size as the basis for recoupment.

(p) If the only commercially available package size exceeds the maximum days' supply and the claim was affirmatively adjudicated, not recoup the claim as an early refill.

(q) In conducting an audit of wholesale invoices, all of the following:

(*i*) Not audit the claims of another carrier or pharmacy benefit manager.

(*ii*) Within 5 business days after a request by the audited pharmacy, provide supporting documentation provided to the carrier or pharmacy benefit manager by the audited pharmacy's suppliers.

(*iii*) Not utilize any of the following as a basis for recoupment:

(A) The national drug code for the dispensed drug is in a quantity that is a subunit or multiple of the purchased drug as reflected on a supporting wholesale invoice.

(B) The correct quantity dispensed is reflected on the audited pharmacy claim.

(C) The drug dispensed by the pharmacy on an audited pharmacy claim is identical to the labeler and product code section under the national drug code. A difference in the package code under the national drug code is not subject to recoupment.

(*iv*) Accept as evidence each of the following:

(A) Supplier invoices issued to the audited pharmacy before the date of dispensing the drug underlying the audited claim.

(B) Invoices issued to the audited pharmacy from any supplier permitted by law to transfer ownership of the drug acquired by the audited pharmacy, subject to validation by the supplier.

(C) Copies of supplier invoices in the possession of the audited pharmacy.

(2) Upon completion of an audit of a pharmacy, the carrier or pharmacy benefit manager shall do all of the following:

(a) Deliver a preliminary written audit report to the pharmacy not later than 60 days after the completion of the audit. The preliminary written audit report must include contact information for the person performing the audit and a description of the appeals process established under subsection (1)(m).

(b) Allow the pharmacy at least 30 days after its receipt of the preliminary written audit report under subdivision (a) to produce documentation to address any discrepancy found during the audit.

(c) If an appeal is not filed, deliver a final written audit report to the pharmacy within 90 days after the time described in subdivision (b) has elapsed. If an appeal is filed, deliver a final written audit report to the pharmacy within 90 days after the conclusion of the appeal.

(d) Except as otherwise provided in this section, recoup disputed money or overpayments or restore underpayments only after the final written audit report is delivered to the pharmacy under subdivision (c).

(3) Except as required by federal law, a carrier or pharmacy benefit manager shall not conduct an extrapolation audit in calculating recoupments, restoration, or penalties for an audit under this section. For the purposes of this subsection, "extrapolation audit" means an audit of a sample of prescription drug benefit

claims submitted by a pharmacy to the carrier that is then used to estimate audit results for a larger batch or group of claims not reviewed during the audit.

(4) Any clerical or record-keeping error, including a typographical error, a scrivener's error, or a computer error, regarding a required document or record that is found during an audit under this section does not, on its face, constitute fraud. An error described in this subsection does not subject the individual involved to criminal penalties without proof of intent to commit fraud. To the extent that an audit results in the identification of a clerical or record-keeping error, including a typographical error, a scrivener's error, or a computer error, in a required document or record, the pharmacy is not subject to recoupment of money by the carrier or pharmacy benefit manager unless clerical error or record-keeping error surpasses the statistical threshold established by the Centers for Medicare and Medicaid Services or the carrier can provide proof of intent to commit fraud or the error results in actual financial harm to the carrier, pharmacy benefit manager, or a covered person or enrollee.

(5) This section does not apply to any of the following:

(a) An audit conducted to investigate fraud, willful misrepresentation, or abuse, including, but not limited to, investigative audits or audits conducted under any other statute that authorizes investigation relating to insurance fraud.

(b) An audit based on a criminal investigation.

(6) This section does not impair or supersede a provision regarding carrier pharmacy audits in the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302. If any provision of this section conflicts with a provision of the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302, with regard to carrier pharmacy audits, the provision in the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302, controls.

History: 2022, Act 11, Eff. Jan. 1, 2024.

550.839 Retail pharmacies; contractual restrictions and limitations; use of untrue, deceptive, or misleading advertisements; reversal and resubmission of claims; termination of pharmacy from pharmacy benefit manager network; retaliation prohibited; "personal representative" defined.

Sec. 29. (1) A contract between a retail pharmacy and a pharmacy benefit manager or plan sponsor must not prohibit the retail pharmacy from offering either of the following as an ancillary service of the retail pharmacy:

(a) The delivery of a prescription drug by mail or common carrier to a patient or personal representative on request of the patient or personal representative if the request is made before the drug is delivered.

(b) The delivery of a prescription to a patient or personal representative by an employee or contractor of the retail pharmacy.

(2) Except as otherwise provided in a contract described in subsection (1), the retail pharmacy shall not charge a plan sponsor or pharmacy benefit manager for the delivery service described in subsection (1).

(3) If a retail pharmacy provides a delivery service described in subsection (1) to a patient, the retail pharmacy must disclose both of the following to the patient or personal representative:

(a) Any fee charged to the patient for the delivery of a prescription drug.

(b) The plan sponsor or pharmacy benefit manager may not reimburse the patient for the fee described in subdivision (a).

(4) Except as otherwise provided in a contract between a mail-order pharmacy or specialty pharmacy and a carrier, health plan, or pharmacy benefit manager, the carrier, health plan, or pharmacy benefit manager shall not require pharmacist or pharmacy accreditation standards or recertification requirements inconsistent with, more stringent than, or in addition to federal and state requirements to obtain reimbursement for a covered drug.

(5) A pharmacy benefit manager shall not cause or knowingly permit the use of any advertisement, promotion, solicitation, representation, proposal, or offer that is untrue, deceptive, or misleading.

(6) A pharmacy benefit manager shall not reverse and resubmit the claim of a network pharmacy:

(a) Without prior and proper notification to the network pharmacy.

(b) Without just cause or attempt to first reconcile the claim with the pharmacy.

(c) More than 90 days after the claim was first affirmatively adjudicated.

(7) The termination of a pharmacy from a pharmacy benefit manager network must not release the retail pharmacy benefit manager from the obligation to make any payment due to the pharmacy for an affirmatively adjudicated claim unless payments are withheld because of an investigation relating to insurance fraud.

(8) A carrier, health plan, or pharmacy benefit manager shall not retaliate against a pharmacist or pharmacy based on the pharmacist's or pharmacy's exercise of any right or remedy under this act. Retaliation prohibited

by this subsection includes any of the following:

(a) Terminating or refusing to renew a contract with the pharmacist or pharmacy.

(b) Subjecting the pharmacist or pharmacy to increased audits.

(c) Failing to promptly pay the pharmacist or pharmacy any money owed by the pharmacy benefit manager to the pharmacist or pharmacy.

(9) This section does not prohibit the use of remote pharmacies, secure locker systems, or other types of pickup stations if such services are otherwise permitted by law.

(10) The provisions of this act may not be waived, voided, or nullified by contract.

(11) As used in this section, "personal representative" means an individual who has authority to act on behalf of another individual in making decisions related to health care as described in 45 CFR 164.502(g).

History: 2022, Act 11, Eff. Jan. 1, 2024.

550.840 Enforcement of act; examination and audit.

Sec. 30. (1) The director shall enforce this act.

(2) The director may examine or audit the relevant books and records of a pharmacy benefit manager providing claims processing services or other drug or device services for a health plan to determine if the pharmacy benefit manager is in compliance with this act.

(3) All of the following apply to information or data acquired during an examination under subsection (2), or otherwise acquired under this act:

(a) The information or data is considered proprietary and confidential.

(b) The information or data is not subject to the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246.

(c) The information or data is only to be used for purposes of ensuring a pharmacy benefit manager's compliance with this act.

History: 2022, Act 11, Eff. Jan. 1, 2024.

550.841 Contract compliance; license requirement.

Sec. 31. A contract between a pharmacy benefit manager and an insurer that exists on the date of licensure of the pharmacy benefit manager must comply with the requirements of this act as a condition of licensure for the pharmacy benefit manager.

History: 2022, Act 11, Eff. Jan. 1, 2024.

550.843 Retention schedule; records, books, papers, and other data; destruction or disposal of certain documents prohibited.

Sec. 33. (1) The director shall establish a retention schedule for all records, books, papers, and other data on file with the department related to the enforcement of this act.

(2) The director shall not order the destruction or other disposal of a record, book, paper, or other data that is any of the following:

(a) Required by law to be filed or kept on file with the department until 10 years have passed.

(b) Filed during the director's administration or administrations.

History: 2022, Act 11, Eff. Jan. 1, 2024.

550.845 Scope of act.

Sec. 35. This act does not apply with respect to a claim that is entirely preempted by federal law, including Medicare Part D or the employee retirement income security act of 1974, Public Law 93-406.

History: 2022, Act 11, Eff. Jan. 1, 2024.

THIRD PARTY ADMINISTRATOR ACT
Act 218 of 1984

AN ACT to provide for the regulation of third party administrators; to provide for the licensure of administrative service managers; to provide for certain powers and duties for certain state agencies and officers; to provide for the confidentiality of certain personal data; and to prescribe penalties for a violation of this act.

History: 1984, Act 218, Eff. Jan. 1, 1985.

Compiler's note: For transfer of the Department of Insurance and Office of the Commissioner on Insurance from the Department of Licensing and Regulation to the Department of Commerce, see E.R.O. No. 1991-9, compiled at MCL 338.3501 of the Michigan Compiled Laws.

For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

The People of the State of Michigan enact:

550.901 Short title.

Sec. 1. This act shall be known and may be cited as the "third party administrator act".

History: 1984, Act 218, Eff. Jan. 1, 1985.

Compiler's note: For transfer of the Department of Insurance and Office of the Commissioner on Insurance from the Department of Licensing and Regulation to the Department of Commerce, see E.R.O. No. 1991-9, compiled at MCL 338.3501 of the Michigan Compiled Laws.

For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.902 Definitions.

Sec. 2. As used in this act:

(a) "Administrative services manager" or "manager" means an individual responsible for conducting the daily operations of a third party administrator.

(b) "Benefit plan" or "plan" means a medical, surgical, dental, vision, or health care benefit plan and may include coverage under a policy or certificate issued by a carrier.

(c) "Board" means the TPA advisory board created under section 19.

(d) "Carrier" means an insurer, including a health maintenance organization, regulated under the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302, or a dental care corporation regulated under 1963 PA 125, MCL 550.351 to 550.373.

(e) "Claim" means a request for payment for administering, filling, or refilling a drug or for providing a pharmacy service or a medical supply or device to an enrollee as that term is defined in section 116 of the insurance code of 1956, 1956 PA 218, MCL 500.116.

(f) "Commissioner" means the director.

(g) "Department" means the department of insurance and financial services.

(h) "Director" means the director of the department.

(i) "ERISA" means the employee retirement income security act of 1974, Public Law 93-406.

(j) "Health plan" means a qualified health plan as that term is defined in section 1261 of the insurance code of 1956, 1956 PA 218, MCL 500.1261.

(k) "Manufacturer" means that term as defined in section 17706 of the public health code, 1978 PA 368, MCL 333.17706.

(*l*) "Person" means an individual, sole proprietorship, partnership, corporation, association, or any other legal entity.

(m) "Personal data" means any record or information pertaining to the diagnosis, treatment, or health of an individual covered by a plan.

(n) "Pharmacy" means that term as defined in section 17707 of the public health code, 1978 PA 368, MCL 333.17707.

(o) Except as otherwise provided in subdivision (p), "pharmacy benefit manager" means an entity that contracts with a pharmacy or a pharmacy services administration organization on behalf of a health plan or carrier to provide pharmacy health services to individuals covered by the health plan or carrier or administration that includes, but is not limited to, any of the following:

(*i*) Contracting directly or indirectly with pharmacies to provide drugs to enrollees or other covered persons.

(*ii*) Administering a drug benefit.

(*iii*) Processing or paying pharmacy claims.

(*iv*) Creating or updating drug formularies.

(*v*) Making or assisting in making prior authorization determinations on drugs.

(*vi*) Administering rebates on drugs. As used in this subparagraph, "rebate" means a formulary discount or remuneration attributable to the use of prescription drugs that is paid by a manufacturer or third party, directly or indirectly, to a pharmacy benefit manager after a claim has been adjudicated at a pharmacy. Rebate does not include a fee, including, but not limited to, a bona fide service fee or administrative fee, that is not a formulary discount or remuneration described in this subparagraph. As used in this subparagraph, "third party" does not include a pharmacy benefit manager.

(*vii*) Establishing a pharmacy network.

(p) "Pharmacy benefit manager" does not include the department of health and human services, a carrier, or an insurer.

(q) "Pharmacy services administration organization" means an entity that provides contracting and other administrative services relating to prescription drug benefits to pharmacies.

(r) "Processes claims" means the administrative services performed in connection with a claim for benefits under a plan.

(s) "Service contract" means the written agreement for the provision of administrative services between the TPA and a plan, a sponsor of a plan, or a carrier.

(t) "Third party administrator" or "TPA" means a person that directly or indirectly processes claims under a service contract and that may also provide 1 or more other administrative services under a service contract, other than under a worker's compensation self-insurance program pursuant to section 611 of the worker's disability compensation act of 1969, 1969 PA 317, MCL 418.611. Third party administrator includes a pharmacy benefit manager. Third party administrator does not include a carrier or employer sponsoring a plan.

History: 1984, Act 218, Eff. Jan. 1, 1985;—Am. 2022, Act 12, Imd. Eff. Feb. 23, 2022.

550.910 Third party administrator; certificate required; requirements; instances in which TPA subject to act; name.

Sec. 10. (1) A person shall not operate as a third party administrator without obtaining and maintaining a certificate of authority pursuant to this act.

(2) A third party administrator shall continue to meet the requirements of this act at all times.

(3) A third party administrator is subject to this act in the following instances:

(a) The TPA is domiciled in this state.

(b) The TPA has its principal administrative office or principal headquarters located in this state.

(c) The TPA solicits a plan or sponsor of a plan or provides administrative services to a plan or sponsor of a plan, which plan or sponsor is either domiciled in this state or has its principal headquarters or principal administrative office in this state. This subdivision shall not apply to a TPA who has been licensed or certified as a TPA in that TPA's state of domicile pursuant to a statute or regulation similar to this act.

(d) The TPA provides substantial administrative services to a carrier for the carrier's business in this state.

(4) Each TPA shall transact its business under its own name. A TPA shall not be permitted to do business in this state under a name which is the same as or which closely resembles the name of a TPA which is authorized to do business under the laws of this state.

History: 1984, Act 218, Eff. Jan. 1, 1985.

550.912 Application for certificate of authority; form, verification, and contents; filing notice of modification.

Sec. 12. (1) An application for a certificate of authority to operate as a TPA shall be in a form prescribed by the commissioner, shall be verified by an officer or authorized representative of the TPA, and shall include all of the following:

(a) All basic organizational documents of the TPA, such as the articles of incorporation, bylaws, articles of association, trade name certificate, and other similar documents and all amendments to those documents.

(b) The names, addresses, official positions, and professional qualifications of the individuals who are responsible for the conduct of the affairs of the TPA, including all administrative services managers, members of the board of directors, board of trustees, executive committee, or other governing board or committee; the officers and shareholders owning stock representing 10% or more of the voting shares of the TPA in the case of a corporation; and the partners or members in the case of a partnership or association.

(c) A description of the TPA, its services, facilities, and personnel.

(d) A power of attorney duly executed by the TPA if not domiciled in this state, appointing the commissioner, the commissioner's successors in office, and the commissioner's duly authorized deputies as the attorney of the TPA in and for this state, upon whom process in any legal action or proceeding against the TPA on a cause of action arising in this state may be served. The fee for such service shall be $5.00, payable at the time of service.

(e) Recent financial statements showing the third party administrator's assets, liabilities, and sources of financial support sufficient in the opinion of the commissioner, upon the advice of the board, to show financial viability of the third party administrator. If the third party administrator's financial affairs are prepared by independent public accountants, a copy of the most recent regular financial statement shall satisfy this requirement unless the commissioner determines that additional or more recent financial information is required for the proper administration of this act.

(f) Such other information as the commissioner may reasonably require. The commissioner may not demand trade secret information from a TPA.

(2) Within 30 days following any significant modification of information submitted with the application for a certificate of authority, a third party administrator shall file a notice of the modification with the commissioner.

History: 1984, Act 218, Eff. Jan. 1, 1985.

550.914 Certificate of authority; issuance; notice of disapproval; continued compliance with subsection (1).

Sec. 14. (1) The commissioner shall issue a certificate of authority to operate as a TPA if the commissioner is satisfied that the TPA has adequate facilities, personnel, and managers to act as a third party administrator.

(2) If the commissioner disapproves an application for a certificate of authority, he or she shall notify the applicant in writing of the reasons for the disapproval.

(3) A TPA shall continue to meet the conditions required under subsection (1) after the certificate of authority is issued.

History: 1984, Act 218, Eff. Jan. 1, 1985;—Am. 2002, Act 74, Imd. Eff. Mar. 15, 2002.

550.916 Repealed. 2002, Act 74, Imd. Eff. Mar. 15, 2002.

Compiler's note: The repealed section pertained to license as administrative services manager.

550.918 Fees; payment; collection; and designation.

Sec. 18. (1) The commissioner shall collect, and the persons affected shall pay to the commissioner, the following fees:

(a) Filing fee to accompany application for third party administrator's certificate of authority	$	200.00.
(b) Certificate of authority for a third party administrator	$	25.00.
(c) Filing fee for annual statement of a third party administrator, each year	$	25.00.

(2) Fees paid under this section shall be designated for the insurance bureau to cover the additional costs incurred as a result of this act.

History: 1984, Act 218, Eff. Jan. 1, 1985;—Am. 2002, Act 74, Imd. Eff. Mar. 15, 2002.

550.919 TPA advisory board; creation; appointment, qualifications, and terms of members; expenses; duty of board; report.

Sec. 19. (1) A TPA advisory board is created. The board shall consist of 7 members appointed by the commissioner, at least 4 of whom shall be individuals employed by TPAs who are not in the employ of a carrier and who do not have a significant ownership interest in a carrier. The members of the board shall serve 3-year terms and shall serve without compensation but shall be reimbursed for their actual and necessary expenses incurred in the performance of their duties. The board shall advise the commissioner as to the operations of this act, including:

(a) The procedure for granting licenses and certificates.

(b) The subject areas for the written examination for managers.

(c) The implementation of this act.

(d) Making recommendations to the commissioner for guidelines for the implementation of sections 40 to 44.

(e) Making recommendations to the commissioner regarding the regulatory standards for excess loss insurance required by section 32(4).

(2) The board shall issue a report to the commissioner on the operations of this act not later than 3 years after the effective date of this act.

History: 1984, Act 218, Eff. Jan. 1, 1985.

550.920 Authority of commissioner.

Sec. 20. The commissioner shall have the same authority with respect to a TPA or manager as he or she does with respect to an insurance agency or agent under the insurance code of 1956, Act No. 218 of the Public Acts of 1956, being sections 500.100 to 500.8302 of the Michigan Compiled Laws, including but not limited to the rights of examination, suspension, revocation, and limitation of authority, and liquidations and receiverships.

History: 1984, Act 218, Eff. Jan. 1, 1985.

550.922 Hearings.

Sec. 22. The commissioner may designate 1 or more persons to conduct hearings provided for under this act, hearings required by the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, being sections 24.201 to 24.315 of the Michigan Compiled Laws, and hearings which the commissioner considers necessary and appropriate for fact-finding or information gathering before making decisions, policies, and determinations allowable or required by law in the course of carrying out the duties of the commissioner. Hearings under this act shall be conducted in the same manner as hearings conducted under the insurance code of 1956, Act No. 218 of the Public Acts of 1956, being sections 500.100 to 500.8302 of the Michigan Compiled Laws.

History: 1984, Act 218, Eff. Jan. 1, 1985.

550.924 Destruction or disposal of records, books, papers, and other data.

Sec. 24. The commissioner is authorized to destroy or otherwise dispose of all records, books, papers, and other data on file with the department which in his or her opinion and on the advice of the attorney general, are of no further material value to the state of Michigan; but the destruction or other disposal thereof shall not be ordered or made by him or her of any records, books, papers, or other data required by law to be filed or kept on file with the insurance bureau until the expiration of a period of 10 years, nor of any such records, books, papers, or other data filed during his or her administration or administrations. Such authorization shall be effected through official rules of the commissioner. However, this authorization shall not extend to articles of incorporation, and amendments thereto, copies of bylaws and amendments thereto, copies of certificates or other written evidence of authorization to transact business or of approval of articles of incorporation and bylaws.

History: 1984, Act 218, Eff. Jan. 1, 1985.

550.926 340B Program entities; reimbursement, co-pay, and discrimination prohibitions; definitions.

Sec. 26. (1) A carrier or third party administrator that is a pharmacy benefit manager shall not prohibit a 340B Program entity or a pharmacy that has a license in good standing in this state under contract with a 340B Program entity from participating in the carrier's or third party administrator that is a pharmacy benefit manager's provider network solely because it is a 340B Program entity or a pharmacy under contract with a 340B Program entity. A carrier or third party administrator that is a pharmacy benefit manager shall not reimburse a 340B Program entity or a pharmacy under contract with a 340B Program entity differently than other similarly situated pharmacies. As used in this subsection, "340B Program entity" means an entity authorized to participate in the federal 340B Program under section 340B of the public health service act, 42 USC 256b.

(2) A carrier or other third party, or a third party administrator that is a pharmacy benefit manager, shall not, except as required by law to prevent a duplicate rebate, require a claim for a drug to include a modifier or otherwise to indicate that the drug is a 340B drug unless the claim is for payment, directly or indirectly, by the Medicaid program. As used in this subsection:

(a) "Medicaid program" means the program for medical assistance established under title XIX of the social security act, 42 USC 1396 to 1396w-6.

(b) "Rebate" means a formulary discount or remuneration attributable to the use of prescription drugs that is paid by a manufacturer or third party, directly or indirectly, to a pharmacy benefit manager after a claim has been adjudicated at a pharmacy. Rebate does not include a fee, including, but not limited to, a bona fide service fee or administrative fee, that is not a formulary discount or remuneration described in this subdivision.

(c) "Third party" does not include a pharmacy benefit manager or carrier.

(d) "340B drug" means a covered drug as that term is defined in 42 USC 256b.

(3) A third party administrator that is a pharmacy benefit manager shall not exclude or discriminate against

a pharmacy solely based on the carrier not having a vested financial interest in the pharmacy. As used in this subsection, "having a vested financial interest" means having ownership, having co-ownership, being a shareholder, or having another connection from which financial gain or loss could be realized.

History: Add. 2022, Act 12, Imd. Eff. Feb. 23, 2022.

550.927 Disclosure of current selling prices; prohibited contract provisions.

Sec. 27. A contract between a carrier or third party administrator that is a pharmacy benefit manager and a pharmacy must not prohibit the pharmacy from disclosing the current selling price of a drug in accordance with section 17757 of the public health code, 1978 PA 368, MCL 333.17757. This section applies to a contract described in this section executed, extended, or renewed on or after the effective date of the amendatory act that added this section.

History: Add. 2022, Act 12, Imd. Eff. Feb. 23, 2022.

550.930 Provision of administrative services pursuant to written service contract; maintenance of books and records; TPA and manager as fiduciary.

Sec. 30. (1) A TPA may only provide administrative services pursuant to a written service contract. For the duration of the service contract, a TPA shall maintain at its principal administrative office the TPA's books and records of all transactions under the service contract in accordance with generally accepted accounting principles or as required by ERISA.

(2) A TPA and a manager are a fiduciary when collecting, expending, and maintaining money for the payment of claims pursuant to the service contract.

History: 1984, Act 218, Eff. Jan. 1, 1985.

550.932 Benefit plan; notice; plan covering less than 500 individuals; service contract between TPA and governmental entity not subject to ERISA; construction of act.

Sec. 32. (1) A TPA, in connection with a benefit plan, shall provide in its service contract a provision that the person contracting for the services shall provide written notice to each individual covered by the plan, which written notice shall contain the following information:

(a) What benefits are being provided.

(b) Of changes in benefits.

(c) The fact that individuals covered by the plan are not insured or are only partially insured, as the case may be.

(d) If the plan is not insured, the fact that in the event the plan or the plan sponsor does not ultimately pay medical expenses that are eligible for payment under the plan for any reason, the individuals covered by the plan may be liable for those expenses.

(e) The fact that the TPA merely processes claims and does not insure that any medical expenses of individuals covered by the plan will be paid.

(f) The fact that complete and proper claims for benefits made by individuals covered by the plan will be promptly processed but that in the event there are delays in processing claims, the individuals covered by the plan shall have no greater rights to interest or other remedies against the TPA than as otherwise afforded them by law.

(2) The written notice required by subsection (1) shall be prominently displayed in the summary plan description or in a separate document. The notice shall be communicated to the individuals covered by the plan within 60 days after becoming covered, upon each republication of the summary plan description, and in any case not less than every 5 years in a manner calculated to be received and understood by the average individual covered by the plan. As used in subsections (1) and (2), "individual covered by a plan" includes only 1 individual per family covered by a plan. The written notice required by this section shall not apply to any plan in effect on the effective date of this act until the earlier of the following:

(a) The due date under ERISA for distributing updated summary plan descriptions.

(b) Two years after the effective date of this act.

(3) Except as provided in subsection (4), a TPA shall not enter into a service contract for a plan covering less than 500 individuals.

(4) A TPA may enter into a service contract for a plan covering less than 500 individuals, if either the TPA makes arrangements for excess loss insurance or the sponsor of the plan is liable for the plan's liabilities and is a sponsor of 1 or more plans covering 500 or more individuals in the aggregate. The commissioner, upon the advice of the board, shall establish the standards for the manner and amount of the excess loss insurance required by this subsection. A TPA may continue to provide administrative services under a service contract for a plan covering less than 500 individuals if the service contract was in existence on the effective date of

this act, including the renewal of that service contract.

(5) A service contract between a TPA and a governmental entity not subject to ERISA, whose plan provides coverage under a collective bargaining agreement utilizing a policy or certificate issued by a carrier before the signing of the service contract, is void unless the governmental entity has provided the written notice described in subsection (1) to the collective bargaining agent and to the members of the collective bargaining unit not less than 30 days before signing the service contract. The voiding of a service contract under this subsection shall not relieve the governmental entity of any obligations to the TPA under the service contract.

(6) Nothing in this act shall be construed to regulate or authorize an employee welfare benefit plan which is a multiple employer welfare arrangement. Nothing in this act shall be construed to permit an actionable interference by a TPA with the rights and obligations of the parties under a collective bargaining agreement.

History: 1984, Act 218, Eff. Jan. 1, 1985.

550.934 Confidentiality.

Sec. 34. (1) A TPA shall provide for the confidentiality of personal data identifying an individual covered by a plan. A TPA shall not disclose records containing personal information that may be associated with an identifiable individual covered by a plan to a person other than the individual to whom the information pertains. Except as is necessary to comply with a court order, an administrator shall not disclose personal data concerning a covered individual without the prior consent of the covered individual. If the individual covered by a plan has authorized the release of information to a third person, the third person shall not release that information unless the individual executes in writing another consent authorizing the additional release.

(2) Subsection (1) shall not be construed to apply to information disclosed for any of the following reasons:

(a) For claims adjudication.

(b) For claims verification.

(c) For other proper plan administration.

(d) For an audit conducted pursuant to ERISA.

(e) To an insurer for the purchase of excess loss insurance and for claims under the excess loss insurance. However, an insurer obtaining information under this subdivision shall be subject to the requirements of subsection (1).

(f) To the plan or a fiduciary of the plan.

(g) To the commissioner. However, information obtained by the commissioner under this subdivision shall be exempt from disclosure under the freedom of information act, Act No. 442 of the Public Acts of 1976, being sections 15.231 to 15.246 of the Michigan Compiled Laws.

(h) As required by law.

History: 1984, Act 218, Eff. Jan. 1, 1985.

550.936 Annual statement; report.

Sec. 36. By July 1, 2022 and each July 1 after that date, a third party administrator shall prepare under oath and file with the director a statement concerning the third party administrator's affairs on a form provided by the director. A third party administrator shall file the annual statement required under this section by July 1 of the year following the year covered by the statement. On request and for good cause shown, the director may grant to a third party administrator a reasonable extension of time not to exceed 30 days within which the statement must be filed. A third party administrator shall pay the annual statement filing fee prescribed in section 18.

History: 1984, Act 218, Eff. Jan. 1, 1985;—Am. 2022, Act 12, Imd. Eff. Feb. 23, 2022.

550.940 Prohibited conduct generally.

Sec. 40. A TPA or manager, in processing claims, shall not do any of the following:

(a) Misrepresent pertinent facts relating to coverage.

(b) Fail to make a good faith effort to acknowledge promptly or to act reasonably and promptly upon communications with respect to a claim for benefits.

(c) Fail to adopt and implement reasonable standards for the prompt investigation of a claim for benefits.

(d) Refuse to process claims without conducting a reasonable investigation based upon the available information.

(e) Fail to communicate affirmation or denial of coverage of a claim for benefits within a reasonable time after a claim has been received.

(f) Fail to make a good faith effort to promptly, fairly, and equitably process a claim for benefits.

(g) Fail to promptly provide a reasonable explanation of the basis for denial or partial denial of a claim for benefits.

(h) Refuse to process claims because of race, color, creed, marital status, sex, national origin, residence, age, disability, or lawful occupation.

(i) Knowingly compel individuals covered by the plan to institute litigation to recover amounts due under a benefit plan by offering substantially less than the amounts due unless the amounts due are reasonably in dispute.

(j) For the purpose of coercing an individual covered by the plan to accept a settlement or compromise of a claim, inform the individual of a policy of the TPA of appealing judicial, arbitration, or administrative hearing decisions which are in favor of individuals covered by the plan.

(k) Delay the investigation or processing of a claim by requiring an individual covered by the plan, or the provider of services to the individual covered by the plan, to submit a preliminary claim and then requiring subsequent submission of a formal claim, seeking solely the duplication of a verification. This subdivision does not apply to the predetermination or precertification of benefits.

History: 1984, Act 218, Eff. Jan. 1, 1985;—Am. 1998, Act 79, Imd. Eff. May 4, 1998.

550.942 Additional prohibited conduct.

Sec. 42. A manager or TPA, in order to induce a person to contract or to continue to contract with the TPA; to induce a person to lapse, forfeit, or surrender a service contract entered into with a TPA; or to induce a person to secure or terminate coverage with a carrier or other person, shall not directly or indirectly:

(a) Offer to make or make an agreement relating to a service contract or issue or deliver to the person money or any other valuable consideration other than as plainly expressed in the service contract.

(b) Give or pay or offer to give or pay, directly or indirectly, a rebate or adjustment of the fee payable under the service contract, or an advantage in the services thereunder, except as reflected in the fee and expressly provided in the service contract.

(c) Make, issue, or circulate, or cause to be made, issued, or circulated, any estimate, illustration, circular, or statement misrepresenting the terms of a service contract, the advantages provided thereunder, or the true nature thereof.

(d) Make a misrepresentation in a comparison, whether oral or written, between service contracts of the TPA and another TPA or between service contracts of the TPA and a carrier.

History: 1984, Act 218, Eff. Jan. 1, 1985.

550.944 Additional prohibited conduct.

Sec. 44. (1) A TPA shall not refuse to enter into a service contract or provide administrative services other than processing claims because of race, color, creed, marital status, sex, national origin, residence, age, disability, or lawful occupation.

(2) A TPA or manager shall not misrepresent the financial condition of a TPA or of any person engaged in the business of insurance, or misrepresent the financial aspects of the services offered by the TPA or make a statement which is maliciously false, maliciously critical of, or maliciously derogatory to the financial condition of another TPA or of a person engaged in the business of insurance.

(3) A TPA or manager shall not misrepresent the nature of the services provided by the TPA, including but not limited to, the existence or identity of any carrier or other TPA involved with the plan; the extent of risk assumed by any particular named carrier, if any; or the regulatory status of the carrier or TPA.

(4) A TPA or manager shall not make, or participate in the making of, any fraudulent statement on a claims form for the purpose of obtaining money or other benefits.

(5) A TPA shall process claims for benefits on a timely basis.

History: 1984, Act 218, Eff. Jan. 1, 1985;—Am. 1998, Act 79, Imd. Eff. May 4, 1998.

550.950 Violation; probable cause; notice; conference; disposition of matter upon agreement of parties; action for damages; hearing; findings and decision; cease and desist order; additional order.

Sec. 50. (1) When the commissioner has probable cause to believe that a TPA or manager is violating, or has violated section 40, indicating a persistent tendency to engage in conduct prohibited by that section, or has probable cause to believe that a TPA or manager is violating, or has violated other provisions of this act, he or she shall give written notice to the TPA or manager, pursuant to the administrative procedures act, Act No. 306 of the Public Acts of 1969, being sections 24.201 to 24.315 of the Michigan Compiled Laws, setting forth the general nature of the complaint against the TPA or manager and the proceedings contemplated under this section. Before the issuance of a notice of hearing, the staff of the bureau of insurance responsible for the

matters which would be at issue in the hearing shall give the TPA or manager an opportunity to confer and discuss the possible complaint and proceedings in person with the commissioner or a representative of the commissioner, and the matter may be disposed of summarily upon agreement of the parties. This subsection shall not be construed to create or diminish any right of a person to bring an action for damages under this section.

(2) A hearing held pursuant to subsection (1) shall be held pursuant to the administrative procedures act, Act No. 306 of the Public Acts of 1969. If, after the hearing, the commissioner determines that the TPA or manager is violating, or has violated section 40, indicating a persistent tendency to engage in conduct prohibited by that section, or has violated or is violating other provisions of this act, the commissioner shall reduce his or her findings and decision to writing, and shall issue and cause to be served upon the TPA or manager a copy of the findings and an order requiring the TPA or manager to cease and desist from engaging in the prohibited activity, and the commissioner may order any of the following:

(a) Payment of a monetary penalty of not more than $500.00 for each violation but not to exceed an aggregate penalty of $5,000.00, unless the TPA or manager knew or reasonably should have known it was in violation of this act, in which case the penalty shall not be more than $2,500.00 for each violation and shall not exceed an aggregate penalty of $25,000.00 for all violations committed in a 6-month period.

(b) Suspension or revocation of the TPA's certificate of authority or the manager's license if the TPA or manager knowingly and persistently violated this act.

(c) Restitution or refund to an aggrieved person.

History: 1984, Act 218, Eff. Jan. 1, 1985.

550.952 Civil fine; suspension or revocation of certificate or license; refusal to issue; grounds for denial, suspension, revocation, or cease and desist order; definition.

Sec. 52. (1) If a TPA or manager violates a cease and desist order under this act and has been given notice and an opportunity for a hearing held under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, the director may order a civil fine of not more than $10,000.00 for each violation, or a suspension or revocation of the TPA's certificate of authority or manager's license, or both the fine and suspension or revocation.

(2) The director may refuse to issue a TPA certificate of authority under this act if the director determines that the TPA or any individual responsible for the conduct of affairs of the TPA is not competent, trustworthy, financially responsible or of good personal and business reputation, or has had an insurance or a TPA certificate of authority or license denied or revoked for cause by any jurisdiction.

(3) The director may deny, suspend, or revoke the license of a TPA, or may issue a cease and desist order if the TPA is not licensed, if the director finds, after notice and opportunity for hearing, any of the following:

(a) That the TPA has violated any lawful rule or order of the director or any provision of the insurance laws of this state.

(b) That the TPA refused to be examined or to produce its accounts, records, and files for examination, or that any individual responsible for the conduct of affairs of the TPA has refused to give information with respect to its affairs or has refused to perform any other legal obligation as to an examination when required by the director.

(c) That the TPA has, without just cause, refused to pay proper claims or perform services arising under its contracts or has, without just cause, caused covered individuals to accept less than the amount due them or caused covered individuals to employ attorneys or bring suit against the TPA or a payor that it represents to secure full payment or settlement of the claims.

(d) That the TPA is required under this act to have a license and fails at any time to meet any qualification for which issuance of a license could have been refused had the failure then existed and been known to the director, unless the director issued a license with knowledge of the grounds for disqualification and had the authority to waive it.

(e) That any of the individuals responsible for the conduct of affairs of the TPA has been convicted of, or has entered a plea of guilty or nolo contendere to, a felony without regard to whether adjudication was withheld.

(f) That the TPA's license has been suspended or revoked in another state.

(g) That the TPA has failed to file a timely statement under section 36 or to pay a filing fee under section 18.

(4) As used in this section, "individual responsible for the conduct of affairs of the TPA" means any of the following:

(a) A member of the board of directors, board of trustees, executive committee, or other governing board or committee.

(b) A principal officer for a corporation or a partner or member for a partnership, association, or limited liability company.

(c) A shareholder or member holding directly or indirectly 10% or more of the voting stock, voting securities, or voting interest of the TPA.

(d) Any person who exercises control or influence over the affairs of the TPA.

History: 1984, Act 218, Eff. Jan. 1, 1985;—Am. 2022, Act 12, Imd. Eff. Feb. 23, 2022.

550.954 Alteration, modification, or setting aside of order.

Sec. 54. The commissioner may at any time, by order, after notice and opportunity for hearing, reopen and alter, modify, or set aside, in whole or in part, an order issued by him or her under this act, when in his or her opinion conditions of fact or of law have so changed as to require that action or if the public interest shall so require.

History: 1984, Act 218, Eff. Jan. 1, 1985.

550.956 Judicial review; petition for review; transcript of record and copy of order or decision; hearing cause as civil case in equity; evidence; duty of court; incomplete record; stay of order or decision; jurisdiction.

Sec. 56. (1) Any final order or decision made, issued, or executed by the commissioner under this act shall be subject to review, after hearing had before the commissioner or a deputy commissioner without leave by the circuit court of Ingham county or the circuit court of the county in which the principal office in this state of the TPA aggrieved by such order or decision is located, or where the person resides against whom such order is directed.

(2) A petition as of right for the review of such order or decision shall be filed within 30 days from the date of service of a copy of said order or decision upon the TPA or other person against whom said order or decision shall run. Copy of such petition for review as filed with and certified by the clerk of the court shall be served upon the commissioner, or in his or her absence upon someone in active charge of the insurance bureau, within 5 days after the filing thereof. If a petition for review is not filed within the 30 days, the party aggrieved shall be deemed to have waived the right to have the merits of the order or decision reviewed, and there shall be no trial of the merits thereof by any court to which application may be made by petition or otherwise. Within 10 days after the service of copy of the petition for review, unless the time be extended by order of court, the commissioner shall prepare and file with the clerk of the court in which the petition for review was filed, a complete transcript of the record of the hearing had before him or her, and a true and certified copy of his or her order or decision.

(3) The cause shall be heard before the court as a civil case in equity upon such transcript of the record and such additional evidence as may be offered by any of the parties at the hearing of the cause before the court. It shall be the duty of the court to hear and determine such petition with all convenient speed. If on the hearing before the court it appears that the record filed by the commissioner is incomplete, the court by appropriate order may direct the commissioner to certify any or all parts of the records so omitted. The commencement of proceedings under this section shall not operate as a stay of the enforcement of the commissioner's order or decision unless so ordered by the court or commissioner, and under such conditions as the court or commissioner may impose. The court shall have the jurisdiction to affirm, modify, or to set aside the order or decision of the commissioner and to restrain the enforcement thereof.

History: 1984, Act 218, Eff. Jan. 1, 1985.

550.958 Self-incrimination; false oath or affirmation.

Sec. 58. (1) A person shall not be excused from attending and testifying, or producing any books, papers, or other documents before any court or magistrate, arbitrator or board of arbitrators, upon any investigation, proceeding, or trial, for a violation of any of the provisions of this act, upon the ground or for the reason that the testimony or evidence documentary or otherwise, required of him or her may tend to incriminate him or her; but a person shall not be prosecuted or subjected to any penalty or forfeiture for or on account of any transaction, matter, or thing concerning which he or she may so testify or produce evidence, documentary or otherwise, and testimony so given or produced shall not be used against him or her upon any criminal investigation or proceeding.

(2) A person required by this act to take an oath or affirmation who makes a false oath or affirmation is guilty of perjury.

History: 1984, Act 218, Eff. Jan. 1, 1985.

550.960 Rules.

Sec. 60. (1) The commissioner, after notice and hearing, may promulgate rules pursuant to the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, being sections 24.201 to 24.315 of the Michigan Compiled Laws, as necessary to effectuate the purposes of this act.

(2) A copy of the rules promulgated under this act and any amendments thereto shall be mailed to each TPA authorized to do business in this state 30 days prior to the effective date thereof.

History: 1984, Act 218, Eff. Jan. 1, 1985.

550.962 Repealed. 2002, Act 74, Imd. Eff. Mar. 15, 2002.

Compiler's note: The repealed section pertained to effective date of act.

EXECUTIVE REORGANIZATION ORDER
E.R.O. No. 2009-22

550.971 Transfer of third party administrator advisory board to department of energy, labor, and economic growth by type III transfer; abolishment of third party administrator advisory board.

WHEREAS, Section 1 of Article V of the Michigan Constitution of 1963 vests the executive power of the State of Michigan in the Governor;

WHEREAS, Section 2 of Article V of the Michigan Constitution of 1963 empowers the Governor to make changes in the organization of the executive branch of state government or in the assignment of functions among its units that the Governor considers necessary for efficient administration;

WHEREAS, there is a continuing need to reorganize functions amongst state departments to ensure efficient administration and effectiveness of government;

WHEREAS, abolishing the Third Party Administrator Advisory Board will contribute to a smaller and more efficient state government;

NOW, THEREFORE, I, Jennifer M. Granholm, Governor of the State of Michigan, by virtue of the power and authority vested in the Governor by the Michigan Constitution of 1963 and Michigan law, order the following:

I. DEFINITIONS

As used in this Order:

A. "Department of Energy, Labor, and Economic Growth" means the principal department of state government created by Section 225 of the Executive Organization Act of 1965, 1965 PA 380, MCL 16.325, and renamed by Executive Order 1996-2, MCL 445.2001, by Executive Order 2003-18, MCL 445.2011, and by Executive Order 2008-20.

B. "Third Party Administrator Advisory Board" or "TPA Advisory Board" means the board created under Section 19 of the Third Party Administrator Act, 1984 PA 218, MCL 550.919.

C. "State Budget Director" means the individual appointed by the Governor pursuant to Section 321 of The Management and Budget Act, 1984 PA 431, MCL 18.1321.

D. "Type III transfer" means that term as defined under Section 3(c) of the Executive Organization Act of 1965, 1965 PA 380, MCL 16.103.

II. TRANSFER OF AUTHORITY

A. The TPA Advisory Board is transferred by Type III transfer to the Department of Energy, Labor, and Economic Growth.

B. The TPA Advisory Board is abolished.

III. IMPLEMENTATION OF TRANSFERS

A. The Director of the Department of Energy, Labor, and Economic Growth shall provide executive direction and supervision for the implementation of all transfers of functions under this Order and shall make internal organizational changes as necessary to complete the transfers under this Order.

B. The functions transferred under this Order shall be administered by the Director of the Department of Energy, Labor, and Economic Growth in such ways as to promote efficient administration.

C. All records, property, and unexpended balances of appropriations, allocations, and other funds used, held, employed, available, or to be made available to the TPA Advisory Board for the activities, powers, duties, functions, and responsibilities transferred under this Order are transferred to the Department of Energy, Labor, and Economic Growth.

D. The State Budget Director shall determine and authorize the most efficient manner possible for handling financial transactions and records in the state's financial management system necessary for the implementation of this Order.

IV. MISCELLANEOUS

A. All rules, orders, contracts, and agreements relating to the functions transferred under this Order lawfully adopted prior to the effective date of this Order shall continue to be effective until revised, amended, repealed, or rescinded.

B. This Order shall not abate any suit, action, or other proceeding lawfully commenced by, against, or before any entity affected under this Order. Any suit, action, or other proceeding may be maintained by, against, or before the appropriate successor of any entity affected under this Order.

C. The invalidity of any portion of this Order shall not affect the validity of the remainder of the Order, which may be given effect without any invalid portion. Any portion of this Order found invalid by a court or other entity with proper jurisdiction shall be severable from the remaining portions of this Order.

In fulfillment of the requirements under Section 2 of Article V of the Michigan Constitution of 1963, the provisions of this Order are effective July 31, 2009 at 12:01 a.m.

History: 2009, E.R.O. No. 2009-22, Eff. July 31, 2009.

MEDICAL CARE SAVINGS ACCOUNT ACT
Act 289 of 1994

550.981-550.988 Repealed. 1994, Act 289, Eff. Jan. 1, 1999.

EXECUTIVE REORGANIZATION ORDER
E.R.O. No. 2013-1

550.991 Creation of department of insurance and financial services; transfer of powers and duties of commissioner of office of financial and insurance regulation to director of department of insurance and financial services by type III transfer; abolishment; transfer of autism coverage reimbursement program from department of licensing and regulatory affairs to department of insurance and financial services.

WHEREAS, Section 1 of Article V of the Michigan Constitution of 1963 vests the executive power of the state of Michigan in the Governor; and

WHEREAS, Section 2 of Article V of the Michigan Constitution of 1963 empowers the Governor to make changes in the organization of the Executive Branch or in the assignment of functions among its units that he considers necessary for efficient administration; and

WHEREAS, Section 8 of Article V of the Michigan Constitution of 1963 provides that each principal department shall be under the supervision of the Governor unless otherwise provided by the Constitution; and

WHEREAS, there is a continued need to reorganize functions among state departments to ensure efficient administration; and

WHEREAS, the insurance and financial services industries are significant components of our state economy, directly employing over 150,000 Michigan residents and generating more than $9 billion in annual payroll; and

WHEREAS, Michigan is home to over 300 state banks and credit unions and 149 insurance companies are domiciled here. Michigan serves as a port of entry and chief U.S. regulator for 5 Canadian insurance companies, and nearly 1,500 foreign insurance companies also do business in this state; and

WHEREAS, it is an important function of state government to protect consumers of insurance and financial services products through public information and effective regulation; and

WHEREAS, the world of insurance and financial services is rapidly changing, health insurance is becoming more accessible, and digital banking is revolutionizing the way that money is used; and

WHEREAS, consolidating all functions related to the regulation of insurance and financial services into a new Department of Insurance and Financial Services will provide a focal point of consumer protection, enable efficient and effective regulation, and position the insurance and financial services sector of Michigan's economy for growth;

NOW, THEREFORE, I, Richard D. Snyder, Governor of the state of Michigan, by virtue of the powers and authority vested in the Governor by the Michigan Constitution of 1963 and Michigan law, order the following:

I. DEFINITIONS

As used in this Order:

A. "Autism Coverage Reimbursement Program" means the program created under the Autism Coverage Reimbursement Act, 2012 PA 101, MCL 550.1831 to 1841.

B. "Commissioner" means the head of the Office of Financial and Insurance Regulation.

C. "Department of Licensing and Regulatory Affairs" means the principal department of state government created as the Department of Commerce under Section 225 of the Executive Organization Act of 1965, 1965 PA 380, MCL 16.325, renamed the Department of Consumer and Industry Services under Executive Order 1996-2, MCL 445.2001, renamed the Department of Labor and Economic Growth under Executive Order 2003-18, MCL 445.2011, and renamed the Department of Licensing and Regulatory Affairs under Executive Order 2011-4, MCL 445.2030.

D. "Department of Insurance and Financial Services" means the principal department of state government created under Section II of this Order.

E. "Office of Financial and Insurance Regulation" means the Office of Financial and Insurance Services created by Executive Order 2000-4, MCL 445.2003, renamed the Office of Financial and Insurance Regulation under Executive Order 2008-2, MCL 445.2005, and reorganized under Executive Order 2012-13.

F. "State Budget Director" means the individual appointed by the Governor pursuant to Section 321 of The Management Budget Act, 1984 PA 431, MCL 18.1321.

G. "Type III transfer" means that phrase as defined in Section 3 of the Executive Organization Act of 1965, 1965 PA 380, MCL 16.103.

II. CREATION OF THE DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

A. The Department of Insurance and Financial Services is created as a principal department in the executive branch of state government. The Department shall regulate the insurance and financial services

industries in this state.

B. The Department shall be headed by a Director of Insurance and Financial Services who shall be appointed by the Governor, with the advice and consent of the Michigan Senate commencing on the date of this Order. The individual appointed as the Director shall serve as a member of the Governor's Cabinet.

C. The position of the Commissioner of the Office of Financial and Insurance Regulation as a member or chairperson of all of the following boards or commissions is transferred to the Director of the Department of Insurance and Financial Services:

a. State Employees Retirement System Board. MCL 38.3(1)(a).

b. Interstate Insurance Product Regulation Compact Commission. MCL 3.1031 Art. II (4), (5) & (8).

c. State Advisory Council on Mental Health and Aging. MCL 330.1941(1).

d. Governing Board, Data Collection Agency for Workers Compensation Data. MCL 500.2402(2)(f).

e. Catastrophic Claims Association Board. MCL 500.3104(13).

f. Multiple Employer Welfare Arrangement Security Fund Board of Trustees. MCL 500. 7080(2).

III. TRANSFER OF OFFICE OF FINANCIAL AND INSURANCE REGULATION FUNCTIONS

A. All the authority, powers, duties, functions and responsibilities of the Commissioner of the Office of Financial and Insurance Regulation created by Executive Order 2000-4, and amended by Executive Order 2008-2, Executive Order 2011-4, and Executive Order 2012-13 are hereby transferred by a Type Ill transfer to the Director of the Department of Insurance and Financial Services as defined by Section 3 of Act No. 380 of the Public Acts of 1965, as amended, being Section 16.103 of the Michigan Compiled Laws.

B. Any and all statutory or other references to the Office of Financial and Insurance Regulation not inconsistent with this Order shall be deemed references to the Department of Insurance and Financial Services.

C. Any and all statutory or other references to the Commissioner of the Office of Financial and Insurance Regulation not inconsistent with this Order shall be deemed references to the Director of the Department of Insurance and Financial Services.

D. The Office of Financial and Insurance Regulation and the Office of Commissioner of the Office of Financial and Insurance Regulation are hereby abolished.

IV. TRANSFER OF AUTISM COVERAGE REIMBURSEMENT PROGRAM FUNCTIONS

The Autism Coverage Reimbursement Program created under the Autism Coverage Reimbursement Act, 2012 PA 101, MCL 550.1831 to 1841, together with all the authority, powers, duties, functions, responsibilities, records, personnel, property, unexpended balances of appropriations, allocations of other funds, including functions of budgeting and procurement, are transferred from the Department of Licensing and Regulatory Affairs to the Department of Insurance and Financial Services. The Director of the Department of Insurance and Financial Services shall replace the Director of the Department of Licensing and Regulatory Affairs as a member of the Autism Council created by Executive Order 2012-11.

V. IMPLEMENTATION OF TRANSFERS

A. The Director of the Department of Insurance and Financial Services shall provide executive direction and supervision for the implementation of all transfers of authority under this Order.

B. The Director of the Department of Insurance and Financial Services and the Director of the Department of Licensing and Regulatory Affairs shall immediately coordinate in order to facilitate the transfer and develop memoranda of record identifying any pending settlements, issues of compliance with applicable federal and state laws and regulations, or other obligations to be resolved related to the authority being transferred.

C. The Director of the Department of Insurance and Financial Services shall establish the internal organization of the Department and allocate and reallocate duties and functions to promote economic and efficient administration and operation of the Department. The Director of the Department of Insurance and Financial Services shall supervise the staff of the Department and shall be responsible for its day-to-day operations.

D. The State Budget Director shall determine and authorize the most efficient manner possible for handling financial transactions and records in the state's financial management system as necessary for the implementation of this Order.

E. The Director of the Department of Insurance and Financial Services may by written instrument delegate a duty or power conferred by law or this Order and the person to whom such duty or power is so delegated may perform such duty or exercise such power at the time and to the extent such duty or power is delegated by the Director of the Department of Insurance and Financial Services.

VI. MISCELLANEOUS

A. All records, personnel, and property used, held, employed, or to be made available to the Office of

Financial and Insurance Regulation and the Department of Licensing and Regulatory Affairs for the activities, powers, duties, functions, and responsibilities transferred by this Order are hereby transferred to the Department of Insurance and Financial Services.

B. All unexpended balances of appropriations, allocations, and other funds used, held, employed, or to be made available to the Office of Financial and Insurance Regulation and the Department of Licensing and Regulatory Affairs for the activities, powers, duties, functions, and responsibilities transferred by this Order are hereby transferred to the Department of Insurance and Financial Services.

C. All rules, orders, contracts, plans, and agreements relating to the functions transferred to the Department of Insurance and Financial Services by this Order lawfully adopted prior to the effective date of this Order shall continue to be effective until revised, amended, or rescinded.

D. Any suit, action, or other proceeding lawfully commenced by, against, or before any entity transferred to the Department of Insurance and Financial Services by this Order shall not abate by reason of the taking effect of this Order. Any lawfully commenced suit, action, or other proceeding may be maintained by, against, or before the appropriate successor of any entity affected by this Order.

E. The invalidity of any portion of this Order shall not affect the validity of the remainder of the Order, which may be given effect without any invalid portion. Any portion of this Order found invalid by a court or other entity with proper jurisdiction shall be severable from the remaining portions of this Order.

In fulfillment of the requirements of Section 2 of Article V of the Michigan Constitution of 1963, the provisions of this Order shall be effective 60 days after the filing of this Order.

History: 2013, E.R.O. No. 2013-1, Eff. Mar. 19, 2013.

Compiler's note: Executive Reorganization Order No. 2013-1 was promulgated January 17, 2013 as Executive Order No. 2013-1, Eff. Mar. 19, 2013.

For transfer of autism coverage reimbursement program from department of licensing and regulatory affairs to department of insurance and financial services, see E.R.O. No. 2013-1, compiled at MCL 550.991.

THE HEALTH BENEFIT AGENT ACT
Act 252 of 1986

AN ACT to regulate the marketing and transacting of certain health benefits; to regulate the agents of health benefit corporations; to establish certain powers and duties of health benefit corporations and agents of health benefit corporations; to establish the powers and duties of certain state officers and agencies; and to provide for certain penalties.

History: 1986, Act 252, Eff. Mar. 31, 1987.

Compiler's note: For transfer of the Department of Insurance and Office of the Commissioner on Insurance from the Department of Licensing and Regulation to the Department of Commerce, see E.R.O. No. 1991-9, compiled at MCL 338.3501 of the Michigan Compiled Laws.

The People of the State of Michigan enact:

550.1001 Short title.

Sec. 1. This act shall be known and may be cited as "the health benefit agent act".

History: 1986, Act 252, Eff. Mar. 31, 1987.

Compiler's note: For transfer of the Department of Insurance and Office of the Commissioner on Insurance from the Department of Licensing and Regulation to the Department of Commerce, see E.R.O. No. 1991-9, compiled at MCL 338.3501 of the Michigan Compiled Laws.

For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.1002 Definitions.

Sec. 2. As used in this act:

(a) "Affiliate" means that term as defined in section 1301 of the insurance code of 1956, Act No. 218 of the Public Acts of 1956, being section 500.1301 of the Michigan Compiled Laws.

(b) "Commissioner" means the commissioner of insurance.

(c) "Control" means that term as defined in section 1301 of the insurance code of 1956, Act No. 218 of the Public Acts of 1956, being section 500.1301 of the Michigan Compiled Laws.

(d) "Health benefit" means any benefit or service lawfully provided by a health benefit corporation.

(e) "Health benefit agent" means a person who meets all of the following criteria:

(*i*) Is a licensed accident and health insurance agent under chapter 12 of the insurance code of 1956, Act No. 218 of the Public Acts of 1956, being sections 500.1201 to 500.1244 of the Michigan Compiled Laws.

(*ii*) Is authorized in writing by a health benefit corporation to act as an agent for the health benefit corporation and a copy of the authorization is filed with the commissioner.

(f) "Health benefit corporation" means:

(*i*) A health care corporation organized under Act No. 350 of the Public Acts of 1980, being sections 550.1101 to 550.1704 of the Michigan Compiled Laws.

(*ii*) A nonprofit dental care corporation organized under Act No. 125 of the Public Acts of 1963, being sections 550.351 to 550.373 of the Michigan Compiled Laws.

(*iii*) A health maintenance organization licensed under part 210 of Act No. 368 of the Public Acts of 1978, being sections 333.21001 to 333.21098 of the Michigan Compiled Laws.

(g) "Influence" means to manage, direct, mandate, or give a reward or benefit to a person. Influence does not mean to respond to a request for information.

(h) "Package" means to sell health benefits simultaneously or in conjunction with the sale of insurance.

(i) "Subscriber" means a person who enters into a contract, or on whose behalf a contract is entered into, with a health benefit corporation for the provision of health benefits.

History: 1986, Act 252, Eff. Mar. 31, 1987.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.1003 Persons authorized to sell health benefits; packaging health benefits with insurance; notify agent of record; annual appointment fee; "agent of record" defined.

Sec. 3. (1) Health benefits may only be sold on behalf of a health benefit corporation by a health benefit agent.

(2) A health benefit agent may package health benefits with insurance the agent is authorized to sell. If an application for health benefits that is packaged with insurance is submitted by an agent to a health benefit

corporation or to an affiliate of a health benefit corporation and the health benefit corporation or the affiliate of a health benefit corporation knows the agent of record for the group's current health benefits, the health benefit corporation or the affiliate of a health benefit corporation shall notify the agent of record of the application unless any of the following apply:

(a) The submitting agent is the agent of record.

(b) Both of the following apply:

(*i*) The group authorizes changing the agent of record to the submitting agent.

(*ii*) The agent of record is not employed by a health benefit corporation or an affiliate of a health benefit corporation.

(c) The group requests in writing that the agent of record not be notified.

(3) If the health benefit corporation or the affiliate of a health benefit corporation notifies the agent of record under subsection (2), the health benefit corporation or the affiliate of a health benefit corporation shall not process the application for 14 days after the notification is given unless either of the following applies:

(a) A shorter period of time is agreed to by the agent of record.

(b) The health benefit corporation or the affiliate of a health benefit corporation receives a written request from the group to proceed with consideration of the application.

(4) A health benefit corporation shall pay to the director of the department of insurance and financial services an annual appointment fee of $5.00 for each health benefit agent who is authorized to sell health benefits on behalf of the health benefit corporation.

(5) As used in this section, "agent of record" means a person that is a health benefit agent authorized to represent a subscriber to transact insurance, including the purchasing, servicing, and maintenance of health benefits and that is shown on the records of the health benefit corporation or the affiliate of a health benefit corporation as the agent to whom commission is to be paid.

History: 1986, Act 252, Eff. Mar. 31, 1987;—Am. 2018, Act 430, Imd. Eff. Dec. 20, 2018.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.1004 Influencing agent prohibited.

Sec. 4. A health benefit corporation shall not attempt in any way to influence an agent in the packaging of health benefits.

History: 1986, Act 252, Eff. Mar. 31, 1987.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.1004a Applicability of certain statutory provisions.

Sec. 4a. (1) The provisions of sections 1, 2, 3, 4(1), (2), (3), (4), (6), 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, and 18 of Act No. 274 of the Public Acts of 1984, as amended, being sections 445.771 to 445.788 of the Michigan Compiled Laws, shall apply to all activities authorized by this act.

(2) The provisions of this act shall apply to an activity of a health benefit corporation notwithstanding the provisions of section 4(5) of Act No. 274 of the Public Acts of 1984, as amended, being section 445.774 of the Michigan Compiled Laws, except where the activity is specifically required by this act or any regulation or orders promulgated by the commissioner pursuant to this act.

History: 1986, Act 252, Eff. Mar. 31, 1987.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.1005 Compensation of health benefit agents.

Sec. 5. Health benefit corporations shall compensate health benefit agents primarily on a reasonable commission basis. Health benefit corporations may provide reasonable bonuses or other reasonable compensation to health benefits agents for the sale of health benefits.

History: 1986, Act 252, Eff. Mar. 31, 1987.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.1006 Authorized agents; requirements, duties, and restrictions; powers of

commissioner.

Sec. 6. (1) Agents licensed under chapter 12 of the insurance code of 1956, Act No. 218 of the Public Acts of 1956, to sell accident and health insurance are deemed to be health benefits agents under this act upon being authorized by a health benefit corporation and filing that authorization with the commissioner.

(2) The requirements, duties, and restrictions of insurance agents and the powers of the commissioner with respect thereto under chapter 20 of the insurance code of 1956, Act No. 218 of the Public Acts of 1956, being sections 500.2001 to 500.2093 of the Michigan Compiled Laws, shall also apply to agents licensed under this act when marketing and selling health benefits to the same extent as if marketing and selling disability insurance.

History: 1986, Act 252, Eff. Mar. 31, 1987.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.1008 Contracts or other arrangements for packaging of health benefits with insurance; policy supplementing health benefits of health maintenance organization.

Sec. 8. (1) Except as otherwise provided in this act, a health care corporation organized under Act No. 350 of the Public Acts of 1980, being sections 550.1101 to 550.1704 of the Michigan Compiled Laws, shall not, either itself or through any affiliate or agent, enter into a contract or other arrangement with any insurer or other person which provides for the packaging of health benefits with insurance.

(2) A health benefit corporation may arrange for excess loss insurance in conjunction with the sale of administrative services benefits.

(3) A health maintenance organization 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, may arrange with an insurer for the insurer to sell a policy to supplement the health benefits of the health maintenance organization.

History: 1986, Act 252, Eff. Mar. 31, 1987.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.1009 Licensing affiliate of health benefit corporation as insurance agent prohibited.

Sec. 9. An affiliate of a health benefit corporation must not be licensed as an insurance agent under chapter 12 of the insurance code of 1956, 1956 PA 218, MCL 500.1201 to 500.1247.

History: 1986, Act 252, Eff. Mar. 31, 1987;—Am. 2018, Act 430, Imd. Eff. Dec. 20, 2018.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.1010 Health benefit agent as fiduciary; evidence of violation of fiduciary responsibility; use of reasonable accounting methods; records required; examination of records; prohibited conduct.

Sec. 10. (1) A health benefit agent shall be a fiduciary for all money received or held by him or her in his or her capacity as an agent. Failure by an agent in a timely manner to turn over the money which he or she holds in a fiduciary capacity to the persons to whom they are owed is prima facie evidence of violation of the agent's fiduciary responsibility.

(2) An agent shall use reasonable accounting methods to record funds received in his or her fiduciary capacity including the receipt and distribution of all premiums due each of his or her health benefit corporations. An agent shall record return premiums received by or credited to him or her which are due a subscriber on certificates reduced or canceled or which are due a prospective purchaser of health benefits as a result of a rejected or declined application. Records required by this section shall be open to examination by the commissioner.

(3) An agent shall not reward or remunerate any person for procuring or inducing business in this state, furnishing leads or prospects, or acting in any other manner as an agent.

(4) A person may not sell or attempt to sell health benefits by means of intimidation or threats, whether express or implied. Except as otherwise provided by law, a person may not induce the purchase of health benefits through a particular agent or from a particular health benefit corporation by means of a promise to sell goods, to lend money, to provide services, or by a threat to refuse to sell goods, to refuse to lend money, or to refuse to provide services.

History: 1986, Act 252, Eff. Mar. 31, 1987.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.1012 Notice of termination of agent's authority; liability; duration of agent's responsibility; cancellation or refusal to renew certificate of subscriber; certain referrals or communications prohibited; records, names of subscribers, and expiration dates of certificates and contracts as property of agent; copies of written communications between health benefit corporations and subscribers; grounds for cancellation of agent's contract or termination of agent's authority; authorizing licensed accident and health insurance agent to sell health benefits.

Sec. 12. (1) A health benefit corporation shall give to the commissioner and the agent immediate written notice of the termination of an agent's authority to represent the health benefit corporation. The notice shall include the full disclosure, with supporting evidence, of acts or omissions by the agent which reasonably may be construed to be a violation of this act, or of any other statute, and acts or omissions which may reflect on the agent's qualifications as an agent or which may adversely affect the public interest. There shall not be liability on the part of, and a cause of action of any nature shall not arise against, the commissioner, a health benefit corporation, or an authorized representative of either for any statement made or evidence provided pursuant to this section.

(2) When an agent's authority to represent a health benefit corporation is terminated, the responsibility of an agent shall continue until the existing certificates of health benefits are canceled, replaced, or have expired. During the period following notice of termination, the agent shall continue to represent the health benefit corporation in servicing existing certificates, but the agent shall not bind a new risk, renew a certificate, nor increase the obligation of the health benefit corporation under the certificate without the approval of the health benefit corporation. A health benefit corporation shall not cancel or refuse to renew the certificate of a subscriber because of the termination of an agent's contract.

(3) A health benefit corporation's records and knowledge of names of subscribers and the expiration dates of certificates and contracts of subscribers who have purchased health benefits from an agent of the health benefit corporation shall not be referred nor communicated by the health benefit corporation to any other agent or person nor used by the health benefit corporation for the purpose of solicitation, unless the agent's authorization has been terminated pursuant to subsection (6)(a), (b), or (c).

(4) If the authorization of an agent authorized to sell health benefits on behalf of a health benefit corporation is terminated, the agent's records, use, and control of the names of subscribers and the expiration dates of certificates and contracts of subscribers who have purchased health benefits from the agent shall remain the property of the agent and be left to his or her undisputed possession, unless the agent's authority is terminated pursuant to subsection (6)(a), (b), or (c).

(5) A copy of any written communication between a health benefit corporation and a subscriber shall be sent to the health benefit agent who sold the health benefits to the subscriber unless either of the following apply:

(a) The information is confidential under section 604 of the nonprofit health care corporation reform act, Act No. 350 of the Public Acts of 1980, being section 550.1604 of the Michigan Compiled Laws.

(b) The health benefit corporation and the health benefit agent otherwise agree.

(6) A health care corporation regulated under the nonprofit health care corporation reform act, Act No. 350 of the Public Acts of 1980, being sections 550.1101 to 550.1754 of the Michigan Compiled Laws shall not cancel an agent's contract or otherwise terminate an agent's authority to represent the health benefit corporation, except for 1 or more of the following reasons:

(a) Malfeasance.

(b) Breach of fiduciary duty or trust.

(c) A violation of this act.

(d) Failure to perform as provided by the contract between the parties.

(7) Upon receipt of a request by any person licensed as an accident and health insurance agent under chapter 12 of the insurance code of 1956, Act No. 218 of the Public Acts of 1956, a health care corporation regulated under the nonprofit health care corporation reform act, Act No. 350 of the Public Acts of 1980, shall authorize in writing that licensed accident and health insurance agent to sell health benefits on behalf of the health care corporation.

History: 1986, Act 252, Eff. Mar. 31, 1987.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the

commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.1014 Suspension, revocation, refusal to grant, or refusal to renew accident and health insurance license; grounds; notice; hearing; summary suspension; subpoenas.

Sec. 14. (1) The commissioner, after notice and opportunity for a hearing, may suspend or revoke the accident and health insurance license of an agent who violates any provision of this act.

(2) After notice and opportunity for a hearing, the commissioner may refuse to grant or renew an accident and health insurance license to act as an agent if he or she determines by a preponderance of the evidence, that it is probable that the business or primary occupation of the applicant will give rise to coercion, indirect rebating of commissions, or other practices in the sale of health benefits which are prohibited by law.

(3) Without prior hearing, the commissioner may order summary suspension of an accident and health insurance license if he or she finds that protection of the public requires emergency action and incorporates this finding in his or her order. The suspension shall be effective on the date specified in the order or upon service of a certified copy of the order on the licensee, whichever is later. If requested, the commissioner shall conduct a hearing on the suspension within a reasonable time but not later than 20 days after the effective date of the summary suspension unless the person whose license is suspended requests a later date. At the hearing, the commissioner shall determine if the suspension should be continued or if the suspension should be withdrawn, and, if proper notice is given, may determine if the license should be revoked. The commissioner shall announce his or her decision within 30 days after conclusion of the hearing. The suspension shall continue until the decision is announced.

(4) The commissioner, or his or her designated deputy, may issue subpoenas with the approval of a circuit court judge of the circuit court of Ingham county to require the attendance and testimony of witnesses and the production of documents necessary to the conduct of the hearing and may designate an employee of the insurance bureau to make service thereof. The subpoenas issued by the commissioner, or his or her designated deputy, may be enforced upon application by them to the circuit court of Ingham county by proceedings in contempt thereof, as provided by law.

History: 1986, Act 252, Eff. Mar. 31, 1987.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.1016 Violation of act; orders; penalties for violation of cease and desist order; injunction.

Sec. 16. (1) If the commissioner finds that a person has violated this act, after an opportunity for a 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, the commissioner shall reduce the findings and decision to writing and shall issue and cause to be served upon the person charged with the violation a copy of the findings and an order requiring the person to cease and desist from the violation. In addition, the commissioner may order any of the following:

(a) Payment of a civil fine of not more than $300.00 for each violation. However, if the person knew or reasonably should have known that he or she was in violation of this act, the commissioner may order the payment of a civil fine of not more than $1,500.00 for each violation. However, an order of the commissioner under this subsection shall not require the payment of civil fines exceeding $10,000.00. A fine collected under this subdivision shall be turned over to the state treasurer and credited to the general fund of the state.

(b) A refund of any overcharges.

(c) That restitution be made to the subscriber or other claimant to cover incurred losses, damages, or other harm attributable to the acts of the person which are found to be in violation of this act.

(d) The suspension or revocation of the person's license or certificate of authority.

(2) The commissioner may by order, after notice and opportunity for hearing, reopen and alter, modify, or set aside, in whole or in part, an order issued under this section, if in the opinion of the commissioner conditions of fact or of law have changed to require that action, or if the public interest requires that action.

(3) If a person knowingly violates a cease and desist order under this act and has been given notice and an opportunity for a hearing held pursuant to the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, the commissioner may order a civil fine of not more than $10,000.00 for each violation, or a suspension or revocation of the person's license or certificate of authority, or both. However, an order issued by the commissioner pursuant to this subsection shall not require the payment of civil fines exceeding $50,000.00. A fine collected under this subsection shall be turned over to the state treasurer and credited to the general fund of the state.

(4) The commissioner may apply to the circuit court of Ingham county for an order of the court enjoining a violation of this act.

History: 1986, Act 252, Eff. Mar. 31, 1987.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.1018 Construction of act.

Sec. 18. This act shall not be construed as authorizing a health benefit corporation or affiliate of a health benefit corporation to market or transact, as defined in sections 402a and 402b of the insurance code of 1956, Act No. 218 of the Public Acts of 1956, being sections 500.402a and 500.402b of the Michigan Compiled Laws, any type of insurance described in chapter 6 of the insurance code of 1956, Act No. 218 of the Public Acts of 1956, being sections 500.600 to 500.644 of the Michigan Compiled Laws.

History: 1986, Act 252, Eff. Mar. 31, 1987.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.1020 Conditional effective date.

Sec. 20. This act shall not take effect unless House Bill No. 5527 of the 83rd Legislature is enacted into law.

History: 1986, Act 252, Eff. Mar. 31, 1987.

Compiler's note: House Bill No. 5527, referred to in MCL 550.1020, was filed with the Secretary of State December 5, 1986, and became P.A. 1986, No. 253, Eff. Mar. 31, 1987.

For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

THE NONPROFIT HEALTH CARE CORPORATION REFORM ACT
Act 350 of 1980

AN ACT to provide for the incorporation of nonprofit health care corporations; to provide their rights, powers, and immunities; to prescribe the powers and duties of certain state officers relative to the exercise of those rights, powers, and immunities; to prescribe certain conditions for the transaction of business by those corporations in this state; to define the relationship of health care providers to nonprofit health care corporations and to specify their rights, powers, and immunities with respect thereto; to provide for a Michigan caring program; to provide for the regulation and supervision of nonprofit health care corporations by the commissioner of insurance; to prescribe powers and duties of certain other state officers with respect to the regulation and supervision of nonprofit health care corporations; to provide for the imposition of a regulatory fee; to regulate the merger or consolidation of certain corporations; to prescribe an expeditious and effective procedure for the maintenance and conduct of certain administrative appeals relative to provider class plans; to provide for certain administrative hearings relative to rates for health care benefits; to provide for the creation of and the powers and duties of certain nonprofit corporations for the purpose of receiving and administering funds for the public welfare; to provide for certain causes of action; to prescribe penalties and to provide civil fines for violations of this act; and to repeal acts and parts of acts.

History: 1980, Act 350, Eff. Apr. 3, 1981;—Am. 1991, Act 60, Imd. Eff. June 27, 1991;—Am. 1994, Act 169, Imd. Eff. June 17, 1994;—Am. 2013, Act 4, Imd. Eff. Mar. 18, 2013.

Compiler's note: For transfer of the Department of Insurance and Office of the Commissioner on Insurance from the Department of Licensing and Regulation to the Department of Commerce, see E.R.O. No. 1991-9, compiled at MCL 338.3501 of the Michigan Compiled Laws.

For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

The People of the State of Michigan enact:

PART 1

550.1101 Short title.

Sec. 101. This act shall be known and may be cited as "the nonprofit health care corporation reform act".

History: 1980, Act 350, Eff. Apr. 3, 1981.

Constitutionality: Procedural fairness is required by the due process clause before governmental action drastically alters essential terms of the contract between nonprofit group health care plans and hospitals and nursing homes providing health care services; however, the guarantee of procedural due process does not necessarily require an adversary proceeding. Convalescent Center v Blue Cross, 414 Mich 247; 324 NW2d 851 (1982).

Administrative hearings under the Administrative Procedures Act, however informal, comport with the procedural fairness required by due process in the absence of an explicit statutory requirement that a contested evidentiary hearing be held. Convalescent Center v Blue Cross, 414 Mich 247; 324 NW2d 851 (1982).

This act is unconstitutional in the following three particulars:

(1) The act's provision for an actuary panel to resolve risk factor disputes is an unconstitutional delegation of legislative authority in that it lacks adequate standards (MCL 550.1205(6)).

(2) The statutory restrictions on administrative services only (ASO) contracts violate equal protection of the laws insofar as they result in arbitrary and discriminatory treatment of health care corporations vis-a-vis commercial insurers (MCL 550.1104(3), 550.1211, 550.1414a, 550.1415, and 550.1607(1)).

(3) The commissioner's authority to issue a cease and desist order based on probable cause against a health care corporation for noncompliance with the act establishes an improper burden of proof (MCL 550.1402(7)).

The Supreme Court ruling on these three areas of this act does not affect the constitutionality of the remainder of the act. Where, as here, the unconstitutional provisions are easily severable, the remainder of the act need not be affected. Blue Cross and Blue Shield of Michigan v Governor, 422 Mich 1; 367 NW2d 1 (1985).

Compiler's note: For transfer of the Department of Insurance and Office of the Commissioner on Insurance from the Department of Licensing and Regulation to the Department of Commerce, see E.R.O. No. 1991-9, compiled at MCL 338.3501 of the Michigan Compiled Laws.

For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1102 Legislative intent and policy.

Sec. 102. (1) It is the purpose of and intent of this act, and the policy of the legislature, to promote an appropriate distribution of health care services for all residents of this state, to promote the progress of the science and art of health care in this state, and to assure for nongroup and group subscribers, reasonable access to, and reasonable cost and quality of, health care services, in recognition that the health care financing system is an essential part of the general health, safety, and welfare of the people of this state. Each corporation subject to this act is declared to be a charitable and benevolent institution and its funds and property shall be exempt from taxation by this state or any political subdivision of this state.

(2) It is the intention of the legislature that this act shall be construed to provide for the regulation and supervision of nonprofit health care corporations by the commissioner of insurance so as to secure for all of the people of this state who apply for a certificate, the opportunity for access to health care services at a fair and reasonable price.

(3) It is the public policy of this state that, in the interest of facilitating access to health care services at a fair and reasonable price, an alternate, expeditious, and effective procedure for the resolution of issues and the maintenance of administrative appeals relative to provider class plans be established and utilized, and to that end, the provisions of this act regarding administrative review of those provider class plans shall be construed so as to minimize uncertainty and delays.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1103 Meanings of words and phrases.

Sec. 103. For the purposes of this act, the words and phrases defined in sections 104 to 108 shall have the meanings ascribed to them in those sections.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1104 Definitions; A to C.

Sec. 104. (1) "Administrative procedures act" means the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, as amended, being sections 24.201 to 24.328 of the Michigan Compiled Laws, or a successor act.

(2) "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.

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

(4) "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 Act No. 176 of the Public Acts of 1939, as amended, being sections 423.1 to 423.30 of the Michigan Compiled Laws, or under Act No. 336 of the Public Acts of 1947, as amended, being sections 423.201 to 423.216 of the Michigan Compiled Laws.

(5) "Commissioner" means the commissioner of insurance. Commissioner includes an authorized designee of the commissioner, if written notice of the delegation of authority has been given as provided in section 601.

(6) "Contingency reserve" means the sum of all assets minus the sum of all liabilities of a health care corporation, as shown in the annual financial statement filed under section 602.

History: 1980, Act 350, Eff. Apr. 3, 1981;—Am. 1993, Act 127, Imd. Eff. July 21, 1993.

Constitutionality: This act is unconstitutional in the following three particulars:

(1) The act's provision for an actuary panel to resolve risk factor disputes is an unconstitutional delegation of legislative authority in that it lacks adequate standards (MCL 550.1205(6)).

(2) The statutory restrictions on administrative services only (ASO) contracts violate equal protection of the laws insofar as they result in arbitrary and discriminatory treatment of health care corporations vis-a-vis commercial insurers (MCL 550.1104(3), 550.1211, 550.1414a, 550.1415, and 550.1607(1)).

(3) The commissioner's authority to issue a cease and desist order based on probable cause against a health care corporation for noncompliance with the act establishes an improper burden of proof (MCL 550.1402(7)).

The Supreme Court ruling on these three areas of this act does not affect the constitutionality of the remainder of the act. Where, as here, the unconstitutional provisions are easily severable, the remainder of the act need not be affected. Blue Cross and Blue Shield of Michigan v Governor, 422 Mich 1; 367 NW2d 1 (1985).

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1105 Definitions; H.

Sec. 105. (1) "Health care benefit" means the right under a certificate to have payment made by a health care corporation 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.

(2) "Health care corporation" means a nonprofit hospital service corporation, medical care corporation, or a consolidated hospital service and medical care corporation incorporated or reincorporated under this act, or incorporated or consolidated under former Act No. 108 or 109 of the Public Acts of 1939.

(3) "Health care facility" means a facility or agency as defined in section 22104 of Act No. 368 of the Public Acts of 1978, being section 333.22104 of the Michigan Compiled Laws, and includes a home health agency, or other facility with the approval of the commissioner.

(4) "Health care provider" or "provider", except as provided in section 301(8)(a), means a health care facility; a person licensed, certified, or registered under parts 161 to 182 of Act No. 368 of the Public Acts of 1978, as amended, being sections 333.16101 to 333.18237 of the Michigan Compiled Laws; any other person or facility, with the approval of the commissioner, who or which meets the standards set by the health care corporation for all contracting providers; and, for purposes of section 414a, any person or facility who or which provides intermediate or outpatient care for substance abuse, as defined in section 414a.

(5) "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.

History: 1980, Act 350, Eff. Apr. 3, 1981;—Am. 1980, Act 430, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1106 Definitions; L to O.

Sec. 106. (1) "Large subscriber group" means a group of 10,000 or more subscribers.

(2) "Medium subscriber group" means a group of 150 or more subscribers, but less than 10,000 subscribers.

(3) "Member", except as used in parts 2 and 3, means a subscriber, a dependent of a subscriber, or any other individual entitled to receive health care benefits under a nongroup or group certificate.

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

(5) "Objectives" means an expected achievement level by a health care corporation of the goals provided in section 504, for a provider class. Insofar as is reasonably practicable, objectives shall be capable of quantitative measurement.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1107 Definitions; P.

Sec. 107. (1) "Participating provider" means a provider that has entered into a participating contract with a health care corporation and that meets the standards set by the corporation for that class of providers.

(2) "Participating contract" means an agreement, contract, or other arrangement under which a provider agrees to accept the payment of the health care corporation as payment in full for health care services or parts of health care services covered under a certificate, as provided for in section 502(1).

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

(4) "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 health care corporation.

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

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

(b) 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.

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

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

(e) A review pursuant to section 608(2).

(6) "Provider class" means classes of providers, as defined in section 105(4), that have a provider contract or a reimbursement arrangement with a health care corporation to render health care services to subscribers, as those classes are established by the corporation.

(7) "Provider class plan" or "plan" means a document containing a reimbursement arrangement and objectives for a provider class, and, in the case of those providers with which a health care corporation contracts, provisions that are included in that contract.

(8) "Provider contract" or "contract" means an agreement between a provider and a health care corporation that contains provisions to implement the provider class plan.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1108 Definitions; R, S.

Sec. 108. (1) "Reimbursement arrangement" means policies, practices, and methods by which a health care corporation makes payments to a provider to implement the provider class plan.

(2) "Small subscriber group" means a group of less than 150 subscribers.

(3) "Subscriber" means an individual who contracts for health care benefits, either individually or through a group, with a health care corporation. Subscriber includes an individual whose contract contains an administrative services only or cost-plus arrangement authorized under section 207(1)(g).

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

PART 2

550.1201 Health care corporation; incorporation; number of persons; payment of cash or other material benefit to subscriber; applicable laws; charitable and benevolent institution; exemption from taxation; certificate of authority; health care benefits and certificates.

Sec. 201. (1) A health care corporation shall not be incorporated in this state except under this act.

(2) Not less than 7 persons, all of whom shall be residents of this state, may form a health care corporation under this act for the purpose of providing 1 or more health care benefits at the expense of the corporation to persons or groups of persons who become subscribers to the plan, under certificates which will entitle each subscriber to certain health care services by providers with which the corporation has contracted for that purpose.

(3) A certificate shall not provide for the payment of cash or any other material benefit to a subscriber or the estate of a subscriber on account of death, illness, or injury except where payment is made to a subscriber for health care services by a provider who has not entered into a participating contract with the corporation or to reimburse a subscriber who has made, or is obligated to make, payment directly to a provider.

(4) A health care corporation shall not be subject to the laws of this state with respect to insurance corporations, except as provided in this act. A health care corporation shall not be subject to the laws of this state with respect to corporations generally.

(5) A health care corporation subject to this act is declared to be a charitable and benevolent institution, and its funds and property shall be exempt from taxation by this state or any political subdivision of this state.

(6) A person shall not act as a health care corporation 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 act.

(7) A health care corporation shall provide only the kinds of health care benefits and certificates authorized by this act. A health care corporation shall not make or issue a certificate relative to health care benefits except as approved or otherwise authorized under this act.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1201a Formation of health care corporation after January 1, 2014; prohibition.

Sec. 201a. Notwithstanding section 201, a health care corporation shall not be formed in this state on or after January 1, 2014.

History: Add. 2013, Act 4, Imd. Eff. Mar. 18, 2013.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1202 Articles of incorporation; contents; number; forms; examination and certification by attorney general; fees.

Sec. 202. (1) Persons associating to form a health care corporation under this act shall subscribe to articles of incorporation that shall contain all of the following:

(a) The names and addresses of the incorporators.

(b) The location of the principal office of the corporation for the transaction of business in this state.

(c) The name by which the corporation shall be known and all assumed names under which the corporation does business. The corporate name shall not include the words insurance, casualty, surety, health and accident, mutual, or other words descriptive of the insurance or surety business, and shall not be so similar to the name of an insurance or surety company doing business in this or other states at the time of incorporation so as to tend, in the judgment of the commissioner, to create confusion in identity with that insurance or surety company.

(d) The purposes of the corporation, which shall be:

(*i*) To provide health care benefits.

(*ii*) 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.

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

(*iv*) To achieve the goals of the corporation relative to access, quality, and cost of health care services, as prescribed in section 504.

(*v*) To offer supplemental coverage to all medicare enrollees as provided in part 4A.

(*vi*) If under contract to serve as fiscal intermediary for the federal medicare program, to do all of the following:

(A) Carry out its contractual responsibilities efficiently, including the timely processing and payment of claims.

(B) Actively represent, in negotiations with the federal government and with providers of medical, hospital, and other health services for which benefits are provided under the federal medicare program, the interests of senior citizens as they relate to cost and quality of, and access to, health care services and administration of the program.

(*vii*) To engage in activity otherwise authorized by this act, within the purposes for which corporations may be organized under this act.

(e) The term of existence of the corporation, which may be in perpetuity.

(f) The time for the holding of the annual meeting of the corporation.

(g) Other terms and conditions not inconsistent with this act, necessary for the conduct of the affairs of the corporation.

(2) The articles shall be in triplicate and upon proper forms as prescribed by the commissioner.

(3) Before the articles or amendments to the articles are effective for any purpose, they shall be submitted to the attorney general for examination. If the attorney general finds the articles or amendments to the articles to be in compliance with this act, the attorney general shall certify this finding to the commissioner. The articles or amendments shall be effective at the time certified by the attorney general.

(4) Each health care corporation shall pay a fee of $250.00 to the attorney general for the examination of its articles of incorporation, or $100.00 for the examination of amendments to the articles of incorporation. Each health care corporation shall pay a filing fee of $100.00 to the commissioner for filing its articles of incorporation or $50.00 for the filing of amendments to the articles of incorporation. The fees prescribed in this subsection shall be deposited in the state treasury and credited to the general fund of the state.

History: 1980, Act 350, Eff. Apr. 3, 1981;—Am. 1988, Act 102, Imd. Eff. Apr. 11, 1988;—Am. 1994, Act 40, Imd. Eff. Mar. 14, 1994.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1203 Amendment or restatement of articles; review; approval.

Sec. 203. By action of its board of directors, a health care corporation may integrate into a single instrument the provisions of its articles of incorporation which are then in effect and operative, as theretofore amended. If the restated articles restate and integrate and also further amend the articles, they shall also be adopted by the board of directors. Any amendment or restatement of the articles shall be subject to review, approval, or both, as provided in section 202(3) or 701, as applicable.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1204 Filing of statements and documents; examination; investigation; additional information; conditions; duties of commissioner.

Sec. 204. (1) Before entering into contracts or securing applications of subscribers, the persons incorporating a health care corporation shall file all of the following in the office of the commissioner:

(a) Three copies of the articles of incorporation, with the certificate of the attorney general required under section 202(3) attached.

(b) A statement showing in full detail the plan upon which the corporation proposes to transact business.

(c) A copy of all certificates to be issued to subscribers.

(d) A copy of the financial statements of the corporation.

(e) Proposed advertising to be used in the solicitation of certificates for subscribers.

(f) A copy of the bylaws.

(g) A copy of all proposed contracts and reimbursement methods.

(2) The commissioner shall examine the statements and documents filed under subsection (1), may conduct any investigation that he or she considers necessary, may request additional oral and written information from the incorporators, and may examine under oath any persons interested in or connected with the proposed health care corporation. The commissioner shall ascertain whether all of the following conditions are met:

(a) The solicitation of certificates will not work a fraud upon the persons solicited by the corporation.

(b) The rates to be charged and the benefits to be provided are adequate, equitable, and not excessive, as defined in section 609.

(c) The amount of money actually available for working capital is sufficient to carry all acquisition costs and operating expenses for a reasonable period of time from the date of issuance of the certificate of authority, and is not less than $500,000.00 or a greater amount, if the commissioner considers it necessary.

(d) The amounts contributed as the working capital of the corporation are payable only out of amounts in excess of minimum required reserves of the corporation.

(e) Adequate and unimpaired surplus is provided, as determined under section 204a.

(3) If the commissioner finds that the conditions prescribed in subsection (2) are met, the commissioner shall do all of the following:

(a) Return to the incorporators 1 copy of the articles of incorporation, certified for filing with the director of the department of consumer and industry services or of any other agency or department authorized by law to administer the business corporation act, 1972 PA 284, MCL 450.1101 to 450.2098, or his or her designated representative, and 1 copy of the articles of incorporation certified for the records of the corporation itself.

(b) Retain 1 copy of the articles of incorporation for the commissioner's office files.

(c) Deliver to the corporation a certificate of authority to commence business and to issue certificates that have been approved by the commissioner, or that are exempted from prior approval pursuant to section 607(2) or (8), entitling subscribers to certain health care benefits.

History: 1980, Act 350, Eff. Apr. 3, 1981;—Am. 2003, Act 59, Eff. July 23, 2003.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1204a Unimpaired surplus.

Sec. 204a. (1) A health care corporation shall possess and maintain unimpaired surplus in an amount determined adequate by the commissioner to comply with section 403 of the insurance code of 1956, 1956 PA 218, MCL 500.403. The commissioner shall follow the risk-based capital requirements as developed by the national association of insurance commissioners in order to determine whether a health care corporation is in adequate compliance with section 403 of the insurance code of 1956, 1956 PA 218, MCL 500.403.

(2) If a health care corporation 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 health care corporation 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 health care corporation 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 health care corporation'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 health care corporation'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.

(5) Subject to this subsection, a health care corporation shall not maintain surplus in an amount that equals or is greater than 200% of the authorized control level under risk-based capital requirements multiplied by 5. If a health care corporation files a risk-based capital report that indicates that its surplus is more than the allowable maximum surplus permitted under this subsection for 2 successive calendar years, the health care corporation shall file a plan for approval by the commissioner to adjust its surplus to a level below the allowable maximum surplus. If the commissioner disapproves the health care corporation's plan, the commissioner shall formulate an alternate plan and forward the alternate plan to the health care corporation. The health care corporation shall begin implementation of the plan immediately upon receipt of approval of its plan by the commissioner or upon receipt of the commissioner's alternate plan.

History: Add. 2003, Act 59, Eff. July 23, 2003.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1205 Repealed. 2003, Act 59, Eff. July 23, 2003.

Compiler's note: The repealed section pertained to accounting and filing practices of health care corporation.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1205a Actuarial practices and accounting principles; financial report.

Sec. 205a. A health care corporation shall report financial information in conformity with sound actuarial practices and statutory accounting principles in the same manner as designated by the commissioner for other carriers pursuant to section 438(2) of the insurance code of 1956, 1956 PA 218, MCL 500.438. Approved permitted practices for the sole purpose of effectuating the transfer to statutory accounting principles under this section may be used by a health care corporation until January 1, 2007.

History: Add. 2003, Act 59, Eff. July 23, 2003.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1206 Funds, property, and business of health care corporation; investments; insurance; prepaid health care benefits.

Sec. 206. (1) The funds and property of a health care corporation shall be acquired, held, and disposed of only for the lawful purposes of the corporation and for the benefit of the subscribers of the corporation as a whole. A health care corporation shall only transact business, receive, collect, and disburse money, and acquire, hold, protect, and convey property, that is properly within the scope of the purposes of the corporation as specifically set forth in section 202(1)(d), for the benefit of the subscribers of the corporation as a whole, and consistent with this act.

(2) The funds of a health care corporation shall be invested only in securities permitted by the laws of this state for the investments of assets of life insurance companies, as described in chapter 9 of the insurance code of 1956, 1956 PA 218, MCL 500.901 to 500.947.

(3) Without regard to the limitation in subsection (2), up to 2% of the assets of the health care corporation may be invested in venture-type investments. For purposes of calculating adequate and unimpaired surplus under section 204a, a venture-type investment shall be carried on the books of a health care corporation at the original acquisition cost, and losses may only be realized as an offset against gains from venture-type investments. All venture-type investments under this subsection shall provide employment or capital investment primarily within this state. Each investment under this subsection is subject to prior approval by the board of directors. As used in this subsection, "venture-type investments" include:

(a) Common stock, preferred stock, limited partnerships, or similar equity interests acquired from the issuer subject to a provision barring resale without consent of the issuer for 5 years from the date of acquisition by the corporation.

(b) Unsecured debt instruments that are either convertible into equity or have equity acquisition rights.

These debt instruments shall be subordinated by their terms to all borrowings of the issuer from other institutional lenders and shall have no part amortized during the first 5 years.

(4) A health care corporation shall not market or transact, as defined in sections 402a and 402b of the insurance code of 1956, 1956 PA 218, MCL 500.402a and 500.402b, any type of insurance described in chapter 6 of the insurance code of 1956, 1956 PA 218, MCL 500.600 to 500.644. This subsection shall not be construed to prohibit the provision of prepaid health care benefits.

History: 1980, Act 350, Eff. Apr. 3, 1981;—Am. 2003, Act 59, Eff. July 23, 2003.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1207 Powers of health care corporation; interests of senior citizens; validity of corporate acts.

Sec. 207. (1) A health care corporation, 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) Contract to provide computer services and other administrative consulting services to 1 or more providers or groups of providers, if the services are primarily designed to result in cost savings to subscribers.

(b) Engage in experimental health care projects to explore more efficient and economical means of implementing the corporation's programs, or the corporation's goals as prescribed in section 504 and the purposes of this act, to develop incentives to promote alternative methods and alternative providers, including nurse midwives, nurse anesthetists, and nurse practitioners, for delivering health care, including preventive care and home health care.

(c) For the purpose of providing health care services to employees of this state, the United States, or an agency, instrumentality, or political subdivision of this state or the United States, or for the purpose of providing all or part of the costs of health care services to disabled, aged, or needy persons, contract with this state, the United States, or an agency, instrumentality, or political subdivision of this state or the United States.

(d) For the purpose of administering any publicly supported health benefit plan, accept and administer funds, directly or indirectly, made available by a contract authorized under subdivision (c), or made available by or received from any private entity.

(e) For the purpose of administering any publicly supported health benefit plan, subcontract with any organization that has contracted with this state, the United States, or an agency, instrumentality, or political subdivision of this state or the United States, for the administration or furnishing of health services or any publicly supported health benefit plan.

(f) Provide administrative services only and cost-plus arrangements for the federal medicare program established by parts A and B of title XVIII of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1395c to 1395i, 1395i-2 to 1395i-5, 1395j to 1395t, 1395u to 1395w, and 1395w-2 to 1395w-4; for the federal medicaid program established under 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; for title V of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 701 to 704 and 705 to 710; for the program of medical and dental care established by the military medical benefits amendments of 1966, Public Law 85-861, 80 Stat. 862; for the Detroit maternity and infant care--preschool, school, and adolescent project; and for any other health benefit program established under state or federal law.

(g) Provide administrative services only and cost-plus arrangements for any noninsured health benefit plan, subject to the requirements of sections 211 and 211a.

(h) Establish, own, and operate a health maintenance organization, subject to the requirements of the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302.

(i) Guarantee loans for the education of persons who are planning to enter or have entered a profession that is licensed, certified, or registered under parts 161 to 182 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18237, and has been identified by the commissioner, with the consultation of the office of health and medical affairs in the department of management and budget, as a profession whose practitioners are in insufficient supply in this state or specified areas of this state and who agree, as a condition of receiving a guarantee of a loan, to work in this state, or an area of this state specified in a listing of shortage areas for the profession issued by the commissioner, for a period of time determined by the commissioner.

(j) Receive donations to assist or enable the corporation to carry out its purposes, as provided in this act.

(k) Bring an action against an officer or director of the corporation.

(*l*) Designate and maintain a registered office and a resident agent in that office upon whom service of process may be made.

(m) Sue and be sued in all courts and participate in actions and proceedings, judicial, administrative, arbitrative, or otherwise, in the same cases as natural persons.

(n) Have a corporate seal, alter the seal, and use it by causing the seal or a facsimile to be affixed, impressed, or reproduced in any other manner.

(o) Subject to chapter 9 of the insurance code of 1956, 1956 PA 218, MCL 500.901 to 500.947, invest and reinvest its funds and, for investment purposes only, purchase, take, receive, subscribe for, or otherwise acquire, own, hold, vote, employ, sell, lend, lease, exchange, transfer, or otherwise dispose of, mortgage, pledge, use, and otherwise deal in and with, bonds and other obligations, shares, or other securities or interests issued by entities other than domestic, foreign, or alien insurers, as defined in sections 106 and 110 of the insurance code of 1956, 1956 PA 218, MCL 500.106 and 500.110, whether engaged in a similar or different business, or governmental or other activity, including banking corporations or trust companies. However, a health care corporation may purchase, take, receive, subscribe for, or otherwise acquire, own, hold, vote, employ, sell, lend, lease, exchange, transfer, or otherwise dispose of bonds or other obligations, shares, or other securities or interests issued by a domestic, foreign, or alien insurer, so long as the activity meets all of the following:

(*i*) Is determined by the attorney general to be lawful under section 202.

(*ii*) Is approved in writing by the commissioner as being in the best interests of the health care corporation and its subscribers.

(*iii*) For an activity that occurred before the effective date of the amendatory act that added subparagraph (*iv*), will not result in the health care corporation owning or controlling 10% or more of the voting securities of the insurer or will not otherwise result in the health care corporation having control of the insurer, either before or after the effective date of the amendatory act that added subparagraph (*iv*). As used in this subparagraph and subparagraph (*iv*), "control" means that term as defined in section 115 of the insurance code of 1956, 1956 PA 218, MCL 500.115.

(*iv*) Subject to section 218 and beginning on the effective date of the amendatory act that added this subparagraph, will not result in the health care corporation owning or controlling part or all of the insurer unless the transaction satisfies chapter 13 of the insurance code of 1956, 1956 PA 218, MCL 500.1301 to 500.1379, and the insurer being acquired is only authorized to sell disability insurance as defined under section 606 of the insurance code of 1956, 1956 PA 218, MCL 500.606, or under a statute or regulation in the insurer's domiciliary jurisdiction that is substantially similar to section 606 of the insurance code of 1956, 1956 PA 218, MCL 500.606.

(p) Purchase, receive, take by grant, gift, devise, bequest or otherwise, lease, or otherwise acquire, own, hold, improve, employ, use and otherwise deal in and with, real or personal property, or an interest therein, wherever situated.

(q) Sell, convey, lease, exchange, transfer or otherwise dispose of, or mortgage or pledge, or create a security interest in, any of its property, or an interest therein, wherever situated.

(r) Borrow money and issue its promissory note or bond for the repayment of the borrowed money with interest.

(s) Make donations for the public welfare, including hospital, charitable, or educational contributions that do not significantly affect rates charged to subscribers.

(t) Participate with others in any joint venture with respect to any transaction that the health care corporation would have the power to conduct by itself.

(u) Cease its activities and dissolve, subject to the commissioner's authority under section 606(2).

(v) Make contracts, transact business, carry on its operations, have offices, and exercise the powers granted by this act in any jurisdiction, to the extent necessary to carry out its purposes under this act.

(w) Have and exercise all powers necessary or convenient to effect any purpose for which the corporation was formed.

(x) Notwithstanding subdivision (o) or any other provision of this act, establish, own, and operate a domestic stock insurance company only for the purpose of acquiring, owning, and operating the state accident fund pursuant to chapter 51 of the insurance code of 1956, 1956 PA 218, MCL 500.5100 to 500.5114, so long as all of the following are met:

(*i*) For insurance products and services the insurer whether directly or indirectly only transacts worker's compensation insurance and employer's liability insurance, transacts disability insurance limited to replacement of loss of earnings, and acts 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 and does not transact any other type of insurance notwithstanding the authorization in chapter 51 of the insurance code of 1956, 1956 PA 218, MCL 500.5100 to 500.5114. This subparagraph does not preclude the insurer from providing either directly or indirectly noninsurance products and services as otherwise

provided by law.

(*ii*) The activity is determined by the attorney general to be lawful under section 202.

(*iii*) The health care corporation does not directly or indirectly subsidize the use of any provider or subscriber information, loss data, contract, agreement, reimbursement mechanism or arrangement, computer system, or health care provider discount to the insurer.

(*iv*) Members of the board of directors, employees, and officers of the health care corporation are not, directly or indirectly, employed by the insurer unless the health care corporation is fairly and reasonably compensated for the services rendered to the insurer if those services were paid for by the health care corporation.

(*v*) Health care corporation and subscriber funds are used only for the acquisition from the state of Michigan of the assets and liabilities of the state accident fund.

(*vi*) Health care corporation and subscriber funds are not used to operate or subsidize in any way the insurer including the use of such funds to subsidize contracts for goods and services. This subparagraph does not prohibit joint undertakings between the health care corporation and the insurer to take advantage of economies of scale or arm's-length loans or other financial transactions between the health care corporation and the insurer.

(2) In order to ascertain the interests of senior citizens regarding the provision of medicare supplemental coverage, as described in section 202(1)(d)(*v*), and to ascertain the interests of senior citizens regarding the administration of the federal medicare program when acting as fiscal intermediary in this state, as described in section 202(1)(d)(*vi*), a health care corporation shall consult with the office of services to the aging and with senior citizens' organizations in this state.

(3) An act of a health care corporation, otherwise lawful, is not invalid because the corporation was without capacity or power to do the act. However, the lack of capacity or power may be asserted:

(a) In an action by a director or a member of the corporate body against the corporation to enjoin the doing of an act.

(b) In an action by or in the right of the corporation to procure a judgment in its favor against an incumbent or former officer or director of the corporation for loss or damage due to an unauthorized act of that officer or director.

(c) In an action or special proceeding by the attorney general to enjoin the corporation from the transacting of unauthorized business, to set aside an unauthorized transaction, or to obtain other equitable relief.

(4) A health care corporation shall not condition the sale or vary the terms or conditions of any product sold by the corporation or by a subsidiary of the corporation by requiring the purchase of any other product from the corporation or from a subsidiary of the corporation.

History: 1980, Act 350, Eff. Apr. 3, 1981;—Am. 1989, Act 260, Imd. Eff. Dec. 26, 1989;—Am. 1993, Act 127, Imd. Eff. July 21, 1993;—Am. 1993, Act 201, Imd. Eff. Oct. 19, 1993;—Am. 1999, Act 210, Imd. Eff. Dec. 21, 1999;—Am. 2003, Act 59, Eff. July 23, 2003.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1208 Action by member; complaint.

Sec. 208. (1) An action may be brought in the right of a health care corporation to procure a judgment in its favor, by a member of the corporate body.

(2) In such an action, the complaint shall allege:

(a) That the plaintiff is a member of the corporate body at the time of bringing the action, and that he or she was a member of the corporate body at the time of the transaction of which he or she complains.

(b) With particularity, the effort of the plaintiff to secure the initiation of the action by the board or the reasons for not making the effort.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1209 Action by member; discontinuance, compromise, or settlement; notice; expense.

Sec. 209. An action authorized by section 208 shall not be discontinued, compromised, or settled without approval by the court having jurisdiction of the action. If the court determines that the interest of the members of the corporate body or of any component thereof will be substantially affected by the discontinuance, compromise, or settlement, the court may direct that notice, by publication or otherwise, be given to the members of the corporate body or any component thereof, whose interests it determines will be so affected. If notice is so directed to be given, the court may determine which 1 or more of the parties to the action shall

bear the expense of giving the notice, in an amount which the court determines and finds reasonable under the circumstances. The amount of this expense shall be awarded as special costs of the action and shall be recoverable in the same manner as statutory taxable costs.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1210 Action by member; reasonable expenses; attorney's fees.

Sec. 210. (1) If an action brought in the right of the corporation is successful, in whole or in part, or if anything is received by the plaintiff or a claimant as a result of a judgment, compromise, or settlement of an action or claim, the court may award the plaintiff or claimant reasonable expenses, including reasonable attorney's fees, and shall direct him or her to account to the corporation for the remainder of the proceeds so received by him or her. This section does not apply to a judgment rendered for the benefit of an injured corporate body member only and limited to a recovery of the loss or damage sustained by him or her.

(2) In an action brought in the right of the corporation by a member of the corporate body, the court having jurisdiction, upon final judgment and finding that the action was brought without reasonable cause, may require the plaintiff to pay to the parties named as defendants the reasonable expenses, including fees of attorneys, incurred by them in the defense of the action.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1211 Administrative services only and cost-plus arrangements; service contracts; fees; administrative costs; marketing policy; notice; coverage, rights, and obligations under collective bargaining agreement; liability of individual; report; “noninsured benefit plan” defined.

Sec. 211. (1) Pursuant to section 207(1)(g), a health care corporation may enter into service contracts containing an administrative services only or cost-plus arrangement. Except as otherwise provided in this section, a corporation shall not enter into a service contract containing an administrative services only or cost-plus arrangement for a noninsured benefit plan covering a group of less than 500 individuals, except that a health care corporation may continue an administrative services only or cost-plus arrangement with a group of less than 500, which arrangement is in existence in September of 1980. A corporation may enter into contracts containing an administrative services only or cost-plus arrangement for a noninsured benefit plan covering a group of less than 500 individuals if either the corporation makes arrangements for excess loss coverage or the sponsor of the plan that covers the individuals is liable for the plan's liabilities and is a sponsor of 1 or more plans covering a group of 500 or more individuals in the aggregate. The commissioner, upon obtaining the advice of the corporations subject to this act, shall establish the standards for the manner and amount of the excess loss coverage required by this subsection. It is the intent of the legislature that the excess loss coverage requirements be uniform as between corporations subject to this act and other persons authorized to provide similar services. The corporation shall offer in connection with a noninsured benefit plan a program of specific or aggregate excess loss coverage.

(2) Relative to actual administrative costs, fees for administrative services only and cost-plus arrangements shall be set in a manner that precludes cost transfers between subscribers subject to either of these arrangements and other subscribers of the health care corporation. Administrative costs for these arrangements shall be determined in accordance with the administrative costs allocation methodology and definitions filed and approved under part 6, and shall be expressed clearly and accurately in the contracts establishing the arrangements, as a percentage of costs rather than charges. This subsection shall not be construed to prohibit the inclusion, in fees charged, of contributions to adequate and unimpaired surplus as provided in section 204a.

(3) Before a health care corporation may enter into contracts containing administrative services only or cost-plus arrangements pursuant to section 207(1)(g), the board of directors of the corporation shall approve a marketing policy for these arrangements that is consistent with this section. The marketing policy may contain other provisions as the board considers necessary. The marketing policy shall be carried out by the corporation consistent with this act.

(4) A corporation providing services under a contract containing an administrative services only or cost-plus arrangement in connection with a noninsured benefit plan shall provide in its service contract a provision that the person contracting for the services in connection with a noninsured benefit plan shall notify

each covered individual of what services are being provided; the fact that individuals are not insured or are not covered by a certificate from the corporation, or are only partially insured or are only partially covered by a certificate from the corporation, as the case may be; which party is liable for payment of benefits; and of future changes in benefits.

(5) A service contract containing an administrative services only arrangement between a corporation and a governmental entity not subject to the employee retirement income security act of 1974, Public Law 93-406, 88 Stat. 829, whose plan provides coverage under a collective bargaining agreement utilizing a policy or certificate issued by a carrier before the signing of the service contract, is void unless the governmental entity has provided the notice described in subsection (4) to the collective bargaining agent and to the members of the collective bargaining unit not less than 30 days before signing the service contract. The voiding of a service contract under this subsection shall not relieve the governmental entity of any obligations to the corporation under the service contract.

(6) Nothing in this section shall be construed to permit an actionable interference by a corporation with the rights and obligations of the parties under a collective bargaining agreement.

(7) An individual covered under a noninsured benefit plan for which services are provided under a service contract authorized under subsection (1) is not liable for that portion of claims incurred and subject to payment under the plan if the service contract is entered into between an employer and a corporation, unless that portion of the claim has been paid directly to the covered individual.

(8) A corporation shall report with its annual statement the amount of business it has conducted as services provided under subsection (1) that are performed in connection with a noninsured benefit plan, and the commissioner shall transmit annually this information to the state treasurer. The commissioner shall submit to the legislature on April 1, 1994, a report detailing the impact of this section on employers and covered individuals, and similar activities under other provisions of law, and in consultation with the state treasurer the total financial impact on the state for the preceding legislative biennium.

(9) As used in this section, "noninsured benefit plan" or "plan" means a health benefit plan without coverage by a health care corporation, health maintenance organization, or insurer or the portion of a health benefit plan without coverage by a health care corporation, health maintenance organization, or insurer that has a specific or aggregate excess loss coverage.

History: 1980, Act 350, Eff. Apr. 3, 1981;—Am. 1984, Act 181, Imd. Eff. July 3, 1984;—Am. 1993, Act 127, Imd. Eff. July 21, 1993;—Am. 2003, Act 59, Eff. July 23, 2003.

Constitutionality: This act is unconstitutional in the following three particulars:

(1) The act's provision for an actuary panel to resolve risk factor disputes is an unconstitutional delegation of legislative authority in that it lacks adequate standards (MCL 550.1205(6)).

(2) The statutory restrictions on administrative services only (ASO) contracts violate equal protection of the laws insofar as they result in arbitrary and discriminatory treatment of health care corporations vis-a-vis commercial insurers (MCL 550.1104(3), 550.1211, 550.1414a, 550.1415, and 550.1607(1)).

(3) The commissioner's authority to issue a cease and desist order based on probable cause against a health care corporation for noncompliance with the act establishes an improper burden of proof (MCL 550.1402(7)).

The Supreme Court ruling on these three areas of this act does not affect the constitutionality of the remainder of the act. Where, as here, the unconstitutional provisions are easily severable, the remainder of the act need not be affected. Blue Cross and Blue Shield of Michigan v Governor, 422 Mich 1; 367 NW2d 1 (1985).

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1211a Definitions; prohibited acts by corporation; processing claims for benefits on timely basis; claim form; notice to covered individuals; notice to corporation of complaint and proceedings contemplated; hearing; findings; order; violation of order; penalty; action and award of actual monetary damages; review; stay of enforcement.

Sec. 211a. (1) As used in this section:

(a) "Noninsured benefit plan" means a health benefit plan without coverage by a health care corporation, health maintenance organization, or insurer or the portion of a health benefit plan without coverage by a health care corporation, health maintenance organization, or insurer that has a specific or aggregate excess loss coverage.

(b) "Process a claim" means the services performed in connection with a claim for benefits including the disbursement of benefit amounts.

(2) A health care corporation providing services under section 211 shall not do any of the following:

(a) Misrepresent pertinent facts relating to coverage.

(b) Fail to acknowledge promptly or to act reasonably and promptly upon communications with respect to a claim for benefits.

(c) Fail to adopt and implement reasonable standards for the prompt investigation of a claim for benefits.

(d) Refuse to process claims without conducting a reasonable investigation based upon the available information.

(e) Fail to communicate affirmation or denial of coverage of a claim for benefits within a reasonable time after a claim has been received.

(f) Fail to attempt in good faith to promptly, fairly, and equitably process a claim for benefits.

(g) Knowingly compel covered individuals to institute litigation to recover amounts due under a benefit plan or certificate by offering substantially less than the amounts due.

(h) For the purpose of coercing a covered individual to accept a settlement or compromise in a claim, inform the covered individual of a corporation policy of appealing administrative hearing decisions that are in favor of covered individuals.

(i) Delay the investigation or processing of a claim by requiring a covered individual, or the provider of services to the covered individual, to submit a preliminary claim and then requiring subsequent submission of a formal claim, seeking solely the duplication of a verification.

(j) Fail to promptly provide a reasonable explanation of the basis for denial or partial denial of a claim for benefits.

(k) Fail to promptly process a claim where liability has become reasonably clear under 1 portion of a benefit plan or certificate in order to influence a settlement under another portion of the benefit plan or certificate.

(*l*) Refuse to enter into a service contract, or refuse to provide services under a service contract because of race, color, creed, marital status, sex, national origin, residence, age, disability, or lawful occupation.

(3) A corporation providing services under section 211 in connection with a noninsured benefit plan shall not, in order to induce a person to contract or to continue to contract with the corporation for the provision of services under a service contract or certificate offered by the corporation; to induce a person to lapse, forfeit, or surrender a certificate or service contract issued by the corporation; or to induce a person to secure or terminate coverage with an insurer, health care corporation, health maintenance organization, or other person, directly or indirectly, do any of the following:

(a) Issue or deliver to the person money or any other valuable consideration.

(b) Offer to make or make an agreement relating to a service contract or certificate other than as plainly expressed in the service contract or certificate.

(c) Offer to give or pay, or give or pay, directly or indirectly, a rebate or adjustment of the rate payable on the service contract or certificate, or an advantage in the services thereunder, except as reflected in the rate and expressly provided in the service contract or certificate. Readjustment of the rate for services provided under the service contract or certificate may be made at the end of a contract or certificate year or contract or certificate period and may be made retroactive.

(d) Make, issue, or circulate, or cause to be made, issued, or circulated, an estimate, illustration, circular, or statement misrepresenting the terms of a service contract or certificate, the advantages provided thereunder, or the true nature thereof.

(e) Make a misrepresentation or incomplete comparison, whether oral or written, between service contracts or certificates of the corporation or between service contracts or certificates of the corporation and an insurer, hospital service corporation, health maintenance organization, or other person.

(4) A corporation providing services under section 211 in connection with a noninsured benefit plan shall process claims for benefits on a timely basis. If not paid on a timely basis, benefits payable to a covered individual shall bear simple interest from a date 60 days after a satisfactory claim form was received by the corporation, at a rate of 12% interest per annum. The interest shall be paid by the noninsured benefit plan in addition to, and at the time of payment of, the claim.

(5) A corporation providing services under section 211 in connection with a noninsured benefit plan shall specify in writing the materials that constitute a satisfactory claim form not later than 30 days after receipt of a claim, unless the claim is settled within 30 days. If a claim form is not supplied as to the entire claim, the amount supported by the claim form shall be considered to be paid on a timely basis if paid within 60 days after receipt of the claim form by the corporation.

(6) A corporation providing services under section 211 in connection with a noninsured benefit plan shall provide in its service contract a provision that the person contracting for the services in connection with a noninsured benefit plan shall notify each covered individual as to what services are being provided; the fact that individuals are not insured or are not covered by a certificate from the corporation, or are only partially insured or are only partially covered by a certificate from the corporation, as the case may be; which party is liable for payment of benefits; and of future changes in benefits.

(7) If the commissioner has probable cause to believe that a corporation is violating, or has violated

subsection (2), indicating a persistent tendency to engage in conduct prohibited by that subsection, or has probable cause to believe that a corporation is violating, or has violated any other subsection of this section, he or she shall give written notice to the corporation, pursuant to the administrative procedures act, setting forth the general nature of the complaint against the corporation and the proceedings contemplated under this section. Before the issuance of a notice of hearing, the staff of the insurance bureau responsible for the matters that would be at issue in the hearing shall give the corporation an opportunity to confer and discuss the possible complaint and proceedings in person with the commissioner or a representative of the commissioner, and the matter may be disposed of summarily upon agreement of the parties. This subsection shall not be construed to diminish the right of a person to bring an action for damages under this section.

(8) A hearing held pursuant to subsection (7) shall be held pursuant to the administrative procedures act. If, after the hearing, the commissioner determines that the corporation is violating, or has violated subsection (2), indicating a persistent tendency to engage in conduct prohibited by that subsection, or has violated or is violating any other subsection of this section, the commissioner shall reduce his or her findings and decision to writing, and shall issue and cause to be served upon the corporation a copy of the findings and an order requiring the corporation to cease and desist from engaging in the prohibited activity. In addition to a cease and desist order, the commissioner may order any of the following:

(a) Payment of a monetary penalty of not more than $500.00 for each violation but not to exceed an aggregate penalty of $5,000.00, unless the corporation knew or reasonably should have known it was in violation of this section, in which case the penalty shall not be more than $2,500.00 for each violation and shall not exceed an aggregate penalty of $25,000.00 for all violations committed in a 6-month period.

(b) Suspension or revocation of the corporation's license or certificate of authority if the corporation knowingly and persistently violated this section.

(c) Refund of any overcharges.

(9) A corporation that violates a cease and desist order of the commissioner issued under subsection (8), after notice and an opportunity for a hearing, and upon order of the commissioner, may be subject to a civil fine of not more than $10,000.00 for each violation.

(10) In addition to other remedies provided by law, an aggrieved covered individual may bring an action for actual monetary damages sustained as a result of a violation of this section. If successful on the merits, the covered individual shall be awarded actual monetary damages or $200.00, whichever is greater. If the corporation shows by a preponderance of the evidence that a violation of this section resulted from a bona fide error notwithstanding the maintenance of procedures reasonably adapted to avoid the error, the amount of recovery shall be limited to actual monetary damages.

(11) The filing of a petition for review does not stay enforcement of action pursuant to this section, but the commissioner may grant, or the appropriate court may order, a stay upon appropriate terms.

(12) The commissioner may at any time, by order, after notice and opportunity for hearing, reopen and alter, modify, or set aside, in whole or in part, an order issued by him or her under this section, when in his or her opinion conditions of fact or of law have so changed as to require that action or if the public interest shall so require.

History: Add. 1993, Act 127, Imd. Eff. July 21, 1993;—Am. 1998, Act 24, Imd. Eff. Mar. 12, 1998.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1212 Action without notice or lapse of time periods; waiver; attorney-in-fact.

Sec. 212. When, under this act or the articles of incorporation or bylaws of a health care corporation or by the terms of an agreement or instrument, a health care corporation or the board of directors of the health care corporation or any committee of the board may take action after notice to any person or after lapse of a prescribed period of time, the action may be taken without notice and without lapse of the period of time, if at any time before or after the action is completed the person entitled to notice or to participate in the action to be taken or, in case of a subscriber, by his or her attorney-in-fact, submits a signed waiver of those requirements. The attorney-in-fact may not be employed by, or receive substantial income from, the health care corporation.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1213 Indemnification.

Sec. 213. (1) A health care corporation may indemnify any person who was or is a party to, or is threatened

to be made a party to, any threatened, pending, or completed action, suit, or proceeding, whether civil, criminal, administrative, or investigative, other than an action by or in the right of the health care corporation, by reason of the fact that he or she is or was a director, member of the corporate body, officer, employee, or agent of the health care corporation, or is or was serving at the request of the health care corporation as a director, officer, employee, or agent of another corporation, partnership, joint venture, trust, or other enterprise. This indemnification shall be against expenses, including attorneys' fees, judgments, fines, and amounts paid in settlement, actually and reasonably incurred by him or her in connection with the action, suit, or proceeding, if he or she acted in good faith and in a manner which he or she reasonably believed to be in, or not opposed to, the best interests of the health care corporation, or its subscribers as a whole, and, with respect to any criminal action or proceeding, had no reasonable cause to believe his or her conduct was unlawful. The termination of any action, suit, or proceeding by judgment, order, settlement, conviction, or upon a plea of nolo contendere or its equivalent, shall not, of itself, create a presumption that the person did not act in good faith and in a manner which he or she reasonably believed to be in or not opposed to the best interests of the health care corporation, or its subscribers as a whole, and, with respect to any criminal action or proceeding, had reasonable cause to believe that his or her conduct was unlawful.

(2) A health care corporation may indemnify any person who was or is a party to, or is threatened to be made a party to, any threatened, pending, or completed action or suit by or in the right of the health care corporation to procure a judgment in its favor, by reason of the fact that he or she is or was a director, member of the corporate body, officer, employee, or agent of the health care corporation, or is or was serving at the request of the health care corporation as a director, officer, employee, or agent of another corporation, partnership, joint venture, trust, or other enterprise. This indemnification shall be against expenses, including attorneys' fees, actually and reasonably incurred by him or her in connection with the defense or settlement of the action or suit, if he or she acted in good faith and in a manner he or she reasonably believed to be in or not opposed to the best interests of the health care corporation, or its subscribers as a whole. However, indemnification shall not be made with respect to any claim, issue, or matter as to which the person has been adjudged to be liable for negligence or misconduct in the performance of his or her duty to the health care corporation unless, and only to the extent that, the court in which the action or suit was brought determines upon application that, despite the adjudication of liability, but in view of all circumstances of the case, the person is fairly and reasonably entitled to indemnity for those expenses which the court considers proper.

(3) To the extent that a director, member of the corporate body, officer, employee, or agent of a health care corporation has been successful on the merits or otherwise in defense of any action, suit, or proceeding referred to in subsection (1) or (2), or in defense of any claim, issue, or matter therein, he or she shall be indemnified against expenses, including attorneys' fees, actually and reasonably incurred by him or her in connection therewith.

(4) Any indemnification under subsection (1) or (2), unless ordered by a court, shall be made by the health care corporation only as authorized in the specific case, upon a determination that indemnification of the director, member of the corporate body, officer, employee, or agent is proper in the circumstances because he or she has met the applicable standard of conduct set forth in subsections (1) and (2). The determination shall be made in any of the following ways:

(a) By the board by a majority vote of a quorum consisting of directors who were not parties to the action, suit, or proceeding.

(b) If such a quorum is not obtainable, by independent legal counsel in a written opinion.

(5) Expenses incurred in defending a civil or criminal action, suit, or proceeding described in subsection (1) or (2) may be paid by the health care corporation in advance of the final disposition of the action, suit, or proceeding, as authorized in the manner provided in subsection (4), upon receipt of an undertaking by or on behalf of the director, member of the corporate body, officer, employee, or agent to repay that amount, unless it is ultimately determined that he or she is entitled to be indemnified by the corporation.

(6) A provision made to indemnify directors, members of the corporate body, or officers in any action, suit, or proceeding referred to in subsection (1) or (2), whether contained in the articles of incorporation, the bylaws, a resolution of the directors, an agreement, or otherwise, shall be invalid only insofar as it is in conflict with subsections (1) to (5) and this subsection. Nothing contained in subsections (1) to (5) and this subsection shall affect any rights to indemnification to which persons other than directors and officers may be entitled by contract or otherwise by law. The indemnification provided in subsections (1) to (5) and this subsection continues as to a person who has ceased to be a director, member of the corporate body, officer, employee, or agent, and shall inure to the benefit of the heirs, executors, and administrators of that person.

(7) A health care corporation may purchase and maintain insurance on behalf of any person who is or was a director, officer, employee, or agent of the corporation, or is or was serving at the request of the health care corporation as a director, officer, employee, or agent of another corporation, partnership, joint venture, trust,

or other enterprise against any liability asserted against him or her and incurred by him or her in that capacity, or arising out of his or her status as described in this subsection, whether or not the health care corporation would have power to indemnify him or her against this liability under subsections (1) to (6).

(8) For the purposes of subsections (1) to (7), references to a health care corporation include all constituent corporations absorbed in a consolidation or merger and the resulting or surviving corporation, so that a person who is or was a director, officer, employee, or agent of a constituent corporation or is or was serving at the request of such a constituent corporation as a director, officer, employee, or agent of another corporation, partnership, joint venture, trust, or other enterprise shall stand in the same position under the provisions of this section with respect to the resulting or surviving corporation as he or she would if he or she had served the resulting or surviving corporation in the same capacity.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1214 Rate of interest.

Sec. 214. A health care corporation may by agreement in writing, and not otherwise, agree to pay a rate of interest in excess of the legal rate, and in that case, the defense of usury is prohibited.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1215 Health care corporation as shareholder in other nonprofit corporation; rights, powers, privileges, and liabilities.

Sec. 215. When a health care corporation, consistent with the purposes of the corporation prescribed in this act, is a shareholder in any other nonprofit corporation, its president and other officers or any of its directors may hold the office of director of the other nonprofit corporation the same as if they were individual shareholders in the other nonprofit corporation. The health care corporation, being a shareholder in the other nonprofit corporation, shall possess and exercise all the rights, powers, privileges, and liabilities of individual shareholders.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1216, 550.1217 Repealed. 2002, Act 559, Imd. Eff. Sept. 27, 2002.

Compiler's note: The repealed sections pertained to merger, consolidation, or dissolution of corporation.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1218 Health care corporation; prohibited actions.

Sec. 218. A health care corporation shall not do any of the following:

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

(b) Except as otherwise provided in section 220, dissolve, merge, consolidate, mutualize, or take any other action that results in a change in direct or indirect control of the health care corporation or sell, transfer, lease, exchange, option, or convey assets that results in a change in direct or indirect control of the health care corporation.

History: Add. 2002, Act 559, Imd. Eff. Sept. 27, 2002;—Am. 2013, Act 4, Imd. Eff. Mar. 18, 2013.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1219 Provisions superseded.

Sec. 219. A nonprofit health care corporation is subject to chapter 37 of the insurance code of 1956, 1956 PA 218, MCL 500.3701 to 500.3723. To the extent that a provision of this act concerning health coverage, including, but not limited to, premiums, rates, filings, and coverages, conflicts with chapter 37 of the insurance code of 1956, 1956 PA 218, MCL 500.3701 to 500.3723, chapter 37 of the insurance code of 1956, 1956 PA 218, MCL 500.3701 to 500.3723, supersedes this act.

History: Add. 2003, Act 59, Eff. July 23, 2003.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1220 Merger of health care corporation with nonprofit mutual disability insurer.

Sec. 220. (1) Notwithstanding any provision of this act to the contrary, a health care corporation may establish, own, operate, and merge with a nonprofit mutual disability insurer formed under chapter 58 of the insurance code of 1956, 1956 PA 218, MCL 500.5800 to 500.5840. The surviving entity of a merger described in this subsection is the nonprofit mutual disability insurer. A merger described in this subsection is exempt from the application of sections 1311 to 1319 of the insurance code of 1956, 1956 PA 218, MCL 500.1311 to 500.1319.

(2) The merger of a health care corporation with a nonprofit mutual disability insurer is effective upon completion of both of the following:

(a) The adoption of a plan of merger by the majority of the boards of directors of both the health care corporation and the nonprofit mutual disability insurer. The health care corporation shall include in the plan of merger that beginning in April of the first full calendar year after the adoption of the plan of merger the surviving entity of a merger described in subsection (1) shall use its best efforts to make annual social mission contributions in an aggregate amount of up to $1,560,000,000.00 over a period of up to 18 years beginning in April of the first full calendar year after the adoption of the plan of merger to a nonprofit corporation created under part 6A. If adopted, the boards of directors shall submit the plan of merger to the commissioner for his or her consideration as provided in subdivision (b). A nonprofit mutual disability insurer is considered to be making its best effort under this subdivision if it makes the annual social mission contribution to a nonprofit corporation created in part 6A when the nonprofit mutual disability insurer's surplus is at least 375% of the authorized control level under risk-based capital requirements.

(b) The approval of the plan of merger by the commissioner. The commissioner shall make a determination to approve or disapprove a plan of merger within 90 days of receipt of the plan, and the commissioner shall not unreasonably withhold approval of a plan of merger submitted under subdivision (a).

(3) Notwithstanding any other provision of this act to the contrary, the directors of a health care corporation may serve as incorporators of the corporate body of, directors of, or officers of the nonprofit mutual disability insurer formed through a merger described in subsection (1).

(4) A merger described in subsection (1) is the dissolution of the health care corporation, and the surviving nonprofit mutual disability insurer assumes the performance of all contracts and policies of the merged health care corporation that exist on the date of the merger, including the participating hospital agreement, and its definition of certificate which excludes as covered services benefits provided pursuant to automobile no-fault or worker's compensation coverage, and all related contract obligations that result from orders relating to hospital provider class plans that are issued by the commissioner after July 1, 2012. However, the officers of a health care corporation may perform any act or acts necessary to close the affairs of the merged health care corporation after the date of the merger.

(5) Notwithstanding anything in this act to the contrary, if the merger of a health care corporation and a nonprofit mutual disability insurer becomes effective as described in subsection (2), the property of the health care corporation is subject to the collection of general ad valorem taxes and applicable specific taxes under the general property tax act, 1893 PA 206, MCL 211.1 to 211.155, beginning December 31, 2013. As provided in section 201, the property of a health care corporation is exempt from taxation before December 31, 2013. This act does not confer an exemption from taxation on a nonprofit mutual disability insurer that merges with a health care corporation.

History: Add. 2013, Act 4, Imd. Eff. Mar. 18, 2013.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

PART 3

550.1301 Board of directors; powers and duties generally; appointment, qualifications, and terms of members; vacancy; officer or employee as voting or nonvoting director; method of selection; definitions; prohibition.

Sec. 301. (1) The property and lawful business of a health care corporation existing and authorized to do business under this act shall be held and managed by a board of directors to consist of not more than 35 members. The board shall exercise the powers and authority necessary to carry out the lawful purposes of the corporation, as limited by this act and the articles of incorporation and the bylaws of the corporation.

(2) Four voting members of the board shall be representatives of the public appointed by the governor by and with the advice and consent of the senate. Two of those members shall be retired individuals 62 years of

age or older. The term of office of each representative of the public shall be 2 years, and until a successor is appointed and qualified. If a vacancy occurs before the conclusion of a 2-year term, the appointment of a representative to complete the term shall be made in the same manner as the original appointment.

(3) The board of directors shall consist of not more than 25% provider directors. In addition to physician and hospital provider directors, not less than 1 provider director shall be a registered professional nurse who shall be representative of licensees under part 172 of the public health code, Act No. 368 of the Public Acts of 1978, as amended, being sections 333.17201 to 333.17242 of the Michigan Compiled Laws, and not less than 1 provider director shall be representative of the provider whose services, in the 1984 calendar year in the case of an existing health care corporation, or, in the calendar year immediately following incorporation in the case of a newly-formed health care corporation, generated the largest number of benefit claims received by the corporation from its subscribers. Other provider directors shall be as broadly representative of provider classes as possible.

(4) The bylaws of a health care corporation may authorize not more than 1 officer or employee of the corporation to serve as a voting or nonvoting director.

(5) The remaining members of the board of directors shall include representatives of large subscriber groups, medium subscriber groups, small subscriber groups, and nongroup subscribers, in proportions which fairly represent the total subscriber population of the health care corporation. However, at least 3 directors shall represent nongroup subscribers, at least 1 of whom shall be a retired individual 62 years of age or older, and at least 3 directors shall represent small subscriber groups. Large and medium subscriber groups shall be represented, to the greatest extent possible, by an equal number of labor and management representatives and shall be categorized as labor subscriber representatives or management subscriber representatives.

(6) The method of selection of the directors, other than the directors who are representatives of the public, and additional provisions and requirements for further refinement or specification regarding the number of directors comprising each component shall be specified in the bylaws. The terms of office of directors, other than the directors who are representatives of the public, and the method for filling vacancies in those offices shall be provided in the bylaws. However, if a term of office of more than 1 year is prescribed by the bylaws, at least 1/3 of the members of the board shall be selected each year.

(7) The method of selection of each category of subscribers entitled to representation on the board under subsection (5) shall maximize subscriber participation to the extent reasonably practicable. This subsection shall permit, but not require, the statewide election of a director or member of the corporate body. The method of selection shall neither permit nor require nomination, endorsement, approval, or confirmation of a candidate or director by the corporate body, the board of directors, or the management of the health care corporation, or any member or members of any of these. This subsection shall not apply to the selection of an officer or employee as a director pursuant to subsection (4). This subsection shall not limit the rights of any director, member of the corporate body, or employee or officer of the health care corporation to participate in the selection process in his or her capacity as a subscriber, to the same extent as any other subscriber may participate.

(8) For the purposes of this section:

(a) "Health care provider" or "provider" includes:

(*i*) A person defined as a health care provider or provider in section 105(4); a person employed by a health care facility, as defined in section 105(3); or a director, officer, or trustee of a health care provider, as defined in section 105(4), unless the person serves in that capacity as a representative selected by the same subscriber group or collective bargaining representative which the person represents on the board of a health care corporation.

(*ii*) Except as provided in subdivision (b), a spouse, child, or parent of a health care provider who resides in the same household.

(*iii*) A person who receives more than 25% of his or her annual income through the provision of goods or services to health care providers, or who is an employee, officer, trustee, or director of a firm or organization which receives more than 25% of its annual income through the provision of goods or services to health care providers.

(b) For purposes of determining whether a director is a provider director, "health care provider" or "provider" does not include a spouse, child, or parent of a health care provider who resides in the same household if all of the following criteria are met:

(*i*) Not more than 1/3 of the total annual household income is earned by that health care provider.

(*ii*) The term of office of the director commences in the 1988 calendar year.

(*iii*) Not more than 2 directors qualify for the exemption under this subdivision.

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

History: 1980, Act 350, Eff. Apr. 3, 1981;—Am. 1988, Act 45, Imd. Eff. Mar. 11, 1988.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1302 Bylaws generally.

Sec. 302. (1) The board of directors shall adopt initial bylaws and may amend or repeal those bylaws or adopt new bylaws, subject to the prior approval or certification by the attorney general. The bylaws may contain any provision for the regulation and management of the affairs of the health care corporation 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 review and approval. The attorney general shall approve the initial bylaws, new bylaws, amendments, or repealers if the attorney general determines that they comply with this act.

(3) If the attorney general 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 setting forth the reasons for the disapproval and any recommendations for change which he or she may wish to suggest, not later than 30 days following their receipt. Bylaws, amendments, and repealers not returned to the health care corporation within this 30-day period shall be considered to comply with this act and shall be considered approved.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1303 Meetings; required provisions in bylaws; notice; waiver; participation by conference telephone or similar communications equipment; quorum; action by board; actions requiring majority vote; record roll call vote; recording vote in minutes.

Sec. 303. (1) Regular or special meetings of the board or a committee of the board shall be held within this state. With respect to regular or special meetings of the board or a committee of the board, 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.

(c) Voting procedures. The use of proxies and 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. Attendance of a director at a meeting constitutes a waiver of notice of the meeting, except in cases in which a director attends a meeting for the express purpose of objecting to the transaction of any business because the meeting is not lawfully called or convened.

(3) Unless otherwise restricted by the articles of incorporation or bylaws, a member of the board or of a committee designated by the board 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 the members of the board then in office, or of the members of a committee thereof, 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 act, 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) The proposal or establishment of rates or rating systems; the adoption of provider class plans or provider contracts; or the adoption of compensation for officers of the corporation.

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

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1304 Books, records, and minutes; copy of minutes; disclosure, publication, and dissemination of minutes; compelling production of books or records.

Sec. 304. (1) A health care corporation shall keep accurate books and records of account and minutes of

the proceedings of the board of directors of the health care corporation, committees of the board, and the corporate body. 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. 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 the request of a member of the board of directors, consistent with the board member's fiduciary duty under section 310, 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, its committee, or the corporate body, 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 as provided in section 603, for those portions of meetings which 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 shall not be subject to examination and free access under section 603.

(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 corporation may invest funds under section 206, 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 health care corporation.

(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 as provided in section 603, 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), and may be disclosed by the commissioner to other persons under section 603(3).

(4) The circuit court, upon proof of a proper purpose, may compel the production of books and records for examination by a subscriber or the attorney general.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1305 Establishment and composition of corporate body; service of members on committees; membership on board of directors.

Sec. 305. (1) A health care corporation may establish a corporate body. The corporate body shall consist of individuals selected in the same manner as individuals are selected to serve as nonpublic members on the board of directors. The size of the corporate body shall be such that, for each nonpublic voting director on the board of directors of the corporation, there are 2 members of the corporate body. The 4 public members selected pursuant to section 301(2) shall be considered to be members of the corporate body as well as members of the board of directors. An additional 4 public members shall be appointed to the corporate body by the governor by and with the advice and consent of the senate, 2 of whom shall be retired individuals 62 years of age or older.

(2) Members of the corporate body may serve on committees of the board of directors. A member of the corporate body may be selected for membership on the board of directors, provided that the selection is made in accordance with the provisions of this part governing the selection of voting directors of the board.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1306 Effect of common directorship, officership, or interest on validity of contract or other transaction; burden of establishing validity of contract; exclusion of common or interested directors in determination of quorum; compensation of directors; bylaws regarding conflict of interest.

Sec. 306. (1) A contract or other transaction between a health care corporation and 1 or more of its directors or officers, or between a health care corporation 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 such common directorship, officership, or interest, or solely because the directors are present at the meeting of the board or committee thereof which 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 corporation 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 or committee, and the board or committee 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 prior to the vote, the minutes of the meeting reflect that announcement, and the officer or director abstained from the vote.

(2) When 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 or committee meeting at the time a contract or transaction described in subsection (1) is authorized, approved, or ratified.

(4) The board, by affirmative vote of a majority of directors in office and irrespective of any personal interest of any of them, may establish reasonable compensation of directors for services to the health care corporation as directors or officers of the health care corporation.

(5) The bylaws of a health care corporation may include provisions regarding conflict of interest which are more stringent than this section.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1307 Advisory councils; committees of board of directors; bylaws regarding membership and emergency meetings and actions.

Sec. 307. The board of directors may establish those advisory councils and, unless otherwise provided in the articles of incorporation or bylaws, those committees it considers necessary to perform its duties. Members of the corporate body may serve on committees of the board of directors. With respect to committees of the board, the bylaws shall include provisions regarding all of the following:

(a) Provisions which 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 executive committee of the health care corporation, and action by that committee on behalf of the board in cases of emergency, as defined by the bylaws.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1308 Committees of board of directors; powers and authority; prohibited activities; emergency actions.

Sec. 308. (1) To the extent provided by resolution of the board or in the bylaws or articles, a committee established pursuant to section 307 may exercise the powers and authority of the board in management of the business and affairs of the health care corporation. The board shall review and may modify subject to the rights of third parties any action or decision of a committee. A committee shall not do any of the following:

(a) Amend the articles of incorporation.

(b) Adopt an agreement of merger or consolidation.

(c) Authorize the sale, lease, or exchange of all or substantially all of the corporation's property and assets.

(d) Approve, adopt, or amend provider contracts, provider class plans, rates charged to subscribers, or a certificate.

(e) Amend the bylaws of the corporation.

(f) Fill vacancies on the board.

(g) Fix compensation of the directors or officers.

(h) Perform other similar acts of a final or binding nature with respect to the business of the corporation.

(2) This section shall not prohibit emergency actions by the executive committee on behalf of the board, as authorized in the bylaws of the health care corporation.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1309 Officers and assistants; selection; restriction; authority and duties; removal; contractual rights; bond; vacancies; compensation; pension.

Sec. 309. (1) The board of directors shall select the officers of the health care corporation and a chairperson, vice-chairperson, and other board officers and assistants as the board considers necessary. However, an officer shall not execute, acknowledge, or verify an instrument in more than 1 capacity. Officers shall have only the authority, and assistants shall perform only those duties, in the management of the property and affairs of the corporation, as is provided in the bylaws or delegated to the officers and assistants by the board of directors, consistent with the bylaws. An officer or assistant may be removed by the board of directors with or without cause, subject to the contract rights, if any, of the officer or assistant. The selection of an officer or assistant does not of itself create contract rights. The board of directors may secure the fidelity of any or all of the officers by bond or otherwise. Unless otherwise provided in the articles or bylaws, the board of directors may fill vacancies in an office described in this subsection which occur for any reason.

(2) A health care corporation shall not pay a salary, compensation, or emolument to a director or officer unless the payment is first authorized by the board of directors of the corporation. A director, officer, assistant, or employee shall not be compensated unreasonably.

(3) A health care corporation shall not grant a pension to an officer or director, or to a member of the family of an officer or director after the death of the officer or director. However, the corporation, pursuant to the terms of a retirement plan adopted by the board of directors of the corporation and approved by the commissioner, may provide for any person who is or has been a salaried employee or officer of the corporation, a pension payable upon retirement, as provided in the approved retirement plan, and life insurance benefits payable at death.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1310 Fiduciary duties; scope and manner of discharge; removal of director for breach of fiduciary duty; notice and hearing.

Sec. 310. (1) With respect to management of the affairs and property of the health care corporations, and in the selection, supervision, and control of committees of the board, employees of the health care corporation, and officers, each director and officer, and the composite board, shall exercise the duties of a fiduciary toward the health care corporation and the subscribers of the health care corporation as a whole, and shall discharge his or her duties with the degree of diligence, care, and skill which an ordinarily prudent person would exercise under the same or similar circumstances in a like position. In discharging his or her duties, a director or officer, when acting in good faith, may rely upon the opinion of counsel for the corporation, upon the report of an independent appraiser selected with reasonable care by the board, or upon financial statements of the corporation represented to the director or officer to be correct by the president or the officer of the corporation having charge of its books of account, or stated in a written report by an independent public or certified public accountant or firm of such accountants fairly to reflect the financial condition of the corporation.

(2) After notice and a hearing before the board, a director may be removed from the board by a vote of 2/3 of the directors selected and serving on the board for a breach of fiduciary duty.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1311 Liability for misapplication or misuse of corporate money or property.

Sec. 311. Each director or officer of a health care corporation shall be individually liable for the misapplication or misuse of corporate money or property caused through the neglect or failure of that director or officer to discharge his or her duties in compliance with the standards prescribed in section 310, or through wilful violation of this act or other laws governing the health care corporation.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1312 Action for failure to perform duties; commencement.

Sec. 312. An action against a director or officer for failure to perform the duties imposed by this act shall be commenced within 3 years after the cause of action has accrued, or within 2 years after the time when the cause of action is discovered, or should reasonably have been discovered, by a person complaining of the failure to perform, whichever occurs sooner.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1313 False statement as misdemeanor; liability for false statement or report; commencement of action for civil liability.

Sec. 313. (1) Except with respect to statements which are subject to prosecution for perjury, as defined in section 423 of Act No. 328 of the Public Acts of 1931, being section 750.423 of the Michigan Compiled Laws, a person, or an agent, director, or officer of a health care corporation, who knowingly makes any false oral or written statement as to a material fact, in or with respect to a report required by this act, or in the course of a hearing or examination held pursuant to this act, is guilty of a misdemeanor. In addition, the person, agent, director, or officer knowingly making the false statement and each person, agent, director, or officer knowingly authorizing, signing, or making the false report shall be jointly and severally personally liable to any person who has become a creditor of the health care corporation upon the faith of the false statement or the false report.

(2) An action for the civil liability imposed by this section shall be commenced within 2 years after discovery of the false statement or within 6 years after the report has been made by the person, agent, director, or officer of the health care corporation, whichever is sooner.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

PART 4

550.1400 Use of most favored nation clause in provider contract.

Sec. 400. (1) Notwithstanding any provision of this act to the contrary, this section applies to the use of a most favored nation clause in a provider contract on and after February 1, 2013.

(2) Subject to subsection (3), beginning February 1, 2013, a health care corporation shall not use a most favored nation clause in any provider contract, including a provider contract in effect on February 1, 2013, unless the most favored nation clause has been filed with and approved by the commissioner. Subject to subsection (3), beginning February 1, 2013, a health care corporation shall not enforce a most favored nation clause in any provider contract without the prior approval of the commissioner.

(3) Beginning January 1, 2014, a health care corporation shall not use a most favored nation clause in any provider contract, including a provider contract in effect on January 1, 2014.

(4) As used in this section, "most favored nation clause" means a clause that does any of the following:

(a) Prohibits, or grants a contracting health care corporation an option to prohibit, a provider from contracting with another party to provide health care services at a lower rate than the payment or reimbursement rate specified in the contract with the health care corporation.

(b) Requires, or grants a contracting health care corporation an option to require, a provider to accept a lower payment or reimbursement rate if the provider agrees to provide health care services to any other party at a lower rate than the payment or reimbursement rate specified in the contract with the health care corporation.

(c) Requires, or grants a contracting health care corporation an option to require, termination or renegotiation of an existing provider contract if a provider agrees to provide health care services to any other

party at a lower rate than the payment or reimbursement rate specified in the contract with the health care corporation.

(d) Requires a provider to disclose, to the health care corporation or its designee, the provider's contractual payment or reimbursement rates with other parties.

History: Add. 2013, Act 4, Imd. Eff. Mar. 18, 2013.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1401 Offering of health care benefits; limiting benefits; division of benefits into classes or kinds; prohibited conduct; grounds for denial of coverage; coordination of benefits, subrogation, and nonduplication of benefits; health care corporation as party in interest; limiting or denying coverage or participation status; requirements for participation and reimbursement; determination by commissioner; definitions.

Sec. 401. (1) A health care corporation 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 corporation specifies with the approval of the commissioner.

(2) A health care corporation 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 health care corporation 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 health care corporation, 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 corporation 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.

(d) Rate, cancel benefits on, refuse to provide benefits for, or refuse to issue or continue a certificate solely because a subscriber or applicant is or has been a victim of domestic violence. A health care corporation shall not be held civilly liable for any cause of action that may result from compliance with this subdivision. This subdivision applies to all health care corporation certificates issued or renewed on or after June 1, 1998. As used in this subdivision, "domestic violence" means inflicting bodily injury, causing serious emotional injury or psychological trauma, or placing in fear of imminent physical harm by threat or force a person who is a spouse or former spouse of, has or has had a dating relationship with, resides or has resided with, or has a child in common with the person committing the violence.

(e) Require a member or his or her dependent or an applicant for coverage or his or her dependent to do either of the following:

(*i*) Undergo genetic testing before issuing, renewing, or continuing a health care corporation certificate.

(*ii*) Disclose whether genetic testing has been conducted or the results of genetic testing or genetic information.

(4) Subsection (3) does not prevent a health care corporation from denying to a resident of this state coverage under a certificate for any of the following grounds:

(a) That the individual was not a member of a group that had contracted for coverage under this certificate.

(b) That the individual is not a member of a group with a size greater than a minimum size established for a certificate pursuant to sound underwriting requirements.

(c) That the individual does not meet requirements for coverage contained in a certificate.

(d) For groups of under 100 subscribers and except as otherwise provided in section 3709 of the insurance code of 1956, 1956 PA 218, MCL 500.3709, that the group that the individual is a member of has failed to enroll enough of its eligible members with the health care corporation. A denial under this subdivision shall be made only if the health care corporation determines that the cost for the portion of the group applying for coverage would be at least 50% more on a per subscriber basis than the per subscriber cost for the whole group. A denial under this subdivision shall not be based on the health status of any individual in the group or his or her dependent. A denial under this subdivision shall be based on sound actuarial principles and may be based on 1 or more of the following:

(*i*) That the contract holder for the group applying for coverage is also offering a self-funded health benefit

plan.

(*ii*) That the group applying for coverage is composed entirely of the contract holder's retiree business segment.

(*iii*) That the average individual age of the members of the group applying for coverage is either 50% higher or 10 years higher than the average individual age for the whole group.

(5) A certificate may provide for the coordination of benefits, subrogation, and the nonduplication of benefits. Savings realized by the coordination of benefits, subrogation, and nonduplication of benefits shall be reflected in the rates for those certificates. If a group certificate issued by the corporation contains a coordination of benefits provision, the benefits shall be payable pursuant to the coordination of benefits act, 1984 PA 64, MCL 550.251 to 550.255.

(6) A health care corporation shall have 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.

(7) A health care corporation shall not directly reimburse a provider in this state who has not entered into a participating contract with the corporation.

(8) A health care corporation 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 health care corporation 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 corporation 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.

(9) Not later than the close of business on the seventh business day after denying coverage under subsection (4)(d), the health care corporation shall notify the commissioner of this denial and shall supply the commissioner with the information used in determining the denial. The commissioner shall determine whether he or she will approve or disapprove the health care corporation denial not later than the close of business on the seventh business day after receipt of the notice and shall promptly notify the health care corporation of his or her determination. The commissioner shall base his or her determination under this subsection on whether the health care corporation met the standards in subsection (4)(d). The health care corporation or the denied contract holder may appeal the commissioner's decision in circuit court. The commissioner shall report to the senate and house of representatives standing committees on insurance issues by May 15, 2005 and biennially thereafter all of the following:

(a) The number of denials made each calendar year by a health care corporation under subsection (4)(d).

(b) The number of denials under subdivision (a) that were approved by the commissioner under this subsection and a summary of the type of group approved.

(c) The number of denials under subdivision (a) that were disapproved by the commissioner under this subsection and a summary of the type of group disapproved.

(d) The number of decisions by the commissioner under this subsection that have been appealed and the results of the appeals.

(10) As used in this section:

(a) "Clinical purposes" includes all of the following:

(*i*) Predicted risk of diseases.

(*ii*) Identifying carriers for single-gene disorders.

(*iii*) Establishing prenatal and clinical diagnosis or prognosis.

(*iv*) Prenatal, newborn, and other carrier screening, as well as testing in high-risk families.

(*v*) Tests for metabolites if undertaken with high probability that an excess or deficiency of the metabolite indicates or suggests the presence of heritable mutations in single genes.

(*vi*) Other tests if their intended purpose is diagnosis of a presymptomatic genetic condition.

(b) "Genetic information" means information about a gene, gene product, or inherited characteristic derived from a genetic test.

(c) "Genetic test" means the analysis of human DNA, RNA, chromosomes, and those proteins and metabolites used to detect heritable or somatic disease-related genotypes or karyotypes for clinical purposes. A genetic test must be generally accepted in the scientific and medical communities as being specifically determinative for the presence, absence, or mutation of a gene or chromosome in order to qualify under this definition. Genetic test does not include a routine physical examination or a routine analysis, including, but not limited to, a chemical analysis, of body fluids, unless conducted specifically to determine the presence, absence, or mutation of a gene or chromosome.

History: 1980, Act 350, Eff. Apr. 3, 1981;—Am. 1984, Act 66, Imd. Eff. Apr. 18, 1984;—Am. 1998, Act 135, Imd. Eff. June 24, 1998;—Am. 2000, Act 26, Imd. Eff. Mar. 15, 2000;—Am. 2003, Act 59, Eff. July 23, 2003.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1401a Health care service rendered by dentist; benefits or reimbursement; “dentist” defined; certificates to which section applicable.

Sec. 401a. (1) If a group or nongroup certificate of a health care corporation provides for health care benefits for a health care service, those benefits or reimbursement for the provision of the service shall not be denied because the service was rendered by a dentist, provided the service was legally performed.

(2) As used in this section, "dentist" means an individual licensed under part 166 of Act No. 368 of the Public Acts of 1978, being sections 333.16601 to 333.16647 of the Michigan Compiled Laws.

(3) This section shall apply only with respect to certificates which are issued or renewed on or after the effective date of this section, and shall apply notwithstanding any certificate provision to the contrary.

History: Add. 1982, Act 290, Imd. Eff. Oct. 7, 1982.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1401b Certificate providing benefits for mental health services; requirements.

Sec. 401b. A certificate issued by a corporation which provides benefits for mental health services shall provide benefits for mental health services provided to an individual by a mental health care provider operated by or under contract with the department of mental health or a county community mental health board in those instances when appropriate mental health services cannot be delivered otherwise, or if the provider of the mental health services is designated by an order of a court; provided that the mental health provider meets the standards set by the corporation for all other providers of the type.

History: Add. 1984, Act 230, Eff. Dec. 20, 1984.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1401c Replacement group certificate with preexisting condition limitation; elimination, reduction, or limitation of benefits; “disability coverage” defined.

Sec. 401c. (1) If existing group disability coverage is replaced by a group certificate with a preexisting condition limitation and insuring 10 or more members, coverage in the replacement certificate applicable to the preexisting condition limitation for an individual who had been covered for that condition by the replaced coverage shall be not less than the lesser of the following:

(a) The coverage of the replacement certificate without application of the preexisting condition limitation.

(b) The benefits of the replaced group disability coverage until the individual's preexisting condition limitation expires under the replacement certificate.

(2) Other than as provided in subsection (1), a replacement group certificate insuring 10 or more members shall not include a limitation upon an individual or exclude an individual who was covered by the group disability coverage being replaced if the individual is a member of the class or classes of individuals eligible for coverage under the replacement certificate.

(3) If existing group disability coverage issued or renewed on or after January 1, 1992 is replaced by a group certificate with a preexisting condition limitation and insuring less than 10 members, the replaced coverage shall extend benefits for the condition excluded by the replacement certificate because of the application of a preexisting condition limitation by providing benefits for that condition until the term of the preexisting condition limitation has expired or 6 months have elapsed, whichever occurs first. An individual not covered for a condition under replaced group disability coverage because the term of a preexisting

condition limitation has not expired is covered for that condition under the replaced coverage pursuant to this subsection when the term of the preexisting condition limitation in the replaced coverage expires. If there is a dispute between the replacement carrier and the replaced carrier as to whether an individual's condition is included within a preexisting condition limitation, benefits shall be paid by the replacement carrier pending resolution of the dispute. This subsection applies only to the extent that benefits would have been available for the preexisting condition under the replaced coverage. This subsection applies only if the replaced master coverage has been in effect for at least 6 months.

(4) If existing group disability coverage issued or renewed on or after January 1, 1992 is replaced by a group certificate with a preexisting condition limitation and insuring less than 10 members, the replacement certificate shall not include a limitation for a period exceeding 6 months upon an individual or exclude an individual who was covered by the group disability coverage being replaced if the individual is a member of the class or classes of individuals eligible for coverage under the replacement certificate.

(5) This section does not preclude an elimination, reduction, or limitation of benefits which applies to an entire plan. This section applies to individuals who are covered under the replaced certificate at the time of replacement and does not apply to individuals who become eligible for or apply for coverage under a replacement group certificate after that replacement certificate is issued.

(6) As used in this section, "disability coverage" means expense-incurred hospital, medical, or surgical coverage.

History: Add. 1989, Act 256, Eff. Jan. 1, 1992.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1401d Services performed by physician's assistant; reimbursement; conditions; applicability of section; supervision by physician; definitions.

Sec. 401d. (1) Subject to subsections (2) and (3), if a health care corporation 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 provided that 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 C of title III of the public health service act, chapter 373, 90 Stat. 2270, 42 U.S.C. 254e.

(b) "Medicaid" means the program of medical assistance established under title XIX of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1396 to 1396g and 1396i to 1396u.

(c) "Medicare" means the federal medicare program established under title XVIII of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1395 to 1395b, 1395b-2, 1395c to 1395i, 1395i-2 to 1395i-4, 1395j to 1395t, 1395u to 1395w-2, 1395w-4 to 1395zz, and 1395bbb to 1395ccc.

(d) "Physician's assistant" means an individual licensed as a physician's assistant under article 15 of the public health code, Act No. 368 of the Public Acts of 1978, being sections 333.16101 to 333.18838 of the Michigan Compiled Laws.

(e) "Rural health clinic" means a rural health clinic as defined under section 1861 of part C of title XVIII of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1395x, and certified to participate in medicaid and medicare.

History: Add. 1991, Act 102, Imd. Eff. Sept. 6, 1991;—Am. 1993, Act 258, Imd. Eff. Nov. 29, 1993.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1401e Group certificate issued by health care corporation; renewal or continuation; guaranteed renewal; discontinuing plan, product, or coverage in nongroup or group market; conditions.

Sec. 401e. (1) Except as otherwise provided in this section, a health care corporation that has issued a nongroup certificate shall renew or continue in force the certificate at the option of the individual.

(2) Except as otherwise provided in this section, a health care corporation that has issued a group certificate shall renew or continue in force the certificate at the option of the sponsor of the plan.

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

(4) A health care corporation shall not discontinue offering a particular plan or product in the nongroup or group market unless the health care corporation does all of the following:

(a) Provides notice to the commissioner and to each covered individual or group, as applicable, provided coverage under the plan or product of the discontinuation at least 90 days before the date of the discontinuation.

(b) Offers to each covered individual or group, as applicable, provided coverage under the plan or product the option to purchase any other plan or product currently being offered in the nongroup market or group market, as applicable, by that health care corporation without excluding or limiting coverage for a preexisting condition or providing a waiting period.

(c) Acts uniformly without regard to any health status factor of enrolled individuals or individuals who may become eligible for coverage in making the determination to discontinue coverage and in offering other plans or products.

(5) A health care corporation shall not discontinue offering all coverage in the nongroup or group market unless the health care corporation does all of the following:

(a) Provides notice to the commissioner and to each covered individual or group, as applicable, of the discontinuation at least 180 days before the date of the expiration of coverage.

(b) Discontinues all health benefit plans issued in the nongroup or group market from which the health care corporation withdrew and, except as allowed under subsection (6), does not renew coverage under those plans.

(6) If a health care corporation discontinues coverage under subsection (5), the health care corporation shall not provide for the issuance of any health benefit plans in the nongroup or group market from which the health care corporation withdrew during the 5-year period beginning on the date of the discontinuation of the last plan not renewed under that subsection.

History: Add. 1996, Act 516, Eff. Oct. 1, 1997;—Am. 2013, Act 4, Imd. Eff. Mar. 18, 2013.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1401f Health care corporation; access to obstetrician-gynecologist.

Sec. 401f. (1) A health care corporation certificate that requires a member to designate a participating primary care provider and provides for annual well-woman examinations and routine obstetrical and gynecologic services shall permit a female member to access an obstetrician-gynecologist for annual well-woman examinations and routine obstetrical and gynecologic services.

(2) A health care corporation shall not require prior authorization or referral for access under subsection (1) to an obstetrician-gynecologist who participates with the health care corporation. A health care corporation may require prior authorization or referral for access to a nonparticipating obstetrician-gynecologist.

(3) A description of the benefit provided by this section shall be included by the health care corporation in a communication sent to the individual or group purchaser of coverage.

History: Add. 1998, Act 412, Eff. Mar. 23, 1999.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1401g Health care corporation; access to pediatric care services.

Sec. 401g. (1) A health care corporation certificate that requires a member to designate a participating primary care provider and provides for dependent care coverage shall permit a dependent minor member to select and access a pediatrician for general pediatric care services.

(2) A health care corporation shall not require prior authorization or referral for access under subsection (1)

to a pediatrician who participates with the health care corporation. A health care corporation may require prior authorization or referral for access to a nonparticipating pediatrician.

History: Add. 1999, Act 178, Imd. Eff. Nov. 16, 1999.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1401h Health care corporation providing prescription drug coverage; formulary restrictions.

Sec. 401h. A health care corporation that provides coverage for prescription drugs and limits those benefits to drugs included in a formulary shall do all of the following:

(a) Provide for participation of participating physicians, dentists, and pharmacists in the development of the formulary.

(b) Disclose to health care providers and upon request to members the nature of the formulary restrictions.

(c) Provide for exceptions from the formulary limitation when a nonformulary alternative is a medically necessary and appropriate alternative. This subdivision does not prevent a health care corporation from establishing prior authorization requirements or another process for consideration of coverage or higher cost-sharing for nonformulary alternatives. Notice as to whether or not an exception under this subdivision has been granted shall be given by the health care corporation within 24 hours after receiving all information necessary to determine whether the exception should be granted.

History: Add. 1999, Act 175, Imd. Eff. Nov. 16, 1999.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1401i Prescription drug coverage; pilot project; provisions; interim report; determination; evaluation.

Sec. 401i. (1) Beginning January 1, 2004, a health care corporation shall establish and offer to provide or include prescription drug coverage in at least 1 nongroup certificate and at least 1 group conversion certificate as a pilot project under this section. This pilot project shall continue through December 1, 2006 and, while in pilot project status, is not subject to the guaranteed renewability provisions of section 401e.

(2) Unless an order of adjustment issued under subsection (4)(b)(*ii*) provides otherwise, a certificate that includes prescription drug coverage under subsection (1) shall include all of the following:

(a) At a minimum, a prescription drug benefit that includes a co-pay of no more than 50% of the health care corporation's approved amount for the payment of prescription drugs, with a minimum co-pay of $10.00 and a maximum co-pay of $100.00 per prescription.

(b) An annual per person benefit maximum of no less than $2,500.00.

(c) A provision that members will be entitled to purchase prescription drugs at a discount under the affinity program offered by the health care corporation once their annual per person prescription drug benefit maximum has been reached.

(3) Not later than July 1, 2005, the health care corporation shall issue an interim report to the commissioner regarding the claims experience of the market segment under this section and the ongoing viability of the pilot project. Not later than July 1, 2006, the health care corporation shall issue a final report to the commissioner regarding the claims experience of the market segment under this section and the ongoing viability of the pilot project.

(4) By December 1, 2006, the commissioner shall determine if the nongroup and group conversion certificates providing the prescription drug benefit under this section provide a useful benefit to its subscribers in an actuarially sound manner. Based upon this determination, the commissioner shall do 1 of the following:

(a) If the commissioner determines that a certificate does provide a useful benefit to its subscribers in an actuarially sound manner, the commissioner shall order the termination of the pilot project designation and order that the program continue indefinitely. If the pilot project is discontinued and the program is continued indefinitely beyond the date prescribed in subsection (3) or (5), then the certificate is subject to the guaranteed renewability provisions of section 401e.

(b) If the commissioner determines that a certificate does not provide a useful benefit to its subscribers in an actuarially sound manner, the commissioner shall do 1 of the following:

(*i*) Order the termination of the pilot project under this section and terminate the offering of prescription drug coverage in the nongroup and group conversion certificates.

(*ii*) Order an adjustment of the pilot project to operate in an actuarially sound manner and order that the pilot project continue for a specified time period. An order of adjustment under this subparagraph may revise

the requirements of subsection (2) regarding coverage required under the certificates.

(5) If the commissioner orders an adjustment of the pilot project under subsection (4), the commissioner shall evaluate the project after 2 years of operation and make a determination in the same manner as prescribed in subsection (4).

History: Add. 2003, Act 41, Eff. July 15, 2003.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1401j Prescription drug coverage; rate differentials; filing.

Sec. 401j. The rates charged to nongroup and group conversion subscribers for a certificate that includes prescription drug coverage pursuant to section 401i may include rate differentials based on age, with not more than 8 separate age bands. The health care corporation shall file its rates for the prescription drug coverage in this section in the same manner and under the same requirements as provided in section 607.

History: Add. 2003, Act 59, Eff. July 23, 2003.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1401k Telemedicine services; provisions; definition; applicability.

Sec. 401k. (1) A group or nongroup health care corporation certificate must not require face-to-face contact between a health care professional and a patient for services appropriately provided through telemedicine, as determined by the health care corporation. Telemedicine services must be provided by a health care professional who is licensed, registered, or otherwise authorized to engage in his or her health care profession in the state where the patient is located. Telemedicine services are subject to all terms and conditions of the certificate agreed upon between the certificate holder and the health care corporation, including, but not limited to, required copayments, coinsurances, deductibles, and approved amounts.

(2) As used in this section, "telemedicine" means the use of an electronic media to link patients with health care professionals in different locations. To be considered telemedicine under this section, the health care professional must be able to examine the patient via a health insurance portability and accountability act of 1996, Public Law 104-91 compliant, secure interactive audio or video, or both, telecommunications system, or through the use of store and forward online messaging.

(3) This section applies to a certificate issued or renewed after December 31, 2012.

History: Add. 2012, Act 214, Imd. Eff. June 28, 2012;—Am. 2020, Act 98, Imd. Eff. June 24, 2020.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1401m Offer of health care benefits to all residents regardless of health status.

Sec. 401m. Until January 1, 2014, a health care corporation established, maintained, or operating in this state shall offer health care benefits to all residents of this state regardless of health status.

History: Add. 2013, Act 4, Imd. Eff. Mar. 18, 2013.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1402 Health care corporation; prohibited conduct; commission or compensation; new preexisting condition limitation waiting period; readjusting rates; participation in trade practice conference for disability insurers; provider class plan not altered or superseded; probable cause to believe provisions violated; notice; disposition of matter by agreement of parties; action for damages; hearing; issuance of cease and desist order; violation of cease and desist order; civil fine; action for actual monetary damage; attorneys' fees.

Sec. 402. (1) A health care corporation shall not do any of the following:

(a) Misrepresent pertinent facts or certificate provisions relating to coverage.

(b) Fail to acknowledge promptly or to act reasonably and promptly upon communications with respect to a claim arising under a certificate.

(c) Fail to adopt and implement reasonable standards for the prompt investigation of a claim arising under a certificate.

(d) Refuse to pay claims without conducting a reasonable investigation based upon the available information.

(e) Fail to affirm or deny coverage of a claim within a reasonable time after a claim has been received.

(f) Fail to attempt in good faith to make a prompt, fair, and equitable settlement of a claim for which liability has become reasonably clear.

(g) Compel members to institute litigation to recover amounts due under a certificate by offering substantially less than the amounts due.

(h) By making reference to written or printed advertising material accompanying or made part of an application for coverage, attempt to settle a claim for less than the amount which a reasonable person would believe was due under the certificate.

(i) For the purpose of compelling a member to accept a settlement or compromise in a claim, make known to the member a policy of appealing from administrative hearing decisions in favor of members.

(j) Attempt to settle a claim on the basis of an application which was altered without notice to, or knowledge or consent of, the subscriber under whose certificate the claim is being made.

(k) Delay the investigation or payment of a claim by requiring a member, or the provider of health care services to the member, to submit a preliminary claim and then requiring subsequent submission of a formal claim, seeking solely the duplication of a verification.

(*l*) Fail to promptly provide a reasonable explanation of the basis for denial of a claim or for the offer of a compromise settlement.

(m) Fail to promptly settle a claim where liability has become reasonably clear under 1 portion of a certificate in order to influence a settlement under another portion of the certificate.

(2) In order to induce a person to contract or to continue to contract with the health care corporation for the provision of health care benefits or administrative or other services offered by the corporation; to induce a person to lapse, forfeit, or surrender a certificate issued by the health care corporation; or to induce a person to secure or terminate coverage with another health care corporation, insurer, health maintenance organization, or other person, a health care corporation shall not, directly or indirectly:

(a) Issue or deliver to the person money or any other valuable consideration.

(b) Offer to make or make an agreement relating to a certificate other than as plainly expressed in the certificate.

(c) Offer to give or pay, or give or pay, directly or indirectly, a rebate or part of the premium, or an advantage with respect to the furnishing of health care benefits or administrative or other services offered by the corporation except as reflected in the rate and expressly provided in the certificate.

(d) Make, issue, or circulate, or cause to be made, issued, or circulated, any estimate, illustration, circular, or statement misrepresenting the terms of a certificate or contract for administrative or other services, the benefits thereunder, or the true nature thereof.

(e) Make a misrepresentation or incomplete comparison, whether oral or written, between certificates of the corporation or between certificates or contracts of the corporation and another health care corporation, health maintenance organization, or other person.

(3) A health care corporation shall not provide a commission or other compensation to the health care corporation's agent or employee for the sale or service of a health care benefits certificate issued to an individual eligible for medicare, unless the amount of the commission or compensation paid in the first year of the certificate is not more than the amount of the commission or compensation that the health care corporation's agent or employee receives for the certificate in each of the 2 subsequent, consecutive annual renewal periods.

(4) A health care corporation shall not issue a certificate to an individual eligible for medicare that provides for a new preexisting condition limitation waiting period if coverage is converted to or replaced by a new or other form of similar coverage with the same health care corporation or any of the health care corporation's affiliates. If the preexisting condition limitation waiting period in the original or replaced certificate has not expired, the replacing certificate may include the remaining term of the preexisting condition limitation waiting period of the replaced certificate. This subsection does not apply to an increase in benefits voluntarily selected by the individual.

(5) Nothing in subsection (2) shall prevent a health care corporation from readjusting the rates charged to a subscriber group which is experience-rated based on the previous claims of the group.

(6) The commissioner shall allow a health care corporation to participate in any trade practice conference for disability insurers convened under section 2047 of Act No. 218 of the Public Acts of 1956, being section 500.2047 of the Michigan Compiled Laws, and may bind a health care corporation to any rules promulgated as provided in that section.

(7) Nothing in this section shall alter or supersede any provider class plan established pursuant to part 5.

(8) If the commissioner has probable cause to believe that a health care corporation is violating, or has violated subsection (1), indicating a persistent tendency to engage in conduct prohibited by that subsection, or has probable cause to believe that a health care corporation is violating, or has violated subsection (2), (3), or

(4), he or she shall give written notice to the corporation, 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, setting forth the general nature of the complaint against the corporation and the proceedings contemplated under this section. Before the issuance of a notice of hearing, the staff of the bureau of insurance responsible for the matters which would be at issue in the hearing shall give the corporation an opportunity to confer and discuss the possible complaint and proceedings in person with the commissioner or a representative of the commissioner, and the matter may be disposed of summarily upon agreement of the parties. This subsection shall not be construed to diminish the right of a person to bring an action for damages under this section.

(9) A hearing held pursuant to subsection (8) shall be held in accordance with section 2030 of the insurance code of 1956, Act No. 218 of the Public Acts of 1956, as amended, being section 500.2030 of the Michigan Compiled Laws. The hearing shall be held pursuant to the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969. If, after the hearing, the commissioner determines that the health care corporation is violating, or has violated subsection (1), indicating a persistent tendency to engage in conduct prohibited by that subsection, or is violating, or has violated subsection (2), (3), or (4), the commissioner shall reduce his or her findings and decision to writing, and shall issue and cause to be served upon the corporation a copy of the findings and an order requiring the corporation to cease and desist from engaging in the prohibited activity. The commissioner may at any time, by order, and after notice and opportunity for a hearing, reopen and alter, modify, or set aside, in whole or in part, an order issued by him or her under this subsection, when in his or her opinion conditions of fact or law have so changed as to require that action, or if the public interest so requires.

(10) A health care corporation which violates a cease and desist order of the commissioner issued under subsection (9), after notice and an opportunity for a hearing, and upon order of the commissioner, may be subject to a civil fine of not more than $10,000.00 for each violation.

(11) In addition to other remedies provided by law, an aggrieved member may bring an action for actual monetary damages sustained as a result of a violation of this section. If successful on the merits, the member shall be awarded actual monetary damages or $200.00, whichever is greater, together with reasonable attorneys' fees. If the health care corporation shows by a preponderance of the evidence that a violation of this section resulted from a bona fide error notwithstanding the maintenance of procedures reasonably adapted to avoid the error, the amount of recovery shall be limited to actual monetary damages.

History: 1980, Act 350, Eff. Apr. 3, 1981;—Am. 1989, Act 132, Eff. Nov. 1, 1989.

Constitutionality: This act is unconstitutional in the following three particulars:

(1) The act's provision for an actuary panel to resolve risk factor disputes is an unconstitutional delegation of legislative authority in that it lacks adequate standards (MCL 550.1205(6)).

(2) The statutory restrictions on administrative services only (ASO) contracts violate equal protection of the laws insofar as they result in arbitrary and discriminatory treatment of health care corporations vis-a-vis commercial insurers (MCL 550.1104(3), 550.1211, 550.1414a, 550.1415, and 550.1607(1)).

(3) The commissioner's authority to issue a cease and desist order based on probable cause against a health care corporation for noncompliance with the act establishes an improper burden of proof (MCL 550.1402(7)).

The Supreme Court ruling on these three areas of this act does not affect the constitutionality of the remainder of the act. Where, as here, the unconstitutional provisions are easily severable, the remainder of the act need not be affected. Blue Cross and Blue Shield of Michigan v Governor, 422 Mich 1; 367 NW2d 1 (1985).

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1402a Terms and conditions of certificate; form; description; requested information; written request; “board certified” defined.

Sec. 402a. (1) A health care corporation shall provide a written form in plain English to subscribers upon enrollment that describes the terms and conditions of the corporation's certificate. The form shall provide a clear, complete, and accurate description of all of the following, as applicable:

(a) The service area.

(b) Covered benefits, including prescription drug coverage, with specifications regarding requirements for the use of generic drugs.

(c) Emergency health coverages and benefits.

(d) Out-of-area coverages and benefits.

(e) An explanation of member financial responsibility for copayments, deductibles, and any other out-of-pocket expenses.

(f) Provision for continuity of treatment if a provider's participation terminates during the course of a member's treatment by that provider.

(g) The telephone number to call to receive information concerning member grievance procedures.

(h) How the covered benefits apply in the evaluation and treatment of pain.

(i) A summary listing of the information available pursuant to subsection (2).

(2) A health care corporation shall provide upon request to members for services offered pursuant to section 502a a clear, complete, and accurate description of any of the following information that has been requested:

(a) The current provider network in the certificate's service area, including names and locations of participating providers by specialty or type of practice, a statement of limitations of accessibility and referrals to specialists, and a disclosure of which providers will not accept new members.

(b) The professional credentials of participating health professionals, including, but not limited to, participating health professionals who are board certified in pain medicine and the evaluation and treatment of pain and have reported that certification to the health care corporation, including all of the following:

(*i*) Relevant professional degrees.

(*ii*) Date of certification by the applicable nationally recognized boards and other professional bodies.

(*iii*) The names of licensed facilities on the provider panel where the health professional presently has privileges for the treatment, illness, or procedure that is the subject of the request.

(c) The licensing verification telephone number for the Michigan department of consumer and industry services that can be accessed for information as to whether any disciplinary actions or open formal complaints have been taken or filed against a health care provider in the immediately preceding 3 years.

(d) Any prior authorization requirements and any limitations, restrictions, or exclusions, including, but not limited to, drug formulary limitations and restrictions by category of service, benefit, and provider, and, if applicable, by specific service, benefit, or type of drug.

(e) Indication of the financial relationships between the health care corporation and any closed provider panel including all of the following as applicable:

(*i*) Whether a fee-for-service arrangement exists, under which the provider is paid a specified amount for each covered service rendered to the participant.

(*ii*) Whether a capitation arrangement exists, under which a fixed amount is paid to the provider for all covered services that are or may be rendered to each covered individual or family.

(*iii*) Whether payments to providers are made based on standards relating to cost, quality, or patient satisfaction.

(f) A telephone number and address to obtain from the health care corporation additional information concerning the items described in subdivisions (a) to (e).

(3) Upon request, any of the information provided under subsection (2) shall be provided in writing. A health care corporation may require that a request under subsection (2) be submitted in writing.

(4) As used in this section, "board certified" means certified to practice in a particular medical or other health profession specialty by the American board of medical specialties or other national health professional organization.

History: Add. 1996, Act 516, Eff. Oct. 1, 1997;—Am. 1998, Act 426, Eff. Apr. 1, 1999;—Am. 2001, Act 242, Imd. Eff. Jan. 8, 2002.

Compiler's note: Enacting section 1 of Act 242 of 2001 provides:

"Enacting section 1. The 2001 amendatory act that added section 402a(4) to the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1402a, shall not be construed as creating a new mandated benefit for any coverages issued under the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1101 to 550.1704."

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1402b Preexisting condition limitation or exclusion; prohibition; exception; "group" defined.

Sec. 402b. (1) For an individual covered under a nongroup certificate or under a certificate not covered under subsection (2), a health care corporation 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 certificate.

(2) A health care corporation shall not exclude or limit coverage for a preexisting condition for an individual covered under a group certificate.

(3) Notwithstanding subsection (1), a health care corporation shall not issue a certificate to a person eligible for nongroup coverage or eligible for a certificate not covered under subsection (2) that excludes or limits coverage for a preexisting condition or provides a waiting period if all of the following apply:

(a) The person's most recent health coverage prior to applying for coverage with the health care

corporation was under a group health plan.

(b) The person was continuously covered prior to the application for coverage with the health care corporation under 1 or more health plans for an aggregate of at least 18 months with no break in coverage that exceeded 62 days.

(c) The person is no longer eligible for group coverage and is not eligible for medicare or medicaid.

(d) The person did not lose eligibility for coverage for failure to pay any required contribution or for an act to defraud a health care corporation, a health insurer, or a health maintenance organization.

(e) If the person was eligible for continuation of health coverage from that group health plan pursuant to the consolidated omnibus budget reconciliation act of 1985, Public Law 99-272, 100 Stat. 82, he or she has elected and exhausted that coverage.

(4) As used in this section, "group" means a group of 2 or more subscribers.

History: Add. 1996, Act 516, Eff. Oct. 1, 1997;—Am. 1999, Act 7, Imd. Eff. Mar. 9. 1999.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1402c Termination of participation between primary care physician and health care corporation; notice to member; effect of termination; definitions.

Sec. 402c. (1) If participation between a primary care physician and a health care corporation terminates, the physician may provide written notice of this termination within 15 days after the physician becomes aware of the termination to each member who has chosen the physician as his or her primary care physician. If a member is in an ongoing course of treatment with any other physician who is participating with the health care corporation and the participation between the physician and the health care corporation terminates, the physician may provide written notice of this termination to the member 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 (2) and (3).

(2) If participation between a member's current physician and a health care corporation terminates, the health care corporation shall permit the member to continue an ongoing course of treatment with that physician as follows:

(a) For 90 days from the date of notice to the member by the physician of the physician's termination with the health care corporation.

(b) If the member 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 member 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 member's life for care directly related to the treatment of the terminal illness.

(3) Subsection (2) applies only if the physician agrees to all of the following:

(a) To participate on a per claim basis and to accept as payment in full reimbursement from the health care corporation at the rates applicable prior to the termination.

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

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

(4) A health care corporation shall provide written notice to each participating physician that if participation between the physician and the health care corporation terminates, the physician may do both of the following:

(a) Notify the health care corporation's members 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 (2) and (3).

(5) This section does not create an obligation for a health care corporation to provide to a member coverage beyond the maximum coverage limits permitted by the health care corporation's certificate with the member. This section does not create an obligation for a health care corporation to expand who may be a primary care physician under a certificate.

(6) 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.

(c) "Terminates" or "termination" includes the nonrenewal, expiration, or ending for any reason of a participation agreement between a physician and a health care corporation, but does not include a termination by the health care corporation for failure to meet applicable quality standards or for fraud.

History: Add. 1999, Act 228, Eff. July 1, 2000;—Am. 2000, Act 485, Imd. Eff. Jan. 11, 2001.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1402d Applicability of MCL 500.2212c to health care corporation.

Sec. 402d. Section 2212c of the insurance code of 1956, 1956 PA 218, MCL 500.2212c, applies to a health care corporation.

History: Add. 2013, Act 31, Eff. Mar. 14, 2014.

550.1403 Payment of benefits; interest; claim form; exception.

Sec. 403. (1) A health care corporation, on a timely basis, shall pay to a member benefits as are entitled and provided under the applicable certificate. When not paid on a timely basis, benefits payable to a member shall bear simple interest from a date 60 days after a satisfactory claim form was received by the health care corporation, at a rate of 12% interest per annum. The interest shall be paid in addition to, and at the time of payment of, the claim. Section 2006(7) to (14) of the insurance code of 1956, 1956 PA 218, MCL 500.2006, applies to a health care corporation.

(2) A health care corporation shall specify in writing the materials that constitute a satisfactory claim form not later than 30 days after receipt of a claim, unless the claim is settled within 30 days. If a claim form is not supplied as to the entire claim, the amount supported by the claim form shall be considered to be paid on a timely basis if paid within 60 days after receipt of the claim form by the corporation. This subsection does not apply to a health care corporation when paying a claim under section 2006(7) to (14) of the insurance code of 1956, 1956 PA 218, MCL 500.2006.

History: 1980, Act 350, Eff. Apr. 3, 1981;—Am. 2002, Act 317, Eff. Oct. 1, 2002.

Compiler's note: Enacting section 1 of Act 317 of 2002 provides:
"Enacting section 1. This amendatory act takes effect on October 1, 2002 and applies to all health care claims with dates of service on and after October 1, 2002."

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1403a Benefits paid by check or written instrument; escheat.

Sec. 403a. Benefits paid by a health care corporation to a subscriber or provider by way of a check or other similar written instrument for the transmission or payment of money, that is not cashed within the period prescribed in the uniform unclaimed property act, shall escheat to the state pursuant to the uniform unclaimed property act.

History: Add. 1990, Act 172, Imd. Eff. July 2, 1990;—Am. 1995, Act 49, Eff. Jan. 1, 1996.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1403b Advertising material prohibited.

Sec. 403b. A health care corporation shall not include in any bill for services or products any advertising material for any other service or product sold by a subsidiary of the corporation.

History: Add. 2003, Act 59, Eff. July 23, 2003.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1404 Violation of MCL 550.1402 or MCL 550.1403; private informal managerial-level conference; review by commissioner; internal procedures; determination by commissioner; expedited grievance procedure; procedural rules; hearing matter as contested case; authorization to act on behalf of member.

Sec. 404. (1) A person who has reason to believe that a health care corporation has violated section 402 or 403, if the violation was with respect to an action or inaction of the corporation with respect to that person, is entitled to a private informal managerial-level conference with the corporation, and to a review before the commissioner or his or her designee through September 30, 2000 and beginning October 1, 2000 before an independent review organization under the patient's right to independent review act, if the conference fails to

resolve the dispute.

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

(a) That a final determination will be made in writing by the health care corporation not later than 35 calendar days after a grievance is submitted in writing by the member. The timing for the 35-calendar-day period may be tolled, however, for any period of time the member is permitted to take under the grievance procedure and for a period of time that shall not exceed 10 days if the health care corporation has not received requested information from a health provider.

(b) A method of providing the person, upon request and payment of a reasonable copying charge, with information pertinent to the denial of a certificate or to the rate charged.

(c) A method for resolving the dispute promptly and informally, while protecting the interests of both the person and the corporation.

(d) That when an adverse determination is made, a written statement in plain English containing the reasons for the adverse determination is provided to the member along with written notifications as required under the patient's right to independent review act.

(e) A method for providing 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.

(3) If the health care corporation fails to provide a conference and proposed resolution within 30 days after a request by a person, or if the person disagrees with the proposed resolution of the corporation after completion of the conference, the person is entitled to a determination of the matter by the commissioner or his or her designee through September 30, 2000 and beginning October 1, 2000 by an independent review organization under the patient's right to independent review act.

(4) A health care corporation shall establish, as part of its internal procedures, an expedited grievance procedure. The expedited grievance procedure shall provide that a determination will be made by the health care corporation not later than 72 hours after receipt of the grievance. Within 10 days after receipt of a determination, the member may request a determination of the matter by the commissioner or his or her designee through September 30, 2000 and beginning October 1, 2000 by an independent review organization under the patient's right to independent review act. If the determination by the health care corporation is made orally, the health care corporation shall provide a written confirmation of the determination to the member not later than 2 business days after the oral determination. An expedited grievance under this subsection applies if a grievance is submitted and a physician, orally or in writing, substantiates that the time frame for a grievance under subsections (1) to (3) would seriously jeopardize the life or health of the member or would jeopardize the member's ability to regain maximum function. This subsection does not apply to a provider's complaint concerning claims payment, handling, or reimbursement for health care services. As used in this section, "grievance" means an oral or written statement, by a member to the health care corporation that the health care corporation has wrongfully refused or failed to respond in a timely manner to a request for benefits or payment.

(5) The commissioner shall by rule establish a procedure for determination under this section, which shall be reasonably calculated to resolve these matters informally and as rapidly as possible, while protecting the interests of both the person and the health care corporation.

(6) If either the health care corporation or a person other than a member disagrees with a determination of the commissioner or his or her designee under this section, the commissioner or his or her designee, if requested to do so by either party, shall proceed to hear the matter as a contested case under the administrative procedures act.

(7) A member 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.

History: 1980, Act 350, Eff. Apr. 3, 1981;—Am. 1996, Act 516, Eff. Oct. 1, 1997;—Am. 2000, Act 250, Imd. Eff. June 29, 2000.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1405 Single billing form; development; explanation of total bill for services.

Sec. 405. (1) A health care corporation, in consultation with the department of social services, shall develop a single billing form to be used for the billing of each of the following: hospital services, physician services, and pharmaceutical services. If such forms are subsequently developed by the federal government, they may be used in the place of forms developed pursuant to this subsection.

(2) A health care corporation shall provide each member with a detailed and accurate explanation of his or her total bill for services rendered by a health care provider and provided under a certificate with a health care corporation, including charges for specific types of services rendered, the date of services rendered, the amounts reimbursed by the corporation, and the reasons for denial of any payments for expenses incurred.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1406 Confidentiality of records; disclosures; consent; policy regarding protection of privacy and confidentiality of personal data; violation as misdemeanor; penalty; civil action for damages; effect of section on governmental agencies; compliance with federal law and regulations; "health care operations" defined.

Sec. 406. (1) A health care corporation 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 that are necessary for the proper review and payment of claims and for health care operations, treatment, and research. Except as is necessary to comply with section 603 or for the purpose of claims adjudication, claims verification, health care operations, treatment, research, payment, health oversight activities, or when required by law, a health care corporation 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 health care corporation 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 corporation, pursuant to subsection (2). If a member has authorized the release of personal data to a specific person, a health care corporation 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 the release of information to a member, pertaining to that member, by telephone, if the identity of the member is verified. This subsection does not preclude 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 health care corporation shall establish and make public the policy of the corporation 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 corporation's implementation of provisions in this act and other applicable laws respecting collection, security, use, release of, and access to personal data.

(b) Identify the routine uses of personal data by the corporation; 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 corporation will release personal data.

(e) Provide that enrollment applications and claim forms developed by the corporation 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 corporation 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 health care corporation 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 health care corporation 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 shall not be construed to limit access to records or to enlarge or diminish the investigative

and examination powers of governmental agencies, as provided for by law.

(6) Compliance by a corporation with the health insurance portability and accountability act of 1996, Public Law 104-191, and regulations promulgated under that act, 45 CFR parts 160 and 164, satisfies subsections (1) and (2).

(7) As used in this section, "health care operations" means that term as defined in 45 CFR 164.501.

History: 1980, Act 350, Eff. Apr. 3, 1981;—Am. 2006, Act 218, Imd. Eff. June 26, 2006.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1407 Complaint system; procedures; response to complaint; access to complaints and responses; record of complaints; annual report; other legal remedies.

Sec. 407. (1) A health care corporation shall establish and maintain a complaint system which affords adequate and reasonable procedures for the expeditious resolution of written complaints initiated by members concerning any matter relating to the provisions of a certificate. At a minimum, procedures shall be developed by a corporation for the resolution of claims for reimbursement; denial, cancellations, or nonrenewals of certificates; and complaints regarding the quality of the services delivered by health care providers and health care facilities which receive reimbursement from the corporation.

(2) A health care corporation, within 30 days after receipt of written complaint, shall give a reasonable written response to each written complaint which it receives. The commissioner shall have free access, as defined in section 603(2), to complaints and responses, which shall be made available to the commissioner for inspection. If the matter complained of is reasonably believed by the complainant to be a violation of section 402 or 403, the complainant shall be entitled to a private informal managerial-level conference with the health care corporation, as provided for in section 404.

(3) The health care corporation shall maintain a complete record of all of the written complaints of its members which the corporation has received since the date of the last examination. This record shall indicate the total number of complaints; and by line of business, the nature of each complaint, the disposition of each complaint, and the time taken to process each complaint.

(4) A health care corporation shall submit to the commissioner an annual report which describes the complaint system of the corporation, and includes a compilation and analysis of the written complaints filed with the corporation, their disposition and underlying causes, and measures being implemented to alleviate those causes. The report shall be compiled in a manner which protects an individual's right to privacy with respect to medical information and shall not disclose the identity of a member by name or other personal identifier without the member's consent pursuant to section 406(1). The annual report shall be a public record.

(5) This section shall not prevent a member from seeking other remedies available by law.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1408 False, dishonest, or fraudulent claim for payment as misdemeanor; penalty; civil action; prosecution.

Sec. 408. Any provider, member, or other person who knowingly makes, presents, or causes to be presented to a health care corporation any false, dishonest, or fraudulent claim for payment to or from the health care corporation, is guilty of a misdemeanor, punishable by a fine of not more than $1,000.00 or imprisonment for not more than 3 months, or both. This section shall not preclude a civil action for recovery of money due the corporation, nor shall it preclude the prosecution of any such provider, member, or other person under the applicable provisions of Act No. 328 of the Public Acts of 1931, as amended, being sections 750.1 to 750.568 of the Michigan Compiled Laws.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1409 Civil action for negligence.

Sec. 409. A civil action for negligence based upon, or arising out of, the health care provider-patient relationship shall not be maintained against a health care corporation.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1409a Coverage for children who are full-time or part-time students; continuing coverage if dependent student takes leave of absence due to illness or injury; eligibility; requirements.

Sec. 409a. (1) Any certificate delivered, issued for delivery, or renewed in this state that provides for coverage for dependent children who are full-time or part-time students shall continue coverage for that dependent student if the dependent student is covered under that certificate and takes a leave of absence from school due to illness or injury. Coverage under this section shall continue for 12 months from the last day of attendance in school or until the dependent reaches the age at which coverage would otherwise terminate, whichever period is shorter.

(2) To qualify for coverage under this section, the dependent student's attending physician shall certify in writing to the health care corporation that it is medically necessary for the dependent student to take a leave of absence from school.

(3) Coverage under this section shall be provided at the same rate as that charged for dependent student status.

(4) A dependent child must continue to meet all other eligibility requirements for dependent coverage in the health care corporation's certificate or rider if the dependent child takes a leave of absence from school due to illness or injury.

History: Add. 2006, Act 538, Eff. Jan. 1, 2007.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1410 Certificate providing coverage of dependent terminating at specified age; exceptions.

Sec. 410. Any certificate issued by a health care corporation that provides that coverage of a dependent of the subscriber terminates at a specified age shall not terminate with respect to an unmarried child who is incapable of self-sustaining employment by reason of developmental disability or physical disability, if the following conditions are met:

(a) The child became incapable before 19 years of age and is chiefly dependent upon the subscriber for support and maintenance.

(b) Before the child turns 19 years of age, or within 31 days after that, the subscriber has submitted proof of the dependent's incapacity to the corporation.

History: 1980, Act 350, Eff. Apr. 3, 1981;—Am. 1998, Act 24, Imd. Eff. Mar. 12, 1998;—Am. 2014, Act 75, Imd. Eff. Mar. 28, 2014.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1410a Provisions of group certificate; electing coverage under group conversion certificate; notice of conversion privilege; requirements of group conversion certificate; premium; issuance; compliance.

Sec. 410a. (1) A group certificate that is issued or renewed in this state after December 31, 1990 shall include provisions consistent with this section.

(2) If an individual subscriber has been continuously covered under a group certificate for at least 3 months immediately prior to termination, the individual subscriber and his or her covered spouse and dependents may elect coverage under a group conversion certificate upon termination. As used in this section, termination includes, but is not limited to, the following:

(a) Discontinuance of a group certificate in its entirety or with respect to a covered class.

(b) Loss of coverage due to voluntary or involuntary termination of employment except for termination of employment because of gross misconduct.

(c) For a surviving spouse or dependent, death of an individual subscriber covered under a group certificate.

(d) An event that causes a person, who is a spouse or dependent of an individual subscriber at the time of the event, to cease to be a qualified family member under a group certificate.

(3) Coverage under a group conversion certificate shall take effect immediately upon the termination of coverage under the group certificate.

(4) Notification of the conversion privilege shall be included in each certificate of coverage.

(5) A master certificate holder shall give written notice to an individual subscriber of the option to elect a group conversion certificate within 14 days after the occurrence of subsection (2)(a) or (b).

(6) An individual subscriber shall notify the health care corporation of his or her election to convert to a group conversion certificate not later than 30 days after termination of coverage. The first premium shall be paid to the health care corporation at the time the individual elects to convert to a group conversion certificate.

(7) A group conversion certificate under this section:

(a) Shall be issued without evidence of insurability.

(b) Shall not use conditions pertaining to health as a basis for classification.

(c) Shall not exclude a preexisting condition that is not excluded by the group certificate solely because it is a preexisting condition.

(d) May provide that benefits may be reduced by the amount of benefits paid for a specific covered service pursuant to the group certificate that has been terminated.

(8) The premium for a group conversion certificate under this section shall be determined using the aggregate experience for all such certificates issued in this state by the health care corporation and in accordance with premium rates applicable to the age, class of risk, and the type and amount of coverage provided. The experience of an individual under a group conversion certificate shall not be an acceptable basis for establishing that individual's rate for his or her group conversion certificate.

(9) A health care corporation is not required to issue a group conversion certificate under this section if any of the following circumstances apply:

(a) The individual is covered for similar benefits and to a similar extent by another expense-incurred hospital, medical, surgical, or sick-care insurance policy or certificate, hospital or medical service subscriber contract, medical practice or other prepayment plan, or other expense-incurred plan or program.

(b) The individual is covered under title XVIII of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1395 to 1395b, 1395b-2, 1395c to 1395i, 1395i-1a to 1395i-3, 1395j to 1395dd, 1395ff to 1395mm, and 1395oo to 1395ccc.

(c) If termination of an individual's coverage under a group certificate occurred because of any of the following:

(*i*) The individual failed to pay any required contribution.

(*ii*) Discontinued group coverage was replaced by group coverage.

(*iii*) The individual acted to defraud the health care corporation.

(10) A group conversion certificate under this section delivered outside this state for a group certificate that was issued and delivered in this state shall comply with this section.

History: Add. 1989, Act 260, Imd. Eff. Dec. 26, 1989.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1410b Premium for group conversion certificate after January 1, 2014; determination; rating factors.

Sec. 410b. Notwithstanding section 410a(8), for a certificate delivered, issued for delivery, or renewed in this state on or after January 1, 2014, the premium for a group conversion certificate under section 410a shall be determined only by using the rating factors set forth in section 3474a of the insurance code of 1956, 1956 PA 218, MCL 500.3474a.

History: Add. 2013, Act 4, Imd. Eff. Mar. 18, 2013.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1411-550.1413a Repealed. 1994, Act 40, Imd. Eff. Mar. 14, 1994.

Compiler's note: The repealed sections pertained to supplemental medicare benefits certificate without preexisting condition exclusion or limitation, medicare supplemental buyer's guide, certificate to complement federal medicare program, and condition to issuance of certificate.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1414 Expired. 1980, Act 430, Eff. Jan. 1, 1982.

Compiler's note: The expired section pertained to treatment of alcoholism and drug abuse.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1414a Treatment of substance abuse; contracts; qualifications of provider; coverage for intermediate and outpatient care for substance abuse required; demonstration projects;

substance abuse advisory committee; report; contracts based on final report; reimbursement; group and nongroup certificates; exceptions; option to decline coverage; charges, terms, and conditions; reduction of coverage; deductibles and copayment provision; minimum coverage; adjustment; definitions; effective date of section.

Sec. 414a. (1) A health care corporation 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 public health for the hospitalization for, or treatment of, substance abuse.

(2) Subject to subsections (3), (5), and (7), a health care corporation 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, Act No. 368 of the Public Acts of 1978, being sections 333.6101 to 333.6523 of the Michigan Compiled Laws, and shall meet the standards set by the corporation for contracting health care facilities.

(4) A health care corporation shall provide coverage for intermediate and outpatient care for substance abuse, upon issuance or renewal, in all group and nongroup certificates other than service-specific certificates, such as certificates providing coverage solely for 1 of the following: dental care; hearing care; vision care; prescription drugs; or another type of health care benefit. Subject to subsections (5) and (7), a health care corporation may enter into contracts with providers for the rendering of intermediate care, outpatient care, or both types of care, for the treatment of substance abuse.

(5) A health care corporation shall enter into and maintain 5-year contracts with not less than 5 providers in this state, as demonstration projects pursuant to section 207(1)(b), for the rendering of inpatient, intermediate, and outpatient care to adolescent substance abuse patients. A provider who contracts with a health care corporation for the rendering of inpatient, intermediate, and outpatient care to adolescent substance abuse patients shall meet all of the following requirements:

(a) Is accredited by the joint commission on accreditation of hospitals, the council on accreditation for families and children, the commission on accreditation of rehabilitation facilities, or the American osteopathic association.

(b) If applicable, has obtained a certificate of need under part 221 of the public health code, Act No. 368 of the Public Acts of 1978, being sections 333.22101 to 333.22181 of the Michigan Compiled Laws.

(c) Is licensed by the office of substance abuse services under article 6 of the public health code, Act No. 368 of the Public Acts of 1978.

(d) Is licensed by the department of social services as a child caring institution under Act No. 116 of the Public Acts of 1973, being sections 722.111 to 722.128 of the Michigan Compiled Laws.

(e) Agrees to follow generally accepted accounting principles and practices.

(f) Agrees to supply all data required to fulfill the objectives of the demonstration program.

(g) Agrees to work with the substance abuse advisory committee and the health care corporation in conducting the evaluation of the demonstration program.

(6) The substance abuse advisory committee is established, with the cooperation of the office of substance abuse services, under the direction of the office of health and medical affairs. The committee shall consist of 7 members to include the director of the office of health and medical affairs or his or her designee, the administrator of the office of substance abuse services or his or her designee, a representative of the department of public health, 2 designees of the chief executive officer of a health care corporation contracting for a demonstration project under subsection (5), a member of the family of an adolescent substance abuser to be appointed by the office of health and medical affairs, and a service provider of an adolescent substance abuse treatment program to be appointed by the office of health and medical affairs. The substance abuse advisory committee shall evaluate each demonstration project and shall report at the conclusion of each demonstration project to the senate and house standing committees responsible for public health issues. A final report of all the demonstration projects shall be issued by not later than December 31, 1994, and shall include evaluations of and recommendations concerning all of the following:

(a) The cost of specialized adolescent substance abuse treatment compared with the effectiveness of adolescent substance abuse treatment.

(b) The cost and effectiveness of the different levels of adolescent substance abuse treatment, including inpatient, intermediate, and outpatient care and aftercare programs.

(7) Based on the final report submitted pursuant to subsection (6), beginning December 31, 1994, a health care corporation shall continue to enter into and maintain contracts with not less than 5 providers in this state, and may enter into additional contracts for the rendering of inpatient, intermediate, and outpatient care to

adolescent substance abuse patients if the provider meets the requirements of subsection (5)(a) to (e). Contracts entered into under this subsection shall be based upon the recommendations of the final report submitted pursuant to subsection (6).

(8) A health care corporation shall reimburse providers for the rendering of inpatient, intermediate, and outpatient care to adolescent substance abuse patients at a rate that shall be commensurate with reimbursement rates for other similar providers rendering inpatient, intermediate, and outpatient care to adolescent substance abuse patients.

(9) In the case of group certificates, if the amount due for a group certificate would be increased by 3% or more because of the provision of the coverage required under subsection (4), the master policyholder shall have the option to decline the coverage required to be provided under subsection (4). In the case of nongroup certificates, if the total amount due for all nongroup certificates of the health care corporation would be increased by 3% or more because of the provision of the coverage required under subsection (4), the subscriber for each such certificate shall have the option to decline the coverage required to be provided under subsection (4).

(10) Charges, terms, and conditions for the coverage for intermediate and outpatient care for substance abuse required to be provided under subsection (4) shall not be less favorable than the maximum prescribed for any other comparable service.

(11) The coverage for intermediate and outpatient care for substance abuse required to be provided under subsection (4) shall not be reduced by terms or conditions which apply to other items of coverage in a certificate, group or nongroup. This subsection shall not be construed to prohibit certificates that provide for deductibles and copayment provisions for coverage for intermediate and outpatient care for substance abuse, as approved by the commissioner.

(12) The coverage for intermediate and outpatient care for substance abuse required to be provided under subsection (4) shall, at a minimum, provide for up to $1,500.00 in health care benefits for intermediate and outpatient care for substance abuse per member per year. This minimum shall be adjusted by March 31, 1982 and by March 31 each year thereafter in accordance with the annual average percentage increase or decrease in the United States consumer price index for the 12-month period ending the preceding December 31.

(13) As used in this section:

(a) "Adolescent" means an individual who is less than 18 years of age, but more than 11 years of age.

(b) "Intermediate care" means the use, in a full 24-hour residential therapy setting, or in a partial, less than 24-hour, residential therapy setting, of any or all of the following therapeutic techniques, as identified in a treatment plan for individuals physiologically or psychologically dependent upon or abusing alcohol or drugs:

(*i*) Chemotherapy.

(*ii*) Counseling.

(*iii*) Detoxification services.

(*iv*) Other ancillary services, such as medical testing, diagnostic evaluation, and referral to other services identified in a treatment plan.

(c) "Outpatient care" means the use, on both a scheduled and a nonscheduled basis, of any or all of the following therapeutic techniques, as identified in a treatment plan for individuals physiologically or psychologically dependent upon or abusing alcohol or drugs:

(*i*) Chemotherapy.

(*ii*) Counseling.

(*iii*) Detoxification services.

(*iv*) Other ancillary services, such as medical testing, diagnostic evaluation, and referral to other services identified in a treatment plan.

(d) "Substance abuse" means that term as defined in section 6107 of the public health code, Act No. 368 of the Public Acts of 1978, being section 333.6107 of the Michigan Compiled Laws.

History: Add. 1980, Act 430, Eff. Jan. 1, 1982;—Am. 1988, Act 345, Imd. Eff. Oct. 25, 1988.

Constitutionality: This act is unconstitutional in the following three particulars:

(1) The act's provision for an actuary panel to resolve risk factor disputes is an unconstitutional delegation of legislative authority in that it lacks adequate standards (MCL 550.1205(6)).

(2) The statutory restrictions on administrative services only (ASO) contracts violate equal protection of the laws insofar as they result in arbitrary and discriminatory treatment of health care corporations vis-a-vis commercial insurers (MCL 550.1104(3), 550.1211, 550.1414a, 550.1415, and 550.1607(1)).

(3) The commissioner's authority to issue a cease and desist order based on probable cause against a health care corporation for noncompliance with the act establishes an improper burden of proof (MCL 550.1402(7)).

The Supreme Court ruling on these three areas of this act does not affect the constitutionality of the remainder of the act. Where, as here, the unconstitutional provisions are easily severable, the remainder of the act need not be affected. Blue Cross and Blue Shield of Michigan v Governor, 422 Mich 1; 367 NW2d 1 (1985).

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1414b Offer of wellness coverage by health care corporation.

Sec. 414b. (1) A health care corporation may offer group wellness coverage. Wellness coverage may provide for an appropriate rebate or reduction in premiums or for reduced copayments, coinsurance, or deductibles, or a combination of these incentives, for participation in any health behavior wellness, maintenance, or improvement program offered by the employer. The employer shall provide evidence of demonstrative maintenance or improvement of the members' health behaviors as determined by assessments of agreed-upon health status indicators between the employer and the health care corporation. Any rebate or premium provided by the health care corporation is presumed to be appropriate unless credible data demonstrate otherwise, but shall not exceed 30% of paid premiums, unless otherwise approved by the commissioner. A health care corporation shall make available to employers all wellness coverage plans that it markets to employers in this state.

(2) A health care corporation may offer nongroup wellness coverage. Wellness coverage may provide for an appropriate rebate or reduction in premiums or for reduced copayments, coinsurance, or deductibles, or a combination of these incentives, for participation in any health behavior wellness, maintenance, or improvement program approved by the health care corporation. The member shall provide evidence of demonstrative maintenance or improvement of the individual's or family's health behaviors as determined by assessments of agreed-upon health status indicators between the member and the health care corporation. Any rebate of premium provided by the health care corporation is presumed to be appropriate unless credible data demonstrate otherwise, but shall not exceed 30% of paid premiums, unless otherwise approved by the commissioner. A health care corporation shall make available to individuals all wellness coverage plans that it markets to individuals in this state.

(3) A health care corporation is not required to continue any health behavior wellness, maintenance, or improvement program or to continue any incentive associated with a health behavior wellness, maintenance, or improvement program.

History: Add. 2006, Act 413, Eff. Mar. 30, 2007;—Am. 2013, Act 4, Imd. Eff. Mar. 18, 2013.

Compiler's note: Enacting section 2 of Act 413 of 2006 provides:

"Enacting section 2. It is only the intent of this amendatory act to promote the availability of health behavior wellness, maintenance, and improvement programs."

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1415 Benefits for prosthetic devices.

Sec. 415. (1) Not later than 12 months after the effective date of this act, a health care corporation 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 shall be exempted 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) Not later than 12 months after the effective date of this act, a health care corporation shall include coverage, in all group and nongroup certificates, to 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.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Constitutionality: This act is unconstitutional in the following three particulars:

(1) The act's provision for an actuary panel to resolve risk factor disputes is an unconstitutional delegation of legislative authority in that it lacks adequate standards (MCL 550.1205(6)).

(2) The statutory restrictions on administrative services only (ASO) contracts violate equal protection of the laws insofar as they result in arbitrary and discriminatory treatment of health care corporations vis-a-vis commercial insurers (MCL 550.1104(3), 550.1211, 550.1414a, 550.1415, and 550.1607(1)).

(3) The commissioner's authority to issue a cease and desist order based on probable cause against a health care corporation for noncompliance with the act establishes an improper burden of proof (MCL 550.1402(7)).

The Supreme Court ruling on these three areas of this act does not affect the constitutionality of the remainder of the act. Where, as

here, the unconstitutional provisions are easily severable, the remainder of the act need not be affected. Blue Cross and Blue Shield of Michigan v Governor, 422 Mich 1; 367 NW2d 1 (1985).

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1416 Coverage for breast cancer diagnostic services, breast cancer outpatient services, and breast cancer rehabilitative services; coverage for breast cancer screening mammography; definitions; effective date of section.

Sec. 416. (1) Subject to dollar limits, deductibles, and coinsurance provisions that are not less favorable than those for physical illness generally, a health care corporation shall offer or include, in each group and nongroup certificate, coverage for breast cancer diagnostic services, breast cancer outpatient treatment services, and breast cancer rehabilitative services.

(2) Subject to dollar limits, deductibles, and coinsurance provisions that are not less favorable than those for physical illness generally, a health care corporation shall offer or include, in each group and nongroup certificate, the following coverage for breast cancer screening mammography:

(a) If performed on a woman 35 years of age or older and under 40 years of age, coverage for 1 screening mammography examination during that 5-year period.

(b) If performed on a woman 40 years of age or older, coverage for 1 screening mammography examination every calendar year.

(3) As used in this section:

(a) "Breast cancer diagnostic services" means a procedure intended to aid in the diagnosis of breast cancer, delivered on an inpatient or outpatient basis, including but not limited to mammography, surgical breast biopsy, and pathologic examination and interpretation.

(b) "Breast cancer rehabilitative services" means a procedure intended to improve the result of, or ameliorate the debilitating consequences of, treatment of breast cancer, delivered on an inpatient or outpatient basis, including but not limited to, reconstructive plastic surgery, physical therapy, and psychological and social support services.

(c) "Breast cancer screening mammography" means a standard 2-view per breast, low-dose radiographic examination of the breasts, using equipment designed and dedicated specifically for mammography, in order to detect unsuspected breast cancer.

(d) "Breast cancer outpatient treatment services" means a procedure intended to treat cancer of the human breast, delivered on an outpatient basis, including but not limited to surgery, radiation therapy, chemotherapy, hormonal therapy, and related medical follow-up services.

(4) This section shall take effect November 1, 1989.

History: Add. 1989, Act 57, Eff. Nov. 1, 1989.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1416a Coverage for drug used in antineoplastic therapy and cost of its administration; conditions.

Sec. 416a. A health care corporation shall provide coverage in each group and nongroup certificate for a federal food and drug administration approved drug used in antineoplastic therapy and the reasonable cost of its administration. Coverage shall be provided regardless of whether the specific neoplasm for which the drug is being used as treatment is the specific neoplasm for which the drug has received approval by the federal food and drug administration if all of the following conditions are met:

(a) The drug is ordered by a physician for the treatment of a specific type of neoplasm.

(b) The drug is approved by the federal food and drug administration for use in antineoplastic therapy.

(c) The drug is used as part of an antineoplastic drug regimen.

(d) Current medical literature substantiates its efficacy and recognized oncology organizations generally accept the treatment.

(e) The physician has obtained informed consent from the patient for the treatment regimen which includes federal food and drug administration approved drugs for off-label indications.

History: Add. 1989, Act 57, Imd. Eff. June 16, 1989.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1416b Establishment of program to prevent onset of clinical diabetes required; report; coverages; “diabetes” defined.

Sec. 416b. (1) A health care corporation 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 health care corporation shall regularly measure the effectiveness of a program provided pursuant to subsection (1) by regularly surveying group and nongroup members covered by the certificate. Not later than 2 years after the effective date of the amendatory act that added this section, each health care corporation 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 health care corporation 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 health care corporation 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.

History: Add. 2000, Act 424, Eff. Mar. 28, 2001.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1416c Off-label use of approved drug; coverage; conditions; compliance; use of copayment, deductible, sanction, or utilization control; limitation; definitions.

Sec. 416c. (1) A health care corporation group or nongroup certificate that provides pharmaceutical coverage shall provide coverage for an off-label use of a federal food and drug administration approved drug and the reasonable cost of supplies medically necessary to administer the drug.

(2) Coverage for a drug under subsection (1) applies if all of the following conditions are met:

(a) The drug is approved by the federal food and drug administration.

(b) The drug is prescribed by an allopathic or osteopathic physician for the treatment of either of the following:

(*i*) A life-threatening condition so long as the drug is medically necessary to treat that condition and the drug is on the plan formulary or accessible through the health plan's formulary procedures.

(*ii*) A chronic and seriously debilitating condition so long as the drug is medically necessary to treat that condition and the drug is on the plan formulary or accessible through the health plan's formulary procedures.

(c) The drug has been recognized for treatment for the condition for which it is prescribed by 1 of the following:

(*i*) The American medical association drug evaluations.

(*ii*) The American hospital formulary service drug information.

(*iii*) The United States pharmacopoeia dispensing information, volume 1, "drug information for the health care professional".

(*iv*) Two articles from major peer-reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal.

(3) Upon request, the prescribing allopathic or osteopathic physician shall supply to the health care corporation documentation supporting compliance with subsection (2).

(4) This section does not prohibit the use of a copayment, deductible, sanction, or a mechanism for appropriately controlling the utilization of a drug that is prescribed for a use different from the use for which the drug has been approved by the food and drug administration. This may include prior approval or a drug utilization review program. Any copayment, deductible, sanction, prior approval, drug utilization review program, or mechanism described in this subsection shall not be more restrictive than for prescription coverage generally.

(5) As used in this section:

(a) "Chronic and seriously debilitating" means a disease or condition that requires ongoing treatment to maintain remission or prevent deterioration and that causes significant long-term morbidity.

(b) "Life-threatening" means a disease or condition where the likelihood of death is high unless the course of the disease is interrupted or that has a potentially fatal outcome where the end point of clinical intervention is survival.

(c) "Off-label" means the use of a drug for clinical indications other than those stated in the labeling approved by the federal food and drug administration.

History: Add. 2002, Act 539, Eff. Jan. 22, 2003.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1416d Coverage for obstetrical and gynecological services by physician or nurse midwife.

Sec. 416d. (1) As used in this section, "nurse midwife" means an individual licensed as a registered professional nurse under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838, who has been issued a specialty certification in the practice of nurse midwifery by the Michigan board of nursing under section 17210 of the public health code, 1978 PA 368, MCL 333.17210.

(2) Effective March 1, 2005, a group or nongroup certificate that provides coverage for obstetrical and gynecological services shall include coverage for obstetrical and gynecological services whether performed by a physician or a nurse midwife acting within the scope of his or her license or specialty certification or shall do 1 or both of the following:

(a) Offer to provide coverage for obstetrical and gynecological services whether performed by a physician or a nurse midwife acting within the scope of his or her license or specialty certification.

(b) Offer to provide coverage for maternity services and gynecological services rendered during pre- and post-natal care whether performed by a physician or a nurse midwife acting within the scope of his or her license or specialty certification.

History: Add. 2004, Act 374, Imd. Eff. Oct. 11, 2004.

550.1416e Diagnosis and treatment of autism spectrum disorders; coverage; prohibition; availability of other benefits; conditions; qualified health plan offered through American health benefit exchange pursuant to federal law; prescription drug plan; coordinated benefits; definitions.

Sec. 416e. (1) Except as otherwise provided in this section, a health care corporation group or nongroup certificate shall provide coverage for the diagnosis of autism spectrum disorders and treatment of autism spectrum disorders. A health care corporation shall not do any of the following:

(a) Limit the number of visits a member may use for treatment of autism spectrum disorders covered under this section.

(b) Deny or limit coverage under this section on the basis that treatment is educational or habilitative in

nature.

(c) Except as otherwise provided in this subdivision, subject coverage under this section to dollar limits, copays, deductibles, or coinsurance provisions that do not apply to physical illness generally. Coverage under this section for treatment of autism spectrum disorders may be limited to a member through 18 years of age and may be subject to a maximum annual benefit as follows:

(*i*) For a covered member through 6 years of age, $50,000.00.

(*ii*) For a covered member from 7 years of age through 12 years of age, $40,000.00.

(*iii*) For a covered member from 13 years of age through 18 years of age, $30,000.00.

(2) This section does not limit benefits that are otherwise available to a member under a certificate. A health care corporation shall utilize evidence-based care and managed care cost-containment practices pursuant to the health care corporation's procedures so long as that care and those practices are consistent with this section. The coverage under this section may be subject to other general exclusions and limitations of the certificate, including, but not limited to, coordination of benefits, participating provider requirements, restrictions on services provided by family or household members, utilization review of health care services including review of medical necessity, case management, and other managed care provisions.

(3) If a member is receiving treatment for an autism spectrum disorder, a health care corporation may, as a condition to providing the coverage under this section, do all of the following:

(a) Require a review of that treatment consistent with current protocols and may require a treatment plan. If requested by the health care corporation, the cost of treatment review shall be borne by the health care corporation.

(b) Request the results of the autism diagnostic observation schedule that has been used in the diagnosis of an autism spectrum disorder for that member.

(c) Request that the autism diagnostic observation schedule be performed on that member not more frequently than once every 3 years.

(d) Request that an annual development evaluation be conducted and the results of that annual development evaluation be submitted to the health care corporation.

(4) Beginning January 1, 2014, a qualified health plan offered through an American health benefit exchange established in this state pursuant to the federal act is not required to provide coverage under this section to the extent that it exceeds coverage that is included in the essential health benefits as required pursuant to the federal act. As used in this subsection, "federal act" means the federal patient protection and affordable care act, Public Law 111-148, as amended by the federal health care and education reconciliation act of 2010, Public Law 111-152, and any regulations promulgated under those acts.

(5) This section does not require the coverage of prescription drugs and related services unless the member is covered by a prescription drug plan. This section does not require a health care corporation to provide coverage for autism spectrum disorders to a member under more than 1 of its certificates. If a member has more than 1 policy, certificate, or contract that covers autism spectrum disorders, the benefits provided are subject to the limits of this section when coordinating benefits.

(6) As used in this section:

(a) "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

(b) "Autism diagnostic observation schedule" means the protocol available through western psychological services for diagnosing and assessing autism spectrum disorders or any other standardized diagnostic measure for autism spectrum disorders that is approved by the commissioner, if the commissioner determines that the diagnostic measure is recognized by the health care industry and is an evidence-based diagnostic tool.

(c) "Autism spectrum disorders" means any of the following pervasive developmental disorders as defined by the diagnostic and statistical manual:

(*i*) Autistic disorder.

(*ii*) Asperger's disorder.

(*iii*) Pervasive developmental disorder not otherwise specified.

(d) "Behavioral health treatment" means evidence-based counseling and treatment programs, including applied behavior analysis, that meet both of the following requirements:

(*i*) Are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual.

(*ii*) Are provided or supervised by a board certified behavior analyst or a licensed psychologist so long as the services performed are commensurate with the psychologist's formal university training and supervised experience.

(e) "Diagnosis of autism spectrum disorders" means assessments, evaluations, or tests, including the autism diagnostic observation schedule, performed by a licensed physician or a licensed psychologist to diagnose whether an individual has 1 of the autism spectrum disorders.

(f) "Diagnostic and statistical manual" or "DSM" means the diagnostic and statistical manual of mental disorders published by the American psychiatric association or other manual that contains common language and standard criteria for the classification of mental disorders and that is approved by the commissioner, if the commissioner determines that the manual is recognized by the health care industry and the classification of mental disorders is at least as comprehensive as the manual published by the American psychiatric association on the effective date of this section.

(g) "Pharmacy care" means medications prescribed by a licensed physician and related services performed by a licensed pharmacist and any health-related services considered medically necessary to determine the need or effectiveness of the medications.

(h) "Psychiatric care" means evidence-based direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

(i) "Psychological care" means evidence-based direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.

(j) "Therapeutic care" means evidence-based services provided by a licensed or certified speech therapist, occupational therapist, physical therapist, or social worker.

(k) "Treatment of autism spectrum disorders" means evidence-based treatment that includes the following care prescribed or ordered for an individual diagnosed with 1 of the autism spectrum disorders by a licensed physician or a licensed psychologist who determines the care to be medically necessary:

(*i*) Behavioral health treatment.

(*ii*) Pharmacy care.

(*iii*) Psychiatric care.

(*iv*) Psychological care.

(*v*) Therapeutic care.

(*l*) "Treatment plan" means a written, comprehensive, and individualized intervention plan that incorporates specific treatment goals and objectives and that is developed by a board certified or licensed provider who has the appropriate credentials and who is operating within his or her scope of practice, when the treatment of an autism spectrum disorder is first prescribed or ordered by a licensed physician or licensed psychologist as described in subdivision (k).

History: Add. 2012, Act 99, Imd. Eff. Apr. 18, 2012.

Compiler's note: Enacting section 1 of Act 99 of 2012 provides:

"Enacting section 1. This amendatory act applies to certificates delivered, executed, issued, amended, adjusted, or renewed in this state beginning 180 days after the date this amendatory act is enacted into law."

550.1417 Hospice care; contracts with health care corporation; description of benefit.

Sec. 417. (1) A health care corporation shall offer to include benefits for hospice care in each certificate that provides benefits for inpatient hospital care.

(2) A health care corporation may enter into contracts with health care providers for the rendering of hospice care. A contracting health care provider shall be a licensed hospice under article 17 of the public health code, Act No. 368 of the Public Acts of 1978, being sections 333.20101 to 333.22260 of the Michigan Compiled Laws, and shall meet the standards set by the corporation for contracting health care providers.

(3) If benefits for hospice care are provided, a description of the hospice benefit shall be included in communications sent to the individual or group purchaser of coverage.

History: Add. 1984, Act 369, Eff. Jan. 1, 1986;—Am. 1994, Act 235, Imd. Eff. June 30, 1994.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1418 Emergency health services; medical coverage required; “stabilization” defined.

Sec. 418. (1) A health care corporation certificate that provides coverage for emergency health services shall provide coverage for medically necessary services provided to a member for the sudden onset of a medical condition that manifests itself by signs and symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the individual's health or to a pregnancy in the case of a pregnant woman, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. A health care corporation shall not require a physician to transfer a patient before the physician determines that the patient has reached the point of stabilization. A health care corporation shall not deny payment for emergency health services up to the

point of stabilization provided to a member under this subsection because of either of the following:

(a) The final diagnosis.

(b) Prior authorization was not given by the health care corporation before emergency health services were provided.

(2) As used in this section, "stabilization" means the point at which no material deterioration of a condition is likely, within reasonable medical probability, to result from or occur during transfer of the patient.

History: Add. 1998, Act 124, Imd. Eff. June 10, 1998;—Am. 2004, Act 8, Imd. Eff. Feb. 20, 2004.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1419 Certificate offering dependent coverage to child; denial of enrollment on certain grounds prohibited.

Sec. 419. A health care corporation certificate that offers dependent coverage shall not deny enrollment to a subscriber's child on any of the following grounds:

(a) The child was born out of wedlock.

(b) The child is not claimed as a dependent on the subscriber's federal income tax return.

(c) The child does not reside with the subscriber or in the health care corporation's service area.

History: Add. 1995, Act 238, Eff. Mar. 28, 1996.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1419a Eligibility of parent for dependent coverage; health coverage of child through noncustodial parent; court or administrative order and notice required.

Sec. 419a. (1) If a parent is eligible for dependent coverage through a health care corporation, the health care corporation shall:

(a) Permit the parent to enroll, under the dependent coverage, a child who is otherwise eligible for coverage without regard to any enrollment season restrictions.

(b) If the parent is enrolled but fails to make application to obtain coverage for the child, enroll the child under dependent coverage upon application by the friend of the court or by the child's other parent through the friend of the court.

(c) Not eliminate the child's coverage unless premiums have not been paid as required by the certificate or the health care corporation is provided with satisfactory written evidence of either of the following:

(*i*) The court or administrative order is no longer in effect.

(*ii*) The child is or will be enrolled in comparable health coverage through another health care corporation, insurer, health maintenance organization, or self-funded health coverage plan that will take effect not later than the effective date of the cancellation of the existing coverage.

(2) If a child has health coverage through a health care corporation of a noncustodial parent, that health care corporation shall do all of the following:

(a) Provide the custodial parent with information necessary for the child to obtain benefits through that coverage.

(b) Permit the custodial parent or, with the custodial parent's approval, the provider to submit a claim for covered services without the noncustodial parent's approval.

(c) If applicable, reimburse or make payment on claims submitted by the custodial parent or medical provider for services obtained or provided under subdivision (b).

(3) This section applies only if a parent is required by a court or administrative order to provide health coverage for a child and the health care corporation is notified of that court or administrative order.

History: Add. 1995, Act 238, Eff. Mar. 28, 1996.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1419b Individual eligible under title XIX of social security act; assignment of rights of subscriber to department of social services.

Sec. 419b. (1) A health care corporation shall not consider whether an individual is eligible for or has available medical assistance under title XIX of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1396 to 1396g and 1396i to 1396v, in this or another state when considering eligibility for coverage or making payments under its plan for eligible subscribers.

(2) If a health care corporation has a legal liability to make payments, and payment for covered expenses

for medical goods or services furnished to an individual has been made under the medical assistance program established under section 105 of the social welfare act, Act No. 280 of the Public Acts of 1939, being section 400.105 of the Michigan Compiled Laws, the department of social services has the rights of the individual to payment by the health care corporation to the extent payment was made by the department of social services's medical assistance program for those medical goods or services.

(3) If the department of social services has been assigned the rights of a subscriber who is eligible for medical assistance under section 105 of Act No. 280 of the Public Acts of 1939 and is covered by a health care corporation, the health care corporation shall not impose requirements on the department of social services that are different from requirements that apply to an agent or assignee of any other covered subscriber.

History: Add. 1995, Act 238, Eff. Mar. 28, 1996.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1420-550.1430 Repealed. 2006, Act 441, Imd. Eff. Oct. 19, 2006.

Compiler's note: The repealed sections pertained to individual and group long-term care coverage.

Popular name: Act 218

550.1435 "Program" defined.

Sec. 435. As used in sections 436 to 439, "program" means the Michigan caring program created in section 436.

History: Add. 1991, Act 60, Imd. Eff. June 27, 1991.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1436 Michigan caring programs for children; creation; contribution requirements; rating methodologies; supersedure of inconsistent provisions.

Sec. 436. There may be created within each health care corporation a Michigan caring program for children. The program shall provide primary health care coverage for children as set forth in section 438 and shall be administered by the health care corporation. Each program shall be described in a certificate that sets forth the benefits provided. A certificate and the contribution to be charged shall be subject to the commissioner's approval. Contribution requirements shall be established in accordance with rating methodologies approved by the commissioner which, over time, shall not result in either gain or loss to the corporation. The rating methodology for a program shall not include any factors otherwise includable pursuant to other sections of this act that are intended to provide for subsidies, surcharges, or administrative costs. Any other provisions of this act that would otherwise apply to a program but which are inconsistent with the provisions of this section and sections 437 to 439 are superseded.

History: Add. 1991, Act 60, Imd. Eff. June 27, 1991.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1437 Eligibility of child for enrollment in program.

Sec. 437. A child is eligible for enrollment in the program if the child meets all of the following:

(a) Is less than 19 years of age.

(b) Is unmarried.

(c) Resides in a household with income 185% or less of the federal poverty level.

(d) Is ineligible to receive health care through title XIX of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1396 to 1396d, 1396f to 1369g, and 1396i to 1396s.

(e) Is enrolled in the program with all other eligible siblings who have no other health care coverage available.

(f) Is a resident of this state.

(g) Has no other health care coverage available.

History: Add. 1991, Act 60, Imd. Eff. June 27, 1991.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1438 Limitation of benefits; provision of other health care benefits.

Sec. 438. (1) Notwithstanding any other provision of this act, a health care corporation may limit the

benefits it will furnish to an eligible child enrolled in the program to the following primary health care benefits:

(a) Doctor office visits for a sick child.

(b) Medically necessary outpatient diagnostic tests.

(c) Emergency medical and accident care in a doctor's office or hospital's emergency room.

(d) Medically necessary outpatient surgery and anesthesia.

(e) Preventive care, including, but not limited to, immunizations and well-child visits to a doctor's office.

(f) Outpatient substance abuse care.

(2) With the commissioner's approval, a health care corporation may provide other health care benefits in addition to the primary health care benefits set forth in subsection (1).

History: Add. 1991, Act 60, Imd. Eff. June 27, 1991.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1439 Fees prohibited; exception; funding; enrollment of children.

Sec. 439. The program shall not charge any fee to an enrolled eligible child or the child's parents or legal guardians except that if prescription drug benefits are offered a co-pay not to exceed $3.00 may be charged. The program shall be funded by private donations and private and public grants. The health care corporation may provide free of charge administrative services to the program as approved by its board of directors and subject to the commissioner's approval. A child shall be enrolled as follows:

(a) Dependent on funding on a first-come, first-served basis unless a named child is part of a group of 10 or more children who are fully sponsored by private donations.

(b) Without regard to health status.

History: Add. 1991, Act 60, Imd. Eff. June 27, 1991.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

PART 4A
MEDICARE SUPPLEMENT CERTIFICATES

550.1451-550.1499a Repealed. 2002, Act 559, Imd. Eff. Sept. 27, 2002;—2006, Act 462, Imd. Eff. Dec. 20, 2006.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

PART 5

550.1501 Contracts with health care facilities.

Sec. 501. (1) A health care corporation subject to this act may enter into contracts with health care facilities in Michigan or health facilities in any other jurisdiction. It is the intent of the legislature that contracts with health facilities outside of Michigan expand access to health care without reducing access to Michigan licensed health facilities.

(2) Contracts entered into under this section with health care facilities licensed in Michigan are subject to the provisions of sections 504 to 518.

History: 1980, Act 350, Eff. Apr. 3, 1981;—Am. 2003, Act 60, Imd. Eff. July 15, 2003.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1501a Special participating contracts with health care providers for provision of primary health care benefits to children enrolled in Michigan caring program.

Sec. 501a. A health care corporation may enter into special participating contracts with health care providers for the provision of primary health care benefits to children enrolled in a Michigan caring program created under section 436. Special participating contracts entered into under this section are not subject to sections 502 to 518.

History: Add. 1991, Act 73, Imd. Eff. July 11, 1991.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1501b Conduct on behalf of or information provided to subscriber by health care provider; prohibition or discouragement by health care corporation.

Sec. 501b. A health care corporation shall not prohibit or discourage a health care provider from advocating on behalf of a subscriber for appropriate medical treatment options pursuant to the grievance procedure in section 404 or from discussing with a subscriber or provider any of the following:

(a) Health care treatments and services.

(b) Quality assurance plans required by law, if applicable.

(c) The financial relationships between the health care corporation and the health care provider including all of the following as applicable:

(*i*) Whether a fee-for-service arrangement exists, under which the provider is paid a specified amount for each covered service rendered to the participant.

(*ii*) Whether a capitation arrangement exists, under which a fixed amount is paid to the provider for all covered services that are or may be rendered to each covered individual or family.

(*iii*) Whether payments to providers are made based on standards relating to cost, quality, or patient satisfaction.

History: Add. 1997, Act 68, Imd. Eff. July 15, 1997.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1501c Provider network.

Sec. 501c. Beginning January 1, 2014, a health care corporation shall establish and maintain a provider network that, at a minimum, satisfies any network adequacy requirements imposed by the commissioner pursuant to federal law.

History: Add. 2013, Act 4, Imd. Eff. Mar. 18, 2013.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1502 Contracts for reimbursement with professional health care providers; private provider-patient relationship; methods of diagnosis or treatment not to be restricted; refusal to reimburse for overutilized services; list of providers; recommendation of provider as misdemeanor; symbol of participation; health maintenance organization not impeded; contracts subject to MCL 550.1504 to 550.1518; participation of freestanding surgical outpatient facility; optometry services; status of license or registration; chiropractic service; physical therapist or physical therapist assistant services.

Sec. 502. (1) A health care corporation may enter into participating contracts for reimbursement with professional health care providers practicing legally in this state for health care services or with health practitioners practicing legally in any other jurisdiction for health care services that the professional health care providers or practitioners may legally perform. A participating contract may cover all members or may be a separate and individual contract on a per claim basis, as set forth in the provider class plan, if, in entering into a separate and individual contract on a per claim basis, the participating provider certifies all of the following to the health care corporation:

(a) That the provider will accept payment from the corporation as payment in full for services rendered for the specified claim for the member indicated.

(b) That the provider will accept payment from the corporation 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 contract entered into under subsection (1) shall provide that the private provider-patient relationship shall be maintained to the extent provided for by law. A health care corporation shall continue to offer a reimbursement arrangement to any class of providers with which it has contracted before August 27, 1985 and that continues to meet the standards set by the corporation for that class of providers.

(3) A health care corporation shall not restrict the methods of diagnosis or treatment of professional health care providers who treat members. Except as otherwise provided in section 502a, each member of the health care corporation shall at all times have a choice of professional health care providers. This subsection does

not apply to limitations in benefits contained in certificates, to the reimbursement provisions of a provider contract or reimbursement arrangement, or to standards set by the corporation for all contracting providers. A health care corporation may refuse to reimburse a health care provider for health care services that are overutilized, including those services rendered, ordered, or prescribed to an extent that is greater than reasonably necessary.

(4) A health care corporation may provide to a member, upon request, a list of providers with whom the corporation contracts, for the purpose of assisting a member in obtaining a type of health care service. However, except as otherwise provided in section 502a, an employee, agent, or officer of the corporation, or an individual on the board of directors of the corporation, shall not make recommendations on behalf of the corporation with respect to the choice of a specific health care provider. Except as otherwise provided in section 502a, an employee, agent, or officer of the corporation, or a person on the board of directors of the corporation who influences or attempts to influence a person in the choice or selection of a specific professional health care provider on behalf of the corporation, is guilty of a misdemeanor.

(5) A health care corporation shall provide a symbol of participation, which can be publicly displayed, to providers who participate on all claims for covered health care services rendered to subscribers.

(6) This section does not impede the lawful operation of, or lawful promotion of, a health maintenance organization owned by a health care corporation.

(7) Contracts entered into under this section with professional health care providers licensed in this state are subject to sections 504 to 518.

(8) A health care corporation shall not deny participation to a freestanding surgical outpatient facility on the basis of ownership if the facility meets the reasonable standards set by the health care corporation for similar facilities, is licensed under part 208 of the public health code, 1978 PA 368, MCL 333.20801 to 333.20821, and complies with part 222 of the public health code, 1978 PA 368, MCL 333.22201 to 333.22260.

(9) Notwithstanding any other provision of this act, if a certificate provides for benefits for services that are within the scope of practice of optometry, a health care corporation is not required to provide benefits or reimburse for a practice of optometry service unless that service was included in the definition of practice of optometry under section 17401 of the public health code, 1978 PA 368, MCL 333.17401, as of May 20, 1992.

(10) Notwithstanding any other provision of this act, a health care corporation is not required to reimburse for services otherwise covered under a certificate if the services were performed by a member of a health care profession, which health care profession was not licensed or registered by this state on or before January 1, 1998 but that becomes a health care profession licensed or registered by this state after January 1, 1998. This subsection does not change the status of a health care profession that was licensed or registered by this state on or before January 1, 1998.

(11) Notwithstanding any other provision of this act, if a certificate provides for benefits for services that are within the scope of practice of chiropractic, a health care corporation is not required to provide benefits or reimburse for a practice of chiropractic service unless that service was included in the definition of practice of chiropractic under section 16401 of the public health code, 1978 PA 368, MCL 333.16401, as of January 1, 2009.

(12) Notwithstanding any other provision of this act, if a certificate provides for benefits for services that are provided by a licensed physical therapist or physical therapist assistant under the supervision of a licensed physical therapist, a health care corporation is not required to provide benefits or reimburse for services provided by a physical therapist or physical therapist assistant unless that service was provided by a licensed physical therapist or physical therapist assistant under the supervision of a licensed physical therapist pursuant to a prescription from a health care professional who holds a license issued under part 166, 170, 175, or 180 of the public health code, 1978 PA 368, MCL 333.16601 to 333.16648, 333.17001 to 333.17084, 333.17501 to 333.17556, and 333.18001 to 333.18058, or the equivalent license issued by another state.

History: 1980, Act 350, Eff. Apr. 3, 1981;—Am. 1984, Act 230, Eff. Dec. 20, 1984;—Am. 1988, Act 38, Eff. Mar. 30, 1989;—Am. 1993, Act 127, Imd. Eff. July 21, 1993;—Am. 1994, Act 440, Eff. Mar. 30, 1995;—Am. 1997, Act 184, Imd. Eff. Dec. 30, 1997;—Am. 1998, Act 24, Imd. Eff. Mar. 12, 1998;—Am. 1998, Act 446, Imd. Eff. Dec. 30, 1998;—Am. 2003, Act 59, Eff. July 23, 2003;—Am. 2009, Act 225, Imd. Eff. Jan. 5, 2010;—Am. 2014, Act 261, Imd. Eff. July 1, 2014.

Compiler's note: Neither Senate Bill No. 493 nor House Bill No. 4494 was enacted into law by the 87th Legislature.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1502a Prudent purchaser agreements; group contracts; option; group contracts under which financial or other advantage realized; additional option; applicability of subsection

(5); individual contracts; rates; contracts subject to MCL 550.1504 to 550.1518; discrimination against class of health care providers; provisions inapplicable to certain contracts or renewals; optometry, chiropractic, and physical therapist or physical therapist assistant services.

Sec. 502a. (1) For the purpose of doing business as an organization under the prudent purchaser act, 1984 PA 233, MCL 550.51 to 550.63, a health care corporation may enter into prudent purchaser agreements with health care providers pursuant to this section and the prudent purchaser act, 1984 PA 233, MCL 550.51 to 550.63.

(2) A health care corporation may offer group contracts under which subscribers shall be required, as a condition of coverage, to obtain services exclusively from health care providers who have entered into prudent purchaser agreements.

(3) An individual who is a member of a group who is offered the option of being a subscriber under a contract under subsection (2) shall also be offered the option of being a subscriber under a contract under subsection (4). This subsection applies only if the group in which the individual is a member has 25 or more members or if the provider panel that is providing the services under the contract is limited by the organization to a specific number under section 3(1) of the prudent purchaser act, 1984 PA 233, MCL 550.53.

(4) A health care corporation may offer group contracts under which subscribers who elect to obtain services from health care providers who have entered into prudent purchaser agreements realize a financial advantage or other advantage by selecting providers who have entered into prudent purchaser agreements. A health care corporation shall not offer a group contract under this subsection that, as a condition of coverage, requires subscribers to obtain services exclusively from health care providers who have entered into prudent purchaser agreements.

(5) Subject to subsection (6), an individual who is a member of a group who is offered the option of being a subscriber under a contract under subsection (2) or (4) shall also be offered the option of being a subscriber under a contract that does not do any of the following:

(a) As a condition of coverage, require subscribers to obtain services exclusively from health care providers who have entered into prudent purchaser agreements.

(b) Give a financial advantage or other advantage to a subscriber who elects to obtain services from health care providers who have entered into prudent purchaser agreements.

(6) Subsection (5) applies only if the group in which the individual is a member has 25 or more members and if the group on December 20, 1984 had health care coverage through the group sponsor.

(7) A health care corporation may offer individual contracts under which subscribers are required, as a condition of coverage, to obtain services exclusively from health care providers who have entered into prudent purchaser agreements. A person to whom a contract described in this subsection is offered shall also be offered a contract that does not do any of the following:

(a) As a condition of coverage, require subscribers to obtain services exclusively from health care providers who have entered into prudent purchaser agreements.

(b) Give a financial advantage or other advantage to a subscriber who elects to obtain services from health care providers who have entered into prudent purchaser agreements.

(8) A health care corporation may offer individual contracts under which subscribers who elect to obtain services from health care providers who have entered into prudent purchaser agreements realize a financial advantage or other advantage by selecting providers who have entered into prudent purchaser agreements. A health care corporation shall not offer an individual contract under this subsection that, as a condition of coverage, requires subscribers to obtain services exclusively from health care providers who have entered into prudent purchaser agreements. A person to whom a contract described in this subsection is offered shall also be offered a contract that does not do any of the following:

(a) As a condition of coverage, require subscribers to obtain services exclusively from health care providers who have entered into prudent purchaser agreements.

(b) Give a financial advantage or other advantage to a subscriber who elects to obtain services from health care providers who have entered into prudent purchaser agreements.

(9) The rates charged by a corporation for coverage under contracts issued under this section shall not be unreasonably lower than what is necessary to meet the expenses of the corporation for providing this coverage and shall not have an anticompetitive effect or result in predatory pricing in relation to prudent purchaser agreement coverages offered by other organizations.

(10) Contracts entered into under this section are not subject to sections 504 to 518.

(11) A health care corporation shall not discriminate against a class of health care providers when entering into prudent purchaser agreements with health care providers for its provider panel. This subsection does not

do any of the following:

(a) Prohibit the formation of a provider panel consisting of a single class of providers if a service provided for in the specifications of a purchaser may be legally provided only by a single class of providers.

(b) Prohibit the formation of a provider panel that conforms to the specifications of a purchaser of the coverage authorized by this section if the specifications do not exclude any class of health care providers who may legally perform the services included in the coverage.

(c) Require an organization that has uniformly applied the standards filed under section 3(3) of the prudent purchaser act, 1984 PA 233, MCL 550.53, to contract with any individual provider.

(12) Nothing in 1984 PA 230 applies to any contract that was in existence before December 20, 1984, or the renewal of that contract.

(13) Notwithstanding any other provision of this act, if coverage under a prudent purchaser agreement provides for benefits for services that are within the scope of practice of optometry, a health care corporation is not required to provide benefits or reimburse for a practice of optometry service unless that service was included in the definition of practice of optometry under section 17401 of the public health code, 1978 PA 368, MCL 333.17401, as of May 20, 1992.

(14) Notwithstanding any other provision of this act, a health care corporation offering coverage under a prudent purchaser agreement is not required to reimburse for services otherwise covered if the services were performed by a member of a health care profession, which health care profession was not licensed or registered by this state on or before January 1, 1998 but that becomes a health care profession licensed or registered by this state after January 1, 1998. This subsection does not change the status of a health care profession that was licensed or registered by this state on or before January 1, 1998.

(15) Notwithstanding any other provision of this act, if coverage under a prudent purchaser agreement provides for benefits for services that are within the scope of practice of chiropractic, a health care corporation is not required to provide benefits or reimburse for a practice of chiropractic service unless that service was included in the definition of practice of chiropractic under section 16401 of the public health code, 1978 PA 368, MCL 333.16401, as of January 1, 2009.

(16) Notwithstanding any other provision of this act, if coverage under a prudent purchaser agreement provides for benefits for services that are provided by a licensed physical therapist or physical therapist assistant under the supervision of a licensed physical therapist, a health care corporation is not required to provide benefits or reimburse for services provided by a physical therapist or physical therapist assistant unless that service was provided by a licensed physical therapist or physical therapist assistant under the supervision of a licensed physical therapist pursuant to a prescription from a health care professional who holds a license issued under part 166, 170, 175, or 180 of the public health code, 1978 PA 368, MCL 333.16601 to 333.16648, 333.17001 to 333.17084, 333.17501 to 333.17556, and 333.18001 to 333.18058, or the equivalent license issued by another state.

History: Add. 1984, Act 230, Eff. Dec. 20, 1984;—Am. 1988, Act 283, Imd. Eff. July 27, 1988;—Am. 1994, Act 440, Eff. Mar 30, 1995;—Am. 1998, Act 446, Imd. Eff. Dec. 30, 1998;—Am. 2009, Act 225, Imd. Eff. Jan. 5, 2010;—Am. 2014, Act 261, Imd. Eff. July 1, 2014.

Compiler's note: Neither Senate Bill No. 493 nor House Bill No. 4494 was enacted into law by the 87th Legislature.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1503 Uniform reporting by health care providers.

Sec. 503. In the course of developing and establishing provider class plans under this part, a health care corporation shall address the issue of uniform reporting by health care providers.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1504 Reimbursement arrangements; goals; definitions; supplemental efforts.

Sec. 504. (1) A health care corporation shall, with respect to providers, contract with or enter into a reimbursement arrangement to assure subscribers reasonable access to, and reasonable cost and quality of, health care services, in accordance with the following goals:

(a) There will be an appropriate number of providers throughout this state to assure the availability of certificate-covered health care services to each subscriber.

(b) Providers will meet and abide by reasonable standards of health care quality.

(c) Providers will be subject to reimbursement arrangements that will assure a rate of change in the total corporation payment per member to each provider class that is not higher than the compound rate of inflation

and real economic growth.

(2) As used in this section:

(a) "Gross national product in constant dollars" means that term as defined and annually published by the United States department of commerce, bureau of economic analysis.

(b) "Implicit price deflator for gross national product" means that term as defined and annually published by the United States department of commerce, bureau of economic analysis.

(c) "Inflation" or "I" means the arithmetic average of the percentage changes in the implicit price deflator for gross national product over the 2 calendar years immediately preceding the year in which the commissioner's determination is being made.

(d) "Compound rate of inflation and real economic growth" means the ratio of the quantity "100 plus inflation", multiplied by the quantity "100 plus real economic growth", to 100; minus 100; or as expressed in the following formula:

$$\left(\frac{(100 + I) \times (100 + REG)}{100} \right) - 100$$

(e) "Rate of change in the total corporation payment per member to each provider class" means the arithmetic average of the percentage changes in the corporation payment per member for that provider class over the 2 years immediately preceding the commissioner's determination.

(f) "Real economic growth" or "REG" means the arithmetic average of the percentage changes in the per capita gross national product in constant dollars over the 4 calendar years immediately preceding the year in which the commissioner's determination is being made.

(3) Nothing in this section shall preclude efforts by a health care corporation supplemental to the goals prescribed in subsection (1).

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1505 Provider class plan; development, modification, implementation, or review; procedures to obtain advice and consultation.

Sec. 505. (1) A health care corporation shall establish and implement procedures to obtain advice and consultation from a provider class, either through individual providers of that class or through 1 or more organizations or associations that represent the provider class, in any combination, in the development of the provider class plan. A health care corporation may negotiate with 1 or more organizations or associations that represent providers in the relevant provider class in the development and modification of the provider class plan and objectives and methods for implementing that plan.

(2) The commissioner shall establish and implement procedures whereby any person, including a subscriber, may offer advice and consultation on the development, modification, implementation, or review of a provider class plan.

(3) A health care corporation shall establish and implement procedures to obtain advice and consultation from subscribers in the development and modification of the provider class plan and objectives for implementing that plan.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1506 Provider class plan; transmitting to commissioner; examination; determination; notice; placing plan into effect; retention of plan for commissioner's records.

Sec. 506. (1) A health care corporation shall transmit a copy of each provider class plan to the commissioner 45 days before the earliest effective date of a provider contract or reimbursement arrangement for the appropriate provider class. The initial provider class plan for each class, which shall include provider contracts and reimbursement arrangements under which the corporation and a provider class are operating on the effective date of this act, shall be transmitted to the commissioner within 45 days after the effective date of this act, except where a provider class plan reimburses on a prospective basis, in which case the plan shall be transmitted within 1 year and 45 days after the effective date of this act.

(2) Upon receipt of a provider class plan, the commissioner shall examine the plan and shall determine only if the plan contains a reimbursement arrangement and objectives for each goal provided in section 504, and, for those providers with which a health care corporation contracts, provisions that are included in that

contract. For purposes of making the determination required by this subsection only, the commissioner shall liberally construe the items contained in a provider class plan.

(3) If the commissioner determines that the plan does not contain a reimbursement arrangement, objectives for each goal provided in section 504, and, for those providers with which a health care corporation contracts, contract provisions, the commissioner, within 15 days after receipt of the plan, shall notify the corporation by certified or registered mail, along with a written statement of the items omitted.

(4) If the commissioner does not notify the health care corporation pursuant to subsection (3), the provider class plan shall be automatically placed into effect, and shall be retained for the commissioner's records. Provider class plans approved by the commissioner or an independent hearing officer under this part shall be considered retained for the commissioner's records under this subsection.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1507 Provider class plan; inclusion and transmittal of items omitted.

Sec. 507. Within 15 days after receipt of the notification as provided in section 506(3), the health care corporation shall include the items omitted from the provider class plan, after taking into consideration any advice and consultation received from providers and subscribers pursuant to section 505, and shall transmit the items omitted, as provided in section 506(1).

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1508 Provider class plan; modifications.

Sec. 508. (1) Except during the 6-month period provided in section 509(2), a provider class plan retained by the commissioner as provided in section 506(4) may be modified by the health care corporation after the retention, under either of the following circumstances:

(a) If the plan was prepared by the health care corporation and is not a plan prepared pursuant to section 511(1) or 515(4). However, the modification shall not take effect until after the modification has been filed with the commissioner.

(b) In all other cases, if the modification has been filed with and is agreed to by the commissioner.

(2) A modification made under subsection (1) shall not extend the time periods provided in section 509(1). In developing plan modifications, a health care corporation shall obtain advice and consultation from providers in the relevant provider class and from subscribers pursuant to section 505. Before agreeing to plan modifications under subsection (1)(b), the commissioner shall obtain advice and consultation pursuant to section 505(2).

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1509 Achievement of goals and objectives; determinations by commissioner.

Sec. 509. (1) The commissioner may determine if the health care corporation has substantially achieved the goals of a corporation as provided in section 504 and achieved the objectives contained in the provider class plan, at the following times:

(a) For a provider contract or a reimbursement arrangement that was in effect prior to the effective date of this act, upon the expiration of 2 years after the filing date under section 506.

(b) For a provider class plan retained by the commissioner as provided in section 506(4), upon the expiration of 2 years after the earliest effective date of the provider contract or a reimbursement arrangement for the appropriate provider class.

(c) For a class plan retained by the commissioner as provided in section 506(4) that has not been subject to a determination under this section within the time period provided in subsection (2), within 2 years after the expiration of that time period.

(2) Before making a determination under subsection (1), and not later than 30 days following expiration of the appropriate 2-year time period described in subsection (1)(a), (b), or (c), the commissioner shall give written notice to the health care corporation, and to each person who has requested a copy of such notice, that he or she intends to make a determination with respect to a particular provider class plan. The commissioner shall have 6 months to reach a determination under subsection (1).

(3) A modification made pursuant to section 508(1) shall not be taken into consideration for purposes of

computing the time periods described in subsections (1) and (2).

(4) The commissioner shall consider all of the following in making a determination pursuant to subsection (1):

(a) Annual reports transmitted pursuant to section 517.

(b) The overall balance of the goals provided in section 504, achieved by the health care corporation under the plan. The commissioner shall give weight to each of the goals provided in section 504, shall not focus on 1 goal independently of the other goals of the corporation, and shall assure that no portion of the corporation's fair share of reasonable costs to the provider are borne by other health care purchasers.

(c) Information submitted or obtained for the record concerning: demographic trends; epidemiological trends; and long-term economic trends, including changes in prices of goods and services purchased by a provider class not already reflected in the calculation in section 504(2)(d); sudden changes in circumstances; administrative agency or judicial actions; changes in health care practices and technology; and changes in benefits that affect the ability of the health care corporation to reasonably achieve the goals provided in section 504.

(d) Health care legislation of this state or of the federal government. As used in this subdivision, "health care legislation" does not include Act No. 218 of the Public Acts of 1956, as amended, being sections 500.100 to 500.8302 of the Michigan Compiled Laws.

(e) Comments received from an individual provider of the appropriate provider group, or from an organization or association that represents the appropriate provider class, and comments received pursuant to section 505(2).

(5) In making a determination pursuant to subsection (1), the commissioner shall provide a detailed statement of findings which support that determination, including a consideration of the information and factors described in subsection (4).

(6) All data, analyses, and factors, quantified or otherwise, at a minimum, shall include the 2-year period being evaluated.

(7) The commissioner shall make a sufficient number of determinations regarding provider class plans under this section, so that during each 3-year period following the effective date of this act, there is a review of provider class plans which, taken together, account for at least 75% of the total corporation payout to providers for the 3-year period.

(8) Determinations by the commissioner shall not be contested case hearings under chapter 4 of the administrative procedures act. This subsection shall not be construed to apply with respect to appeals under section 515.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1510 Additional determinations by commissioner.

Sec. 510. (1) After considering the information and factors described in section 509(4), the goals of a health care corporation as provided in section 504, and the objectives contained in the provider class plan, the commissioner shall determined 1 of the following:

(a) That the provider class plan achieves the goals of the corporation as provided in section 504.

(b) That although the provider class plan does not substantially achieve 1 or more of the goals of the corporation, a change in the provider class plan is not required because there has been competent, material, and substantial information obtained or submitted to support a determination that the failure to achieve 1 or more of the goals was reasonable due to factors listed in section 509(4).

(c) That a provider class plan does not substantially achieve 1 or more of the goals of the corporation as provided in section 504.

(2) The commissioner shall notify the health care corporation, and each person who has requested a copy of such notice, of a determination under subsection (1) by certified or registered mail. Determinations made pursuant to subsection (1)(b) or (c) shall include a concise written statement of specific findings supporting that determination.

(3) An existing provider contract or reimbursement arrangement shall remain in effect until a new provider class plan has been retained and placed into effect as provided in section 506(4). A provider class plan shall not be subject to further review until the expiration of the time period provided in section 509(1).

(4) A provider class plan with respect to which a determination was made under subsection (1)(a) or (b) shall not be subject to further review until the expiration of 2 years following the determination.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Compiler's note: Near the end of subsection (1), "determined" evidently should read "determine."

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1511 Provider class plan; transmittal to commissioner; preparation by commissioner.

Sec. 511. (1) Upon receipt of notice under section 510(2), the health care corporation, within 6 months or a period determined by the commissioner pursuant to section 512, shall transmit to the commissioner a provider class plan that substantially achieves the goals, achieves the objectives, and substantially overcomes the deficiencies enumerated in the findings made by the commissioner pursuant to section 510(2). In developing a provider class plan under this subsection, the corporation shall obtain advice and consultation from providers in the provider class and subscribers, using procedures established pursuant to section 505.

(2) If, after the expiration of 6 months or a period determined by the commissioner pursuant to section 512, the health care corporation has failed to act pursuant to subsection (1), the commissioner shall prepare a provider class plan pursuant to section 513(2)(a), for that provider class.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1512 Extension of 6-month period provided in MCL 550.511(1); determination.

Sec. 512. The commissioner may extend the 6-month period provided in section 511(1) once, for not more than 90 days, if the commissioner determines that a health care corporation requires additional time to assess the findings made by the commissioner or to prepare a provider class plan that substantially achieves the goals, achieves the objectives, and substantially overcomes the deficiencies enumerated in the findings. In making a determination under this section, the commissioner shall consider the number of provider class plans, the extent of the changes to each plan, and the stage of development of each plan being prepared by the health care corporation pursuant to section 511(1).

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1513 Provider class plan; examination; automatic retention; placing plan into effect; preparation of plan by commissioner; notice.

Sec. 513. (1) Upon receipt of a provider class plan under section 511(1), the commissioner, after considering the information and factors described in section 509(4), within 90 days shall examine the plan and determine if the plan substantially achieves the goals, achieves the objectives, and substantially overcomes the deficiencies enumerated in the findings made by the commissioner. If the commissioner determines that the plan substantially achieves the goals, achieves the objectives, and substantially overcomes the deficiencies enumerated in the findings made by the commissioner, the plan shall be automatically retained and placed into effect as provided in section 506.

(2) If the commissioner determines that the plan does not substantially achieve the goals, does not achieve the objectives, and does not substantially overcome the deficiencies enumerated in the findings made by the commissioner pursuant to section 510(2), the commissioner shall do all of the following:

(a) Prepare a provider class plan that substantially achieves the goals, achieves the objectives, and substantially overcomes the deficiencies enumerated in the findings made pursuant to section 510(2), and transmit that plan to the health care corporation. A provider class plan prepared pursuant to this subdivision shall be retained for the commissioner's records and placed into effect as provided in section 506(4), unless a request for an appeal is made under subdivision (b).

(b) Give written notice to the health care corporation of an opportunity for an appeal pursuant to section 515. The notice shall state that a request for an appeal shall be made by the corporation within 30 days after the receipt of notice under this subdivision.

(3) In making a determination pursuant to subsection (1), or preparing a plan pursuant to subsection (2)(a), the commissioner shall obtain advice and consultation pursuant to section 505(2). The commissioner shall also forward a copy of each notice issued under subsection (2)(b) to each person requesting a copy. The copy shall notify the person of an opportunity for an appeal pursuant to section 515, and that a request for such an appeal is required to be made within 30 days after the receipt of notice given under this subsection.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1514 Appeal; selection and qualifications of hearing officer; consolidation; annual report.

Sec. 514. (1) All appeals under this part shall be held before an independent hearing officer. The state court administrator shall compile and maintain a list of individuals possessing all of the following qualifications:

(a) Is a retired circuit court judge.

(b) Is a resident of this state.

(c) Is not engaged in the provision of health care services.

(d) Is not an officer or employee of a health care provider, health care corporation, or an employee of this state. For purposes of this subdivision, an employee of an educational institution shall not be considered to be employed by this state.

(2) The hearing officer shall be selected at random by the commissioner from the list described in subsection (1), on a per appeal basis. If the individual selected is performing judicial duties, another individual shall be selected.

(3) The hearing officer shall have the power to consolidate appeals related to a provider class.

(4) The commissioner shall prepare and file with the appropriate standing committees of the legislature an annual report regarding the operation of the appeals procedure prescribed in this part, including data regarding the identity of individuals available to serve as independent hearing officers whose names are on the administrator's list; the number of appeals heard; the nature of the controversy involved; the disposition of the appeal; and whether a judicial appeal was subsequently taken, and the disposition of that appeal.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1515 Appeal; parties; request; time; relief; transmittal of provider class plan to hearing officer; determinations.

Sec. 515. (1) An appeal may be brought from any action or determination of the commissioner under section 509(1), 510(1), or 513(1) or (2), by a subscriber, the health care corporation, the attorney general, an employer, an organization or association representing a subscriber or an employer, or an organization or association representing the affected provider class. An appeal may also be brought by a person whose contractual or legal rights, duties, or privileges are substantially affected. The request for an appeal shall identify the issue or issues which the affected party asserts are involved, and how the party is aggrieved. The independent hearing officer shall determine the standing of any party to appeal.

(2) An appeal from an action or determination of the commissioner under this part shall be brought within 30 days after the action or determination. All appeal hearings shall begin within 30 days after receipt of a request for an appeal. The appeal shall be conducted pursuant to chapter 4 of the administrative procedures act.

(3) In an appeal pursuant to this section, the relief available to a person, and the decision of an independent hearing officer hearing an appeal, shall be limited to the following:

(a) Affirming or reversing a determination of the commissioner under sections 509(1) and 510(1).

(b) Determining, based on the information and factors described in section 509(4) and the standards prescribed in section 516, 1 of the following:

(*i*) That the provider class plan prepared by the corporation under section 511(1) was prepared in compliance with that section and shall be retained as provided in section 506(4).

(*ii*) That the provider class plan prepared by the commissioner under section 513(2)(a) was prepared in compliance with that section and shall be retained as provided in section 506(4).

(*iii*) That a provider class plan described in subparagraph (*i*) or (*ii*) was not prepared in compliance with section 511(1) or 513(2)(a), respectively, and shall not be retained as provided in section 506(4). In this case, the hearing officer shall order the corporation to prepare and submit a provider class plan as provided in subsection (4). Detailed findings must accompany the determination made by the hearing officer pursuant to this subdivision.

(4) Within 180 days after receipt of the hearing officer's determination made under subsection (3)(b)(*iii*), the health care corporation shall transmit to the hearing officer a provider class plan that is in conformance with the findings of the hearing officer and that substantially achieves the goals of a health care corporation as provided in section 504. In developing a provider class plan under this subsection, the corporation shall obtain advice and consultation from providers in the provider class and subscribers, using procedures established pursuant to section 505.

(5) After receipt of a provider class plan transmitted by the health care corporation pursuant to subsection

(4), the hearing officer shall determine 1 of the following:

(a) That the provider class plan prepared by the corporation shall be retained as provided in section 506(4).

(b) That the provider class plan prepared by the corporation should not be retained as provided in section 506(4), and the commissioner may suspend or limit the corporation's certificate of authority until the corporation submits a provider class plan which the hearing officer determines should be retained as provided in section 506(4).

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1516 Provider class plan; standards.

Sec. 516. (1) All provider class plans retained by the commissioner under section 513 or approved by the hearing officer shall maintain the following standards for all providers:

(a) Responsible cost controls shall exist that balance quality, accessibility, and cost.

(b) The health care corporation shall promote programs and policies which encourage cost-effective behavior by providers in accordance with the provisions of this act, and in accordance with all of the following:

(*i*) There shall be a reasonable basis for believing that the programs will be effective.

(*ii*) The programs applicable to a provider class shall be reviewed to avoid duplication or inconsistency, to the extent practicable.

(c) There shall be a fair and reasonable appeals process established and maintained by the health care corporation for aggrieved providers.

(d) There shall be a reasonable period for implementation of changes.

(e) There shall be reasonably prompt payment by the health care corporation to providers who render covered health care services.

(2) In addition to the standards prescribed in subsection (1), the following standards shall apply to hospitals:

(a) To the extent practicable, reimbursement control shall be expressed in the aggregate to individual hospitals.

(b) No portion of the health care corporation's fair share of hospitals' reasonable financial requirements shall be borne by other health care purchasers. However, this subdivision shall not preclude reimbursement arrangements which include financial incentives and disincentives.

(c) The health care corporation's programs and policies shall not unreasonably interfere with the hospital's ability and responsibility to manage its operations.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1517 Annual report.

Sec. 517. A health care corporation shall transmit an annual report for each provider class to the commissioner regarding the level of achievement of the goals provided in section 504. The report shall include data necessary to a determination of the corporation's compliance or noncompliance with the goals, as prescribed in section 504, and compliance with objectives contained in the provider class plan. The report shall be in accordance with forms and instructions prescribed by the commissioner and shall include information as necessary to evaluate the considerations of section 509(4). The report may include other information the corporation deems relevant.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1518 Considerations and standards; applicability; appeal.

Sec. 518. The considerations set forth in section 509(4) and the standards set forth in section 516 shall only apply for purposes of this act and may be appealed only as specifically provided in this act. An appeal from a final determination of an independent hearing officer shall be conducted pursuant to chapter 6 of the administrative procedures act, except that the appeal shall be taken within 30 days after the final determination, upon leave granted, in the court of appeals.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

PART 6

550.1601 Regulation and supervision of health care corporation; delegation of authority.

Sec. 601. (1) A health care corporation shall be subject to regulation and supervision by the commissioner as provided in this act.

(2) A designee of the commissioner shall not be authorized to act on behalf of the commissioner under this act unless prior written notice of the delegation of authority has been given to a health care corporation subject to that delegated authority.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1602 Statement of condition; statistical, financial, and other reports.

Sec. 602. (1) Not later than March 1 each year, subject to a 30-day extension that may be granted by the commissioner, a health care corporation shall file in the office of the commissioner a sworn statement verified by at least 2 of the principal officers of the corporation showing its condition as of the preceding December 31. The statement shall be in a form and contain those matters that the commissioner prescribes for a health care corporation, including those matters contained in section 204a. The statement shall include the number of members and the number of subscribers' certificates issued by the corporation and outstanding.

(2) The commissioner, by order, may require a health care corporation to submit statistical, financial, and other reports for the purpose of monitoring compliance with this act.

History: 1980, Act 350, Eff. Apr. 3, 1981;—Am. 2003, Act 59, Eff. July 23, 2003.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1603 Visitation and examination; access to books, papers, and documents; witnesses; expenses; disclosure of information; reporting violation; action by attorney general; ex parte order directing compliance.

Sec. 603. (1) The commissioner may visit and examine the affairs of a health care corporation. The corporation shall in every way facilitate an examination or visitation.

(2) The power of examination shall include free access to all of the books, papers, and documents that relate to the business of the corporation, except as provided in section 304(2)(d). Free access shall include the right to copy and reproduce at the place of business of the health care corporation and to require delivery of any materials to the office of the commissioner in Lansing within 5 working days after the request is made. If the corporation is unable to respond to the request within 5 working days, the corporation shall specify a date certain by which the corporation will respond. However, the date certain shall not be later than 15 working days after the request is made unless the commissioner agrees to a longer period of time. Witnesses may be summoned and qualified under oath, and examination may be made of the corporation's officers, agents, or employees or of other persons having knowledge of the affairs, transactions, and conditions of the corporation. Except as provided in section 603a, the per diem, traveling, reproduction, and other necessary expenses in connection with visitation and examination shall be paid by the corporation and shall be credited to the general fund of the state.

(3) Information provided to the commissioner that is disclosable only to the commissioner under section 304(2) shall not be disclosed by the commissioner to other persons until such time as the minutes pertaining to that information may be disclosed under section 304(3).

(4) If it appears from any examination or report that this act or any other law of this state has been violated, the commissioner immediately shall report the violation to the attorney general in writing. The attorney general shall then take action on the alleged violation, as the facts warrant. Unless the public health, safety, or welfare otherwise clearly requires, before commencement of a proceeding against a health care corporation resulting from a report, the corporation shall be furnished a copy of the examination report and shall be given an informal opportunity to show compliance with the law.

(5) Upon the request of the commissioner, the attorney general may petition for, and the circuit court may issue, an ex parte order from the circuit court directing a corporation to comply with this section. The corporation shall be entitled to an expedited hearing to challenge the ex parte order.

History: 1980, Act 350, Eff. Apr. 3, 1981;—Am. 1994, Act 169, Imd. Eff. June 17, 1994.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1603a Health care corporation subject to MCL 500.224 and 500.225; costs and expenses.

Sec. 603a. A health care corporation is subject to sections 224(4) through (13) and 225 of the insurance code of 1956, Act No. 218 of the Public Acts of 1956, being sections 500.224 and 500.225 of the Michigan Compiled Laws, instead of the costs and expenses that may be imposed by the commissioner pursuant to section 603.

History: Add. 1994, Act 169, Imd. Eff. June 17, 1994.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1604 Confidentiality; violation as misdemeanor; penalty.

Sec. 604. (1) The commissioner shall ensure that confidentiality of records containing personal data which may be associated with identifiable individuals. Except as is necessary to comply with a court order, or for the purposes of claim adjudication or when required by law, the commissioner shall not disclose records containing personal data which may be associated with an identifiable individual without the prior informed consent of the individual to whom the data pertain. The individual's consent shall be in writing. If an individual has authorized the release of personal data to a specific person, that person shall not release the data to a third person unless the individual executes in writing another informed consent authorizing that additional release.

(2) The commissioner shall ensure the confidentiality of data which discloses reimbursement levels for specific procedures or services of specific providers and data which, if disclosed, can be used to calculate those reimbursement levels. This subsection shall apply only if the data are not already generally known to providers and if the disclosure of the data would be harmful to the achievement of the goals set forth in section 504. Only that portion of a record dealing with data described in this subsection shall be exempt from disclosure. A person, whose request for a hearing has been granted by the commissioner, may examine the data and shall be subject to the same confidentiality requirements as the commissioner under this subsection.

(3) The commissioner shall ensure the confidentiality of any trade secrets of the corporation, except for information required to be disclosed under Act No. 442 of the Public Acts of 1976, as amended, being sections 15.231 to 15.246 of the Michigan Compiled Laws.

(4) Subject to the provisions of subsections (1) to (3), information which a health care corporation provides to or files with the commissioner shall be governed by Act No. 442 of the Public Acts of 1976, as amended, being sections 15.231 to 15.246 of the Michigan Compiled Laws.

(5) A person who violates the confidentiality provisions of this section is guilty of a misdemeanor, punishable by a fine of not more than $1,000.00 for each violation.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1605 Certificate of authority; suspension or limitation; circumstances; order; hearing; notice.

Sec. 605. (1) Upon due notice and an opportunity for an evidentiary hearing pursuant to the administrative procedures act, the commissioner may suspend or limit the certificate of authority of a health care corporation if the commissioner determines that any of the following circumstances exist:

(a) The health care corporation does not meet the requirements of this act respecting the adequacy of its reserves.

(b) The health care corporation is using methods or practices in the conduct of its business which render further transactions hazardous or injurious to subscribers of the corporation or the public.

(c) The health care corporation refuses or fails to comply with this act or with a lawful order of the commissioner.

(2) If the commissioner finds that the public health, safety, or welfare requires emergency action and incorporates this finding into an order, a summary suspension or limitation of a certificate of authority may be ordered. The suspension or limitation shall be effective on the date specified in the order or upon service of a certified copy of the order on the health care corporation, whichever is later, and shall be effective during the proceedings. The corporation shall have the right to an administrative hearing within 5 days to show why the summary suspension or limitation should be terminated.

(3) An order of limitation may restrict the solicitation of certificates, the renewal of business in force, and

the solicitation, offer, or acceptance of contracts, and may impose other conditions to continued authorization as are reasonably necessary to protect the subscribers of the corporation or the public. The commissioner shall terminate an order of limitation when the circumstance giving rise to the order ceases to exist.

(4) Upon suspension or limitation of a corporation's certificate of authority, if the commissioner considers it necessary or desirable for the protection of the subscribers of the corporation or the public, the commissioner may publish notice of the suspension or limitation in 1 or more newspapers of general circulation in the state.

(5) An emergency order by the commissioner which suspends or limits a corporation's certificate of authority shall be for a period not to exceed 1 year and, after opportunity of hearing, the commissioner for good cause may extend the period of suspension or limitation for additional periods not to exceed 1 year.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1606 Authority of commissioner regarding officers and directors; authority as to dissolution, taking over, or liquidation of corporations; insolvency defined.

Sec. 606. (1) The commissioner shall have the same authority regarding the officers and directors of a health care corporation as the commissioner has with respect to the officers and directors of insurers under sections 249 and 250 of the insurance code of 1956, 1956 PA 218, MCL 500.249 and 500.250.

(2) The commissioner shall have the same authority with respect to the dissolution, taking over, or liquidation of corporations formed or doing business under this act as is provided in chapter 81 of the insurance code of 1956, 1956 PA 218, MCL 500.8101 to 500.8159. For purposes of this subsection, a health care corporation shall be considered to be insolvent if its liabilities exceed its assets, unless otherwise defined in chapter 81 of the insurance code of 1956, 1956 PA 218, MCL 500.8101 to 500.8159.

History: 1980, Act 350, Eff. Apr. 3, 1981;—Am. 2003, Act 59, Eff. July 23, 2003.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1607 Submission of new or revised certificate and applicable proposed rates; approval or disapproval; exemption; circumstances and conditions; notice; implementation of certificates and rates.

Sec. 607. (1) A health care corporation shall submit a copy of any new or revised certificate to the commissioner along with applicable proposed rates and rate rationale. The certificates, and applicable proposed rates, shall be deemed approved and effective 30 days after filing with the commissioner, except as otherwise provided in this section. The commissioner may subsequently disapprove any certificate deemed approved.

(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 609.

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

(c) If a certificate reduces the scope, amount, or duration of benefits so as to have the effect of reducing the comprehensiveness of existing health care benefits available to groups or to individuals. The commissioner may approve a certificate which reduces the scope, amount, or duration of health care benefits if the commissioner determines that the certificate will be offered as an alternative in addition to an existing certificate which provides comprehensive health care benefits and if the commissioner determines that approval of the alternative certificate will not adversely affect the opportunity for groups or individuals to obtain comprehensive health care benefits.

(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 609.

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

(5) If the commissioner disapproves a certificate and any applicable proposed rates under this section, he or she shall issue a notice of disapproval which specifies in what respects a filing fails to meet the requirements of this act. The notice shall state that the filing shall not become effective.

(6) If the commissioner approves, or approves with modifications, a certificate and any applicable proposed rates under this section, he or she shall issue 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 act, 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 health care corporation, the commissioner may allow certificates and rates to be implemented prior to filing to allow implementation of a new certificate on the date requested.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Constitutionality: This act is unconstitutional in the following three particulars:

(1) The act's provision for an actuary panel to resolve risk factor disputes is an unconstitutional delegation of legislative authority in that it lacks adequate standards (MCL 550.1205(6)).

(2) The statutory restrictions on administrative services only (ASO) contracts violate equal protection of the laws insofar as they result in arbitrary and discriminatory treatment of health care corporations vis-a-vis commercial insurers (MCL 550.1104(3), 550.1211, 550.1414a, 550.1415, and 550.1607(1)).

(3) The commissioner's authority to issue a cease and desist order based on probable cause against a health care corporation for noncompliance with the act establishes an improper burden of proof (MCL 550.1402(7)).

The Supreme Court ruling on these three areas of this act does not affect the constitutionality of the remainder of the act. Where, as here, the unconstitutional provisions are easily severable, the remainder of the act need not be affected. Blue Cross and Blue Shield of Michigan v Governor, 422 Mich 1; 367 NW2d 1 (1985).

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1608 Rates charged to nongroup subscribers for certificate; methodology and definitions of rating system, formula, component, and factor used to calculate rates for group subscribers for certificate; filing; approval, disapproval, or modification; standard; burden of proof; effective date of proposed rate; rate adjustments; implementation prior to approval; examination of financial arrangement; formulae, and factors.

Sec. 608. (1) The rates charged to nongroup subscribers for each certificate shall be filed in accordance with section 610 and shall be subject to the prior approval of the commissioner. 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 609. The burden of proof that rates to be charged meet these standards shall be upon the health care corporation proposing to use the rates.

(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 610 and shall be subject to the prior approval of the commissioner. The definition of a group, including any clustering principles applied to nongroup subscribers or small group subscribers for the purpose of group formation, shall be subject to the prior approval of the commissioner. However, if a Michigan caring program is created under section 436, that program shall be defined as a group program for the purpose of establishing rates. 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 609. In addition, the commissioner may from time to time review the records of the corporation to determine proper application of a rating system, formula, component, or factor with respect to any group. The corporation shall refile for approval under this subsection, every 3 years, 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 shall be upon the health care corporation proposing to use the rating system, formula, component, or factor.

(3) A proposed rate shall not take effect until a filing has been made with the commissioner and approved under section 607 or this section, as applicable, except as provided in subsections (4) and (5).

(4) Upon request by a health care corporation, the commissioner may allow rate adjustments to become effective prior to 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.

(5) Implementation prior to approval may be allowed if the health care corporation is participating with 1 or more health care corporations to underwrite a group whose employees are located in several states. Upon request from the commissioner, the corporation 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.

History: 1980, Act 350, Eff. Apr. 3, 1981;—Am. 1991, Act 73, Imd. Eff. July 11, 1991.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1609 Excessive rate; administrative expense budget; equitable rate; adequate rate; line of business to be self-sustaining; cost transfers for benefit of senior citizens and group conversion subscribers.

Sec. 609. (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 adequate and unimpaired surplus as provided in section 204a; 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 health care corporation. 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 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 health care corporation 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 health care corporation.

(5) Except for identified cost transfers, each line of business, over time, shall be self-sustaining. However, there may be cost transfers for the benefit of senior citizens and group 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 health care corporation as reported in the most recent annual statement of the corporation. Group conversion subscribers are those who have maintained coverage with the health care corporation on an individual basis after leaving a subscriber group.

History: 1980, Act 350, Eff. Apr. 3, 1981;—Am. 1991, Act 61, Eff. July 11, 1991;—Am. 2003, Act 59, Eff. July 23, 2003.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1610 Filing of information and materials relative to proposed rate; notice; approval, approval with modifications, or disapproval; additional information and materials; determination; notice; visitation and examination; expenses; order; effect of inability to approve 1 or more rating classes of business within line of business; information in support of nongroup rate filing; public inspection of information; forms and instructions for filing proposed rates.

Sec. 610. (1) Except as provided under section 608(4) or (5), a filing of information and materials relative to a proposed rate shall be made not less than 120 days before the proposed effective date of the proposed rate. A filing shall not be considered to have been received until there has been substantial and material compliance with the requirements prescribed in subsections (6) and (8).

(2) Within 30 days after a filing is made of information and materials relative to a proposed rate, the commissioner shall do either of the following:

(a) Give written notice to the corporation, and to each person described under section 612(1), that the filing is in material and substantial compliance with subsections (6) and (8) and that the filing is complete. The

commissioner shall then proceed to approve, approve with modifications, or disapprove the rate filing 60 days after receipt of the filing, based upon whether the filing meets the requirements of this act. However, if a hearing has been requested under section 613, the commissioner shall not approve, approve with modifications, or disapprove a filing until the hearing has been completed and an order issued.

(b) Give written notice to the corporation that the corporation has not yet complied with subsections (6) and (8). The notice shall state specifically in what respects the filing fails to meet the requirements of subsections (6) and (8).

(3) Within 10 days after the filing of notice pursuant to subsection (2)(b), the corporation shall submit to the commissioner such additional information and materials, as requested by the commissioner. Within 10 days after receipt of the additional information and materials, the commissioner shall determine whether the filing is in material and substantial compliance with subsections (6) and (8). If the commissioner determines that the filing does not yet materially and substantially meet the requirements of subsections (6) and (8), the commissioner shall give notice to the corporation pursuant to subsection (2)(b) or use visitation of the corporation's facilities and examination of the corporation's records to obtain the necessary information described in the notice issued pursuant to subsection (2)(b). The commissioner shall use either procedure previously mentioned, or a combination of both procedures, in order to obtain the necessary information as expeditiously as possible. The per diem, traveling, reproduction, and other necessary expenses in connection with visitation and examination shall be paid by the corporation, and shall be credited to the general fund of the state.

(4) If a filing is approved, approved with modifications, or disapproved under subsection (2)(a), the commissioner shall issue a written order of the approval, approval with modifications, or disapproval. If the filing was approved with modifications or disapproved, the order shall state specifically in what respects the filing fails to meet the requirements of this act and, if applicable, what modifications are required for approval under this act. If the filing was approved with modifications, the order shall state that the filing shall take effect after the modifications are made and approved by the commissioner. If the filing was disapproved, the order shall state that the filing shall not take effect.

(5) The inability to approve 1 or more rating classes of business within a line of business because of a requirement to submit further data or because a request for a hearing under section 613 has been granted shall not delay the approval of rates by the commissioner which could otherwise be approved or the implementation of rates already approved, unless the approval or implementation would affect the consideration of the unapproved classes of business.

(6) Information furnished under subsection (1) in support of a nongroup rate filing shall include the following:

(a) Recent claim experience on the benefits or comparable benefits for which the rate filing applies.

(b) Actual prior trend experience.

(c) Actual prior administrative expenses.

(d) Projected trend factors.

(e) Projected administrative expenses.

(f) Contributions for risk and contingency reserve factors.

(g) Actual health care corporation contingency reserve position.

(h) Projected health care corporation contingency reserve position.

(i) Other information which the corporation considers pertinent to evaluating the risks to be rated, or relevant to the determination to be made under this section.

(j) Other information which the commissioner considers pertinent to evaluating the risks to be rated, or relevant to the determination to be made under this section.

(7) A copy of the filing, and all supporting information, except for the information which may not be disclosed under section 604, shall be open to public inspection as of the date filed with the commissioner.

(8) The commissioner shall make available forms and instructions for filing for proposed rates under sections 608(1) and 608(2). The forms with instructions shall be available not less than 180 days before the proposed effective date of the filing.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1611 Legislative intent.

Sec. 611. It is the intent of the legislature to promote uniformity of rates among subscribers to the greatest extent practicable.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1612 Notice of rate filing; contents of request for hearing; advertisements; limitation on fee for copy of rate filing; waiver or reduction of fee; calculation of costs.

Sec. 612. (1) Upon receipt of a rate filing under section 610, the commissioner immediately shall notify each person who has requested in writing notice of those filings within the previous 2 years, specifying the nature and extent of the proposed rate revision and identifying the location, time, and place where the copy of the rate filing described in section 610(7) shall be open to public inspection and copying. The notice shall also state that if the person has standing, the person shall have, upon making a written request for a hearing within 60 days after receiving notice of the rate filing, an opportunity for an evidentiary hearing under section 613 to determine whether the proposed rates meet the requirements of this act. The request shall identify the issues which the requesting party asserts are involved, what portion of the rate filing is requested to be heard, and how the party has standing. The corporation shall place advertisements giving notice, containing the information specified above, in at least 1 newspaper which serves each geographic area in which significant numbers of subscribers reside.

(2) The commissioner may charge a fee for providing, pursuant to subsection (1), a copy of the rate filing described in section 610(7). The commissioner may charge a fee for providing a copy of the entire filing to a person whose request for a hearing has been granted by the commissioner pursuant to section 613. The fee shall be limited to actual mailing costs and to the actual incremental cost of duplication, including labor and the cost of deletion and separation of information as provided in section 14 of Act No. 442 of the Public Acts of 1976, being section 15.244 of the Michigan Compiled Laws. Copies of the filing may be provided free of charge or at a reduced charge if the commissioner determines that a waiver or reduction of the fee is in the public interest because the furnishing of a copy of the filing will primarily benefit the general public. In calculating the costs under this subsection, the commissioner shall not attribute more than the hourly wage of the lowest paid, full-time clerical employee of the insurance bureau to the cost of labor incurred in duplication and mailing and to the cost of separation and deletion. The commissioner shall use the most economical means available to provide copies of a rate filing.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1613 Request for hearing; standing of person; access to filing; confidentiality; penalty; appointment and qualifications of independent hearing officer; commencement of hearing; discovery; conducting hearing; burden of proving compliance; factors in rendering proposal for decision; order rendering decision; withdrawal of order.

Sec. 613. (1) If the request for a hearing under this section is with regard to a rate filing not yet acted upon under section 610(2)(a), no such action shall be taken by the commissioner until after the hearing has been completed. However, the commissioner shall proceed to act upon those portions of a rate filing upon which no hearing has been requested. Within 15 days after receipt of a request for a hearing, the commissioner shall determine if the person has standing. If the commissioner determines that the person has standing, the person may have access to the entire filing subject to the same confidentiality requirements as the commissioner under section 604, and shall be subject to the penalty provision of section 604(5). Upon determining that the person has standing, the commissioner shall immediately appoint an independent hearing officer before whom the hearing shall be held. In appointing an independent hearing officer, the commissioner shall select a person qualified to conduct hearings, who has experience or education in the area of health care corporation or insurance rate determination and finance, and who is not otherwise associated financially with a health care corporation or a health care provider. The person selected shall not be currently or actively employed by this state. For purposes of this subsection, an employee of an educational institution shall not be considered to be employed by this state. For purposes of this section, a person has "standing" if any of the following circumstances exist:

(a) The person is, or there are reasonable grounds to believe that the person could be, aggrieved by the proposed rate.

(b) The person is acting on behalf of 1 or more named persons described in subdivision (a).

(c) The person is the commissioner, the attorney general, or the health care corporation.

(2) Not more than 30 days after receipt of a request for a hearing, and upon not less than 15 days' notice to all parties, the hearing shall be commenced. Each party to the hearing shall be given a reasonable opportunity

for discovery before and throughout the course of the hearing. However, the hearing officer may terminate discovery at any time, for good cause shown. The hearing officer shall conduct the hearing pursuant to the administrative procedures act. The hearing shall be conducted in an expeditious manner. At the hearing, the burden of proving compliance with this act shall be upon the health care corporation.

(3) In rendering a proposal for a decision, the hearing officer shall consider the factors prescribed in section 609.

(4) Within 30 days after receipt of the hearing officer's proposal for decision, the commissioner shall by order render a decision which shall include a statement of findings.

(5) The commissioner shall withdraw an order of approval or approval with modifications if the commissioner finds that the filing no longer meets the requirements of this act.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1614 Interim rates; petition; determination; granting interim rate; final rate determination; refunds or adjustments; limitation on order establishing interim rate adjustment; rates to which section applicable.

Sec. 614. (1) Not less than 75 days after a filing is received, as provided in section 610, the health care corporation may petition the commissioner, who shall make a determination with respect to interim rates and shall order interim rates in the amount prescribed in subsection (2). Interim rates shall not be implemented if the commissioner finds that the health care corporation has substantially contributed to the delay or that the health care corporation has not provided information requested by the commissioner relative to a determination under this section. The interim rate determination shall not be a contested case under chapter 4 of the administrative procedures act.

(2) The commissioner shall grant an interim rate, in an amount as determined by the commissioner, if the commissioner makes a finding that the corporation has made a convincing showing that there is probable cause to believe that the failure to grant the interim rate will result in an underwriting loss for that line of business for the period for which rates are being requested. As used in this subsection, "underwriting loss" means the difference between income from current rates plus investment income, and projected claims plus projected administrative expenses.

(3) If the final rate determination results in approval of a lower rate, appropriate refunds or adjustments, as determined by the commissioner, shall be made to reflect payments made in excess of the approved rate.

(4) The order establishing an interim rate adjustment made pursuant to this section shall be limited to adjusting rates for certificates then in effect, and shall not be used to alter certificates or implement new certificates.

(5) This section shall apply only to rates subject to section 608(1) for which a hearing has been requested.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1615 Review of final order or decision.

Sec. 615. Any final order or decision made, issued, or executed by the commissioner under this act after a hearing held before the commissioner or a deputy commissioner pursuant to the administrative procedures act shall be subject to review as provided in chapter 6 of the administrative procedures act without leave by the circuit court for Ingham county.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1616 Endorsing, filing, and indexing documents; notice of refusal to file; judicial review; certificate of correction; persons adversely affected by correction; documents to which section inapplicable.

Sec. 616. (1) If a document required or permitted to be filed with the commissioner under this act substantially conforms to the requirements of this act, the commissioner shall endorse upon it the word "filed" with the commissioner's official title and the dates of receipt and of filing, and shall file and index the document or a reproduction of the document pursuant to the records media act in his or her office. If so requested at the time of delivery of the document to his or her office, the commissioner shall include the hour

of filing in his or her endorsement on the document.

(2) If the commissioner fails promptly to file a document, other than an annual report or a supplemental statement, submitted for filing under this act, the commissioner, within 10 days after receipt from the person submitting the document for filing of a written request for the filing of the document, shall give written notice of the refusal to file to that person, specifying the reasons for the failure to file the document. From the disapproval, the person may seek judicial review pursuant to sections 103, 104, and 106 of the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, being sections 24.303, 24.304, and 24.306 of the Michigan Compiled Laws.

(3) If a document relating to a health care corporation filed with the commissioner under this act is an inaccurate record of the corporation action referred to in the document or was defectively or erroneously executed, the document may be corrected by filing with the commissioner a certificate of correction on behalf of the corporation. A certificate, entitled "certificate of correction of . . . (correct title of document and name of corporation)" shall be signed as provided in this act with respect to the document being corrected and shall be filed with the commissioner. The certificate shall set forth the name of the corporation, the date the document to be corrected was filed by the commissioner, the provision in the document as corrected or eliminated, and, if the execution was defective, the proper execution. The corrected document is effective in its corrected form as of its original filing date except as to a person who relied upon the inaccurate portion of the document and was, as a result of the inaccurate portion of the document, adversely affected by the correction.

(4) This section does not apply with respect to documents filed pursuant to part 5 or this part.

History: 1980, Act 350, Eff. Apr. 3, 1981;—Am. 1992, Act 197, Imd. Eff. Oct. 5, 1992.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1617 Rules.

Sec. 617. The commissioner may promulgate rules which the commissioner considers necessary to carry out the purposes of, and to execute and enforce this act. The rules shall be promulgated pursuant to the administrative procedures act.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1618 Compliance with new procedures, benefits, or contracts.

Sec. 618. Whenever any section of this act requires a health care corporation to implement any new procedure, provide any new benefit, or enter into any new contract, the commissioner shall give the health care corporation a reasonable time to comply with the requirements.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1619 Injunction; declaratory and equitable relief; enforcement of act or rules.

Sec. 619. (1) The attorney general may bring an action, or apply to the circuit court for a court order, to enjoin a health care corporation from transacting business, receiving, collecting, or disbursing money, or acquiring, holding, protecting, or conveying property if that corporate activity is not authorized under this act.

(2) The attorney general may apply to the circuit court for a court order enjoining an alleged violation of this act or other equitable or extraordinary relief to enforce this act.

(3) A political subdivision of this state, an agency of this state, or any person may bring an action in the circuit court for Ingham county for declaratory and equitable relief against the commissioner or to compel the commissioner to enforce this act or rules promulgated under this act.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1620 Certificate subject to policy and certificate issuance and rate filing requirements; establishment of reasonable open enrollment periods; frequency and duration; denial, condition, or discrimination.

Sec. 620. (1) Notwithstanding any provision of this act to the contrary, a certificate delivered, issued for

delivery, or renewed in this state on or after January 1, 2014 by a health care corporation is subject to the policy and certificate issuance and rate filing requirements of the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302, including the rating factor requirements of section 3474a of the insurance code of 1956, 1956 PA 218, MCL 500.3474a.

(2) For a certificate delivered, issued for delivery, or renewed in this state on or after January 1, 2014, subject to the prior approval of the commissioner, a health care corporation may establish reasonable open enrollment periods.

(3) The commissioner shall establish minimum standards for the frequency and duration of open enrollment periods established under subsection (2). The commissioner shall uniformly apply the minimum standards for the frequency and duration of open enrollment periods established under this subsection to all health care corporations.

(4) A health care corporation offering coverage during an open enrollment period established under subsection (2) shall not deny or condition the issuance or effectiveness of a certificate and shall not discriminate in the pricing of the certificate on the basis of health status, claims experience, receipt of health care, or medical condition.

History: Add. 2013, Act 4, Imd. Eff. Mar. 18, 2013.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

PART 6A
HEALTH ENDOWMENT FUND CORPORATIONS

550.1651 Definitions.

Sec. 651. As used in this part:

(a) "Board" means the board of a health endowment fund corporation incorporated under this part.

(b) "Executive director" means the executive director of a fund appointed by the board.

(c) "Fund" means a health endowment fund corporation organized as a nonprofit corporation under section 653.

History: Add. 2013, Act 4, Imd. Eff. Mar. 18, 2013.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1652 Health endowment fund corporation; incorporation; conflict of interest; appointment of board members; vacancy; terms; quorum; vote; business open to public; notice; meeting in closed session; minutes; compensation.

Sec. 652. (1) A health endowment fund corporation shall not be incorporated in this state except under this part.

(2) A board shall adopt a conflict of interest policy. A board member with a direct or indirect interest in any matter before the fund shall disclose the member's interest to the board before the board takes any action on the matter. The board shall record the member's disclosure in the minutes of the board meeting. If a board member or a member of his or her immediate family, organizationally or individually, would derive a direct and specific benefit from a decision of the board, that member shall recuse himself or herself from the discussion and the vote on the issue.

(3) Subject to this subsection, the governor shall appoint the members of a board with the advice and consent of the senate. An individual who is an employee, officer, or board member of a health care corporation; a lobbyist affiliated with a health care corporation; or an employee of a health insurer, health care provider, or third party administrator is not eligible to be appointed and shall not be appointed to a board under this subsection. On or before the expiration of 60 days after the incorporation of a fund under section 653, the governor shall appoint the following initial members of the board with the advice and consent of the senate:

(a) One member from a list of 3 or more individuals recommended by the senate majority leader.

(b) One member from a list of 3 or more individuals recommended by the speaker of the house of representatives.

(c) One member representing the interests of minor children.

(d) One member representing the interests of senior citizens.

(e) Two members of the general public.

(f) One member representing the business community.

(g) One member from a list of 3 or more individuals recommended by the house minority leader.

(h) One member from a list of 3 or more individuals recommended by the senate minority leader.

(4) A vacancy on a board shall be filled in the same manner as the initial appointment under subsection (3). Except as otherwise provided in this subsection, a board member shall be appointed for a term of 4 years or until a successor is appointed, whichever is later. For the initial members appointed under subsection (3), 3 members shall be appointed for 2-year terms, 3 members shall be appointed for 3-year terms, and 3 members shall be appointed for 4-year terms.

(5) Six members of a board constitute a quorum for the transaction of business at a meeting of the board. An affirmative vote of 5 board members is necessary for official action of a board.

(6) The business that a board may perform shall be conducted at a meeting of the board that is held in this state, is open to the public, and is held in a place that is available to the general public. However, a board may establish reasonable rules and regulations to minimize disruption of a meeting of the board. At least 10 days and not more than 60 days before a meeting, a board shall provide public notice of its meeting at its principal office and on its internet website. A board shall include in the public notice of its meeting the address where board minutes required under subsection (7) may be inspected by the public. A board may meet in a closed session for any of the following purposes:

(a) To consider the hiring, dismissal, suspension, or disciplining of board members or employees or agents of the fund.

(b) To consult with its attorney.

(c) To comply with state or federal law, rules, or regulations regarding privacy or confidentiality.

(7) A board shall keep minutes of each meeting. Board minutes shall be open to public inspection, and the board shall make the minutes available at the address designated on the public notice of its meeting under subsection (6). A board shall make copies of the minutes available to the public at the reasonable estimated cost for printing and copying. A board shall include all of the following in its board minutes:

(a) The date, time, and place of the meeting.

(b) Board members who are present and absent.

(c) Board decisions made at a meeting open to the public.

(d) All roll call votes taken at the meeting.

(8) Board members shall serve without compensation. However, board members may be reimbursed for their actual and necessary expenses incurred in the performance of their official duties as board members.

History: Add. 2013, Act 4, Imd. Eff. Mar. 18, 2013.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1653 Charitable purpose nonprofit corporation; receipt and administration of funds; articles of incorporation; grants; conflict with other provisions of law; social mission contributions; fund as private, nonprofit corporation.

Sec. 653. (1) A charitable purpose nonprofit corporation may be incorporated on a nonstock, directorship basis, under the nonprofit corporation act, 1982 PA 162, MCL 450.2101 to 450.3192 consistent with this part and, if incorporated under this section, shall be organized to receive and administer funds for the public welfare. The articles of incorporation must include the word "Michigan" and the phrase "health endowment fund" in the name of the fund. As soon as practicable after the incorporation of a fund under this subsection, the fund shall apply for and make its best effort to obtain tax-exempt status under section 501(c)(3) of the internal revenue code, 26 USC 501.

(2) The articles of incorporation of a fund must provide that the fund is organized for the following purposes:

(a) Supporting efforts that improve the quality of health care while reducing costs to residents of this state.

(b) Benefitting the health and wellness of minor children and seniors throughout this state with a significant focus in the following areas:

(*i*) Access to prenatal care and reduction of infant mortality rates.

(*ii*) Health services for foster and adopted children.

(*iii*) Access to healthy food.

(*iv*) Wellness programs and fitness programs.

(*v*) Access to mental health services.

(*vi*) Technology enhancements.

(*vii*) Health-related transportation needs.

(*viii*) Foodborne illness prevention.

(c) Awarding grants for a term not exceeding 3 years in duration for projects that will promote the

purposes of the fund.

(d) Subsidizing the cost of individual medigap coverage to medicare-eligible individuals in this state who demonstrate a financial need in order to be able to purchase individual medigap coverage.

(3) The board shall establish a comprehensive and competitive process to award grants.

(4) The nonprofit corporation act, 1982 PA 162, MCL 450.2101 to 450.3192, applies to a fund. If a provision relating to a fund under this part conflicts with other state law, this part controls.

(5) If a fund is eligible to receive social mission contributions under section 220(2), the eligible fund shall implement a program to disburse money to subsidize the cost of individual medigap coverage to medicare-eligible individuals in this state who demonstrate a financial need in order to be able to purchase individual medigap coverage. The commissioner shall develop a means test to be used to determine if a medicare-eligible individual applicant is eligible for the medigap coverage subsidy provided for in this subsection and shall submit the test developed to the attorney general for approval.

(6) If a fund is eligible to receive social mission contributions under section 220(2), beginning on the first day of the third August after the fund receives its initial social mission contribution, and ending on the thirty-first day of the eighth December after the fund receives its initial social mission contribution, the fund shall disburse $120,000,000.00 to subsidize the cost of individual medigap coverage purchased by medicare-eligible individuals in this state, subject to subsection (5).

(7) A fund is a private, nonprofit corporation organized for charitable purposes and is not a state agency, governmental agency, or other political subdivision of this state. Money of a fund is held by the fund for the purposes consistent with this part and is not money of this state or a political subdivision of this state and shall not be deposited in the state treasury. A member of a board is not a public officer of this state.

History: Add. 2013, Act 4, Imd. Eff. Mar. 18, 2013.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1654 Executive director.

Sec. 654. (1) A board shall appoint an executive director to serve as the chief executive officer of the fund. The executive director shall serve at the pleasure of the board. The executive director may employ staff and hire consultants as necessary with the approval of the board. The board shall determine compensation for the executive director and staff employed under this subsection and shall approve contracts under this subsection.

(2) The executive director shall display on the fund internet website information relevant to the public, as defined by the board, concerning the fund's operations and efficiencies, as well as the board's assessments of those activities.

History: Add. 2013, Act 4, Imd. Eff. Mar. 18, 2013.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1655 Disbursement, expenditure, and investment of money by fund; system of financial accounting, controls, audits, and reports; appointment of audit committee; duties of executive director; requirement to keep accurate accounting; cooperation with investigation.

Sec. 655. (1) Subject to this section, a fund may disburse money contributed to the fund each year, not including any interest, earnings, or unrealized gains or losses on those contributions, for the purposes of the fund as described in section 653. A fund may expend a portion of the money contributed to the fund in each year following the initial contribution to the fund according to the following schedule:

(a) Years 1 through 4, 80%.

(b) Years 5 through 8, 67%.

(c) Years 9 through 12, 60%.

(d) Years 13 through 18, 25%.

(2) On and after the date that the accumulated principal of money held by a fund reaches $750,000,000.00, the fund shall maintain that amount for investment to provide an ongoing income to the fund. On and after the date that the accumulated principal in the fund reaches $750,000,000.00, the board shall not allow the accumulated principal of the fund to fall below $750,000,000.00 due to expenditures made for the purposes of the fund as described in section 653.

(3) A fund may expend money received by the fund from any source in a fiscal year of the fund that is in excess of the amount required to maintain the accumulated principal goals as described in subsection (2), not including any interest, earnings, or unrealized gains or losses on those funds, on the reasonable administrative

costs of the fund and for the purposes of the fund as described in this part. The investment of fund money and donations by the fund are under the exclusive control and discretion of the fund and are not subject to requirements applicable to public funds.

(4) A fund may invest accumulated principal in the fund only in securities permitted by the laws of this state for the investment of assets of life insurance companies, as described in chapter 9 of the insurance code of 1956, 1956 PA 218, MCL 500.901 to 500.947.

(5) A fund's articles of incorporation or bylaws must provide for a system of financial accounting, controls, audits, and reports. The board annually shall have an audit of the fund conducted by an independent public accountant firm, and the auditor's audit report and findings shall be submitted to the board. The expense of an audit required under this subsection is considered a reasonable administrative cost under subsection (3).

(6) A fund's articles of incorporation or bylaws must require that the board shall appoint from its members an audit committee consisting of no fewer than 3 members and for the audit committee to contract with an independent auditing firm to provide an annual financial audit in accordance with applicable auditing standards.

(7) The executive director shall do all of the following:

(a) Review and certify external auditor reports.

(b) Make external auditor reports available to the board and to the general public.

(c) Develop and implement corrective actions to address weaknesses identified in an audit report.

(8) The articles of incorporation or bylaws of a fund must require the fund to keep an accurate accounting of all activities, receipts, and expenditures and annually submit to the board, the governor, the senate and house of representatives appropriations committees, and the senate and house of representatives standing committees on health policy a report regarding those accountings.

(9) A fund and its directors, officers, and employees shall fully cooperate with any investigation conducted by this state or a federal agency under its authority under state or federal law, to do any of the following:

(a) Investigate the affairs of the fund.

(b) Examine the assets and records of the fund.

(c) Require periodic reports in relation to the activities undertaken by the fund in compliance with applicable law.

History: Add. 2013, Act 4, Imd. Eff. Mar. 18, 2013.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

PART 7

550.1701 Formal reorganization not required; duties of health care corporation; amendments to articles and bylaws; description of board restructuring; review; certification; statement of reasons for disapproval; judicial remedies; effect of noncompliance; extension of corporate existence; powers undiminished.

Sec. 701. (1) Each health care corporation on the effective date of this act shall be subject to this act without formal reorganization under this act, and shall be considered to exist under this act. However, within 120 days following the effective date of this act, the health care corporation shall do all of the following:

(a) Amend its articles of incorporation and bylaws to conform to the requirements of this act, subject to the certification of the attorney general, as provided in subsection (2).

(b) Restructure its board of directors to conform with the requirements of this act. The restructuring shall be described, shall be in writing, and shall be subject to the certification of the attorney general, as provided in subsection (2).

(c) After complying with subdivisions (a) and (b), obtain from the commissioner a new certificate of authority.

(2) Relative to the changes required by this act, amendments to the articles and bylaws, and a written description of the board restructuring shall be submitted to the attorney general and to the commissioner. If the attorney general finds that the amendments and restructuring conform to all statutory requirements, and that they comply with this act and ensure fair and equitable representation of the subscribers of the corporation, 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 corporation, and with any other individual or organization.

(3) If the attorney general approves the amendments and restructuring, the attorney general shall certify his or her approval to the board. The amendments, and restructuring as described, shall take effect 10 days after the certification. If the attorney general disapproves all or any part of the amendments or restructuring, or

both, the attorney general shall return the disapproved amendments or the written description of the restructuring, or both, to the board with a written statement setting forth the reasons for the disapproval and any recommendations for change which he or she may wish to suggest.

(4) If the amendments, written description of restructuring, or both, required by this act are not submitted to the attorney general and the commissioner within 120 days after the effective date of this act, or if the amendments, written description, or both, are disapproved as provided in this section, the commissioner and the attorney general shall, and the corporation may, seek judicial remedies as provided for by law in the circuit court in this state.

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

(6) The corporate existence of each health care corporation 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).

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1702 Discontinuation of certain rules; continuation of certain orders and approvals.

Sec. 702. Rules which were promulgated under former Act No. 108 or 109 of the Public Acts of 1939, shall not continue in effect under this act. Orders issued and approvals granted by the commissioner under former Act No. 108 or 109 of the Public Acts of 1939, shall continue in effect until rescinded or withdrawn by the commissioner under this act.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Compiler's note: Acts 108 and 109 of 1939, referred to in this section, were repealed by Act 350 of 1980.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1703 Repeal of MCL 550.301 to 550.316 and 550.501 to 550.517.

Sec. 703. The following acts and parts of acts are repealed:

(a) Act No. 108 of the Public Acts of 1939, as amended, being sections 550.301 to 550.316 of the Compiled Laws of 1970.

(b) Act No. 109 of the Public Acts of 1939, as amended, being sections 550.501 to 550.517 of the Compiled Laws of 1970.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1704 Effective date.

Sec. 704. This act shall take effect April 3, 1981.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

HEALTH INSURANCE CLAIMS ASSESSMENT ACT
Act 142 of 2011

550.1731-550.1741 Repealed. 2018, Act 173, Eff. Oct. 1, 2018

INSURANCE PROVIDER ASSESSMENT ACT
Act 175 of 2018

AN ACT to impose an assessment on certain insurance providers; to impose certain duties and obligations on certain insurance providers, state departments, agencies, and officials; to create certain funds; to authorize certain expenditures; and to impose certain remedies and penalties.

History: 2018, Act 175, Imd. Eff. June 11, 2018.

The People of the State of Michigan enact:

550.1751 Short title.

Sec. 1. This act shall be known and may be cited as the "insurance provider assessment act".

History: 2018, Act 175, Imd. Eff. June 11, 2018.

550.1753 Definitions.

Sec. 3. As used in this act:

(a) "Department" means the department of treasury.

(b) "Excess loss" or "stop loss" means coverage that provides insurance protection against the accumulation of total claims exceeding a stated level for a group as a whole or protection against a high-dollar claim on any 1 individual.

(c) "Federal employee health benefit" means the program of health benefits plans, as defined in 5 USC 8901, available to federal employees under 5 USC 8901 to 8914.

(d) "Fund" means the insurance provider fund created in section 13.

(e) "Health insurer" means an insurer authorized under the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302, to deliver, issue for delivery, or renew in this state a health insurance policy. Health insurer includes a health maintenance organization. Health insurer does not include a state department or agency administering a plan of medical assistance under the social welfare act, 1939 PA 280, MCL 400.1 to 400.119b, or a person administering a self-funded plan.

(f) "Insurance provider" means a Medicaid managed care organization or a health insurer.

(g) "Medicaid contracted health plan" means a contracted health plan as that term is defined in section 106 of the social welfare act, 1939 PA 280, MCL 400.106.

(h) "Medicaid managed care organization" means a Medicaid contracted health plan or a specialty prepaid health plan.

(i) "Medicare" means the federal Medicare program established under title XVIII of the social security act, 42 USC 1395 to 1395*lll*.

(j) "Member months" means the total number of individuals for whom the insurance provider has recognized revenue for 1 month. If revenue is recognized for only part of a month for an individual, a prorated partial member month may be counted. Member months are determined by the department of insurance and financial services and do not include individuals enrolled in short-term medical, 1-time limited duration, noncomprehensive medical, specified disease, limited benefit, accident only, accidental death and dismemberment, disability income, long-term care, Medicare supplement, stand-alone dental, dental, Medicare, Medicare advantage, Medicare part D, vision, prescription, other individual write-in coverage, federal employee health benefit, Tricare, other group write-in coverage, credit, stop loss, excess loss, administrative services only, or administrative services contracts.

(k) "Specialty prepaid health plan" means an entity designated by the department of health and human services as a regional entity pursuant to section 204b of the mental health code, 1974 PA 258, MCL 330.1204b, or a specialty prepaid health plan pursuant to section 232b of the mental health code, 1974 PA 258, MCL 330.1232b, to provide mental health services, services to individuals with developmental disabilities, and substance use disorder services.

History: 2018, Act 175, Imd. Eff. June 11, 2018.

550.1755 Waiver request; notification of member months, rate, and insurance providers by tier.

Sec. 5. (1) If the department of health and human services has not already submitted an application to the federal Centers for Medicare and Medicaid Services to request a waiver, for a period of not less than 5 years, of the broad-based and uniformity provisions of section 1903(w)(3)(B) and (C) of title XIX of the social security act, 42 USC 1396b, relating to the assessment imposed under this act, the department of health and human services shall submit the request before October 1, 2018 and as necessary thereafter to implement this

act.

(2) Within 30 days after the effective date of this act, the department of health and human services shall notify the department of the number of member months and the rate to be imposed on these member months under section 7(1)(a)(*i*) for the 2018-2019 state fiscal year and identify the specialty prepaid health plans subject to the assessment under this act.

(3) Within 30 days after the effective date of this act, the department of insurance and financial services shall provide the department with a list of insurance providers by tier that are subject to the assessment under this act.

History: 2018, Act 175, Imd. Eff. June 11, 2018.

550.1757 Assessment; levy; rates; payment method.

Sec. 7. (1) Beginning on the first day of the calendar quarter in which the director of the department of health and human services notifies the secretary of state and the department in writing that the federal Centers for Medicare and Medicaid Services has approved its request for a waiver of the broad-based and uniformity provisions of section 1903(w)(3)(B) and (C) of title XIX of the social security act, 42 USC 1396b, for implementation of this act or October 1, 2018, whichever is later, there is levied and imposed an annual assessment on the number of member months for each insurance provider reported on its annual financial statement filed with the department of insurance and financial services or the department of health and human services, whichever is applicable, for the previous calendar year at the following rates in the following circumstances:

(a) For tier 1, a Medicaid contracted health plan's member months supported with federal funds authorized under subchapter XIX of the social security act, 42 USC 1396 to 1396w-5, as follows:

(*i*) For the number of member months and the dollar amount necessary per member month, as determined each year by the department of health and human services, to achieve a result of between 1.00 and 1.02 on the statistical test imposed by the federal Centers for Medicare and Medicaid Services according to 42 CFR 433.68(e).

(*ii*) For each remaining member month not assessed under subparagraph (*i*), $1.20 per member month.

(b) For tier 2, a health insurer's member months not supported with federal funds authorized under subchapter XIX of the social security act, 42 USC 1396 to 1396w-5, $2.40 per member month.

(c) For tier 3, a specialty prepaid health plan's member months supported with federal funds authorized under subchapter XIX of the social security act, 42 USC 1396 to 1396w-5, $1.20 per member month.

(2) Beginning May 15 and by each May 15 thereafter, the department of insurance and financial services and the department of health and human services shall make available to the department the number of member months for each insurance provider and the necessary assessment information for the department to calculate the assessment due under this act, including the number of member months and the rate to be imposed in accordance with subsection (1)(a)(*i*) to satisfy the statistical test.

(3) For the initial year of implementation only, the department shall notify each insurance provider after June 15, 2018 but before October 15, 2018, of the number of member months and the rate imposed on these member months in accordance with subsection (1)(a)(*i*) and of its assessment, prorated for 2 quarters, due based on the insurance provider's member months for the previous calendar year. The initial assessment is payable in 2 equal installments. Each insurance provider shall submit the payments to the department by January 30, 2019 and April 30, 2019.

(4) The department shall notify each insurance provider after June 1, but before June 15 each year after implementation, of the number of member months and the rate imposed on these member months under subsection (1)(a)(*i*) and of its annual assessment due under this act based on the insurance provider's member months for the previous calendar year. The assessment is payable on a quarterly basis and each insurance provider shall submit quarterly payments on July 30, October 30, January 30, and April 30 to the department for the amount of the assessment imposed under this act with respect to the number of member months reported on its financial statements for the previous calendar year.

(5) If a due date falls on a Saturday, Sunday, state holiday, or legal banking holiday, the payments are due on the next succeeding business day.

(6) The department may require that payment of the assessment be made by an electronic funds transfer method approved by the department.

History: 2018, Act 175, Imd. Eff. June 11, 2018.

550.1759 Records; failure to file return or keep proper records; right of department to impose assessment.

Sec. 9. (1) An insurance provider liable for the assessment under this act shall keep accurate and complete

records and pertinent documents as may be required by the department. Records required by the department shall be retained for a period of 4 years after the assessment imposed under this act to which the records apply is due or as otherwise provided by law.

(2) If the department considers it necessary, the department may require a person, by notice served upon that person, to make a return, render under oath certain statements, or keep certain records the department considers sufficient to show whether that person is liable for the assessment under this act.

(3) If an insurance provider fails to file a return or keep proper records as may be required under this section, or if the department has reason to believe that any records kept or returns filed are inaccurate or incomplete and that additional assessments are due, the department may compute the amount of the assessment due from the insurance provider based on information that is available or that may become available to the department. An assessment under this subsection is considered prima facie correct under this act, and an insurance provider has the burden of proof for refuting the assessment.

History: 2018, Act 175, Imd. Eff. June 11, 2018.

550.1761 Administration of assessment; conflicting provisions of law; rules; annual report.

Sec. 11. (1) The department shall administer the assessment imposed under this act under 1941 PA 122, MCL 205.1 to 205.31, and this act. If 1941 PA 122, MCL 205.1 to 205.31, and this act conflict, the provisions of this act apply. The assessment imposed under this act is a tax for the purpose of 1941 PA 122, MCL 205.1 to 205.31.

(2) The department is authorized to promulgate rules to implement this act under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328.

(3) The assessment imposed under this act shall not be considered an assessment or burden for purposes of the tax, or as a credit toward or payment in lieu of the tax under section 476a of the insurance code of 1956, 1956 PA 218, MCL 500.476a.

(4) The department shall submit an annual report to the state budget director, the senate and house of representatives standing committees on appropriations, and the senate and house fiscal agencies not later than 120 days after May 15 that states the amount of revenue collected from insurance providers under this act for the immediately preceding state fiscal year and the costs incurred for administration and compliance requirements under this act for the immediately preceding state fiscal year.

History: 2018, Act 175, Imd. Eff. June 11, 2018.

550.1763 Insurance provider fund; establishment; creation; deposit; transfer of money.

Sec. 13. (1) All money received and collected under this act shall be deposited by the department in the insurance provider fund established in this section.

(2) The insurance provider fund is created within the state treasury and shall be administered by the department for auditing purposes.

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

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

(a) Beginning in the 2018-2019 state fiscal year, the first $14,000,000.00 to be appropriated for the payment of actuarially sound capitation rates to Medicaid managed care organizations, and each state fiscal year thereafter, the amount necessary to continue to support the payment of actuarially sound capitation rates to Medicaid managed care organizations.

(b) For the 2018-2019 state fiscal year, to appropriate an amount not to exceed $315,000,000.00 to offset the net revenue lost under the health insurance claims assessment act, 2011 PA 142, MCL 550.1731 to 550.1741.

(c) For the 2019-2020 state fiscal year, to appropriate an amount not to exceed $240,000,000.00 to offset the net revenue lost under the health insurance claims assessment act, 2001 PA 142, MCL 550.1731 to 550.1741.

(d) To pay administrative and compliance costs in accordance with section 15.

(e) The balance of the fund remaining after the appropriations described in subdivisions (a), (b), (c), and (d) shall be transferred to a separate restricted account within the insurance provider fund and only used as appropriated by the legislature.

(5) Money in the fund at the close of the fiscal year shall remain in the fund and shall not lapse to the general fund.

History: 2018, Act 175, Imd. Eff. June 11, 2018.

550.1765 Appropriation for administration.

Sec. 15. For administration and compliance requirements created by this act, in the 2018-2019 state fiscal year and each fiscal year thereafter, the department shall receive from the insurance provider fund created in section 13 an amount not to exceed 1/2 of 1% of the annual remittances under this act in the 2018-2019 state fiscal year, subject to annual appropriation by the legislature.

History: 2018, Act 175, Imd. Eff. June 11, 2018.

550.1767 Failure to pay assessment, interest, or penalty; final determination; written notice to director; suspension or revocation of certificate of authority to transact insurance.

Sec. 17. The department shall provide the director of the department of insurance and financial services with written notice of any final determination that an insurance provider has failed to pay an assessment, interest, or penalty when due. The director of the department of insurance and financial services may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state, or the license to operate in this state, of any insurance provider that fails to pay an assessment, interest, or penalty due under this act. A suspension of a certificate of authority to transact insurance in this state or a license to operate in this state under this section shall not be withdrawn unless any delinquent assessment, interest, or penalty has been paid.

History: 2018, Act 175, Imd. Eff. June 11, 2018.

GROUP HEALTH PLAN ACT
Act 239 of 1995

AN ACT to regulate certain group health plans; to provide for certain powers and duties for certain persons; and to prescribe penalties.

History: 1995, Act 239, Eff. Mar. 28, 1996.

The People of the State of Michigan enact:

550.1801 Short title.

Sec. 1. This act shall be known and may be cited as the "group health plan act".

History: 1995, Act 239, Eff. Mar. 28, 1996.

550.1803 “Plan” defined.

Sec. 3. As used in this act, "plan" means a group health plan as defined in section 607 of part 6 of subtitle B of title 1 of the employee retirement income security act of 1974, Public Law 93-406, 29 U.S.C. 1167, and subject to that act.

History: 1995, Act 239, Eff. Mar. 28, 1996.

550.1805 Plan offering dependent coverage to child; denial of enrollment on certain grounds prohibited.

Sec. 5. A plan that offers dependent coverage shall not deny enrollment to a covered individual's child on any of the following grounds:

(a) The child was born out of wedlock.

(b) The child is not claimed as a dependent on the covered individual's federal income tax return.

(c) The child does not reside with the covered individual or in the plan's service area.

History: 1995, Act 239, Eff. Mar. 28, 1996.

550.1807 Eligibility of parent for dependent coverage; health coverage of child through noncustodial parent; duties of plan administrator; court or administrative order and notice required.

Sec. 7. (1) If a parent is eligible for dependent coverage through a plan, the plan administrator shall:

(a) Permit the parent to enroll, under the dependent coverage, a child who is otherwise eligible for coverage without regard to any enrollment season restrictions.

(b) If the parent is enrolled but fails to make application to obtain coverage for the child, enroll the child under dependent coverage upon application by the friend of the court or by the child's other parent through the friend of the court.

(c) Not eliminate the child's coverage unless premiums have not been paid as required by the plan or the plan administrator is provided with satisfactory written evidence of either of the following:

(*i*) The court or administrative order is no longer in effect.

(*ii*) The child is or will be enrolled in comparable health coverage through another plan, insurer, health care corporation, or health maintenance organization that will take effect not later than the effective date of the cancellation of the existing coverage.

(2) If a child has health coverage through the plan of a noncustodial parent, that plan administrator shall do all of the following:

(a) Provide the custodial parent with information necessary for the child to obtain benefits through that coverage.

(b) Permit the custodial parent or, with the custodial parent's approval, the provider to submit a claim for covered services without the noncustodial parent's approval.

(c) Make payment on claims submitted under subdivision (b) directly to the custodial parent or medical provider.

(3) This section applies only if a parent is required by a court or administrative order to provide health coverage for a child and the plan is notified of that court or administrative order.

History: 1995, Act 239, Eff. Mar. 28, 1996.

550.1809 Individual eligible under title XIX of social security act; assignment of rights of insured to department of social services.

Sec. 9. (1) A plan shall not consider whether an individual is eligible for or has available medical

assistance under title XIX of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1396 to 1396g and 1396i to 1396v, in this or another state when considering eligibility for coverage or making payments for eligible covered individuals.

(2) If a plan has a legal liability to make payments, and payment for covered expenses for medical goods or services furnished to an individual has been made under the medical assistance program established under section 105 of the social welfare act, Act No. 280 of the Public Acts of 1939, being section 400.105 of the Michigan Compiled Laws, the department of social services has the rights of the individual to payment by the plan to the extent payment was made by the department of social services's medical assistance program for those medical goods or services.

(3) If the department of social services has been assigned the rights of a covered individual who is eligible for medical assistance under section 105 of Act No. 280 of the Public Acts of 1939 and is covered by the plan, the plan shall not impose requirements on the department of social services that are different from requirements that apply to an agent or assignee of any other covered individual.

History: 1995, Act 239, Eff. Mar. 28, 1996.

550.1811 Violation; fine.

Sec. 11. A violation of this act is subject to a civil fine of not more than $500.00 for each violation.

History: 1995, Act 239, Eff. Mar. 28, 1996.

AUTISM COVERAGE REIMBURSEMENT ACT
Act 101 of 2012

AN ACT to create an autism coverage reimbursement program to encourage insurance and health coverage providers to provide autism coverage; to impose certain duties on certain state departments, agencies, and officials; to create certain funds; to authorize certain expenditures; and to provide for an appropriation.

History: 2012, Act 101, Imd. Eff. Apr. 18, 2012.

Compiler's note: For transfer of autism coverage reimbursement program from department of licensing and regulatory affairs to department of insurance and financial services, see E.R.O. No. 2013-1, compiled at MCL 550.991.

The People of the State of Michigan enact:

550.1831 Short title.

Sec. 1. This act shall be known and may be cited as the "autism coverage reimbursement act".

History: 2012, Act 101, Imd. Eff. Apr. 18, 2012.

Compiler's note: For transfer of autism coverage reimbursement program from department of licensing and regulatory affairs to department of insurance and financial services, see E.R.O. No. 2013-1, compiled at MCL 550.991.

550.1833 Definitions.

Sec. 3. As used in this act:

(a) "Autism coverage reimbursement program" or "program" means the autism coverage reimbursement program created under section 5.

(b) "Autism diagnostic observation schedule", "autism spectrum disorders", "diagnosis of autism spectrum disorders", and "treatment of autism spectrum disorders" mean those terms as defined under section 416e of the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1416e, and section 3406s of the insurance code of 1956, 1956 PA 218, MCL 500.3406s.

(c) "Carrier" means any of the following:

(*i*) An insurer or health maintenance organization regulated under the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302.

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

(*iii*) A specialty prepaid health plan.

(*iv*) A group health plan sponsor including, but not limited to, 1 or more of the following:

(A) An employer if a group health plan is established or maintained by a single employer.

(B) An employee organization if a plan is established or maintained by an employee organization.

(C) If a plan is established or maintained by 2 or more employers or jointly by 1 or more employers and 1 or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties that establish or maintain the plan.

(d) "Department" means the department of licensing and regulatory affairs.

(e) "Excess loss" or "stop loss" means coverage that provides insurance protection against the accumulation of total claims exceeding a stated level for a group as a whole or protection against a high-dollar claim on any 1 individual.

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

(g) "Federal employee health benefit program" means the program of health benefits plans, as defined in 5 USC 8901, available to federal employees under 5 USC 8901 to 8914.

(h) "Fund" means the autism coverage fund created in section 7.

(i) "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 USC 1002, to the extent that the plan provides medical care, 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.

(j) "Medicaid" means the program of medical assistance established under title XIX of the social security act, 42 USC 1396 to 1396w-5.

(k) "Medicare" means the federal medicare program established under title XVIII of the social security act, 42 USC 1395 to 1395kkk-1.

(*l*) "Medicare advantage plan" means a plan of coverage for health benefits under part C of title XVIII of

the social security act, 42 USC 1395w-21 to 1395w-28.

(m) "Medicare part D" means a plan of coverage for prescription drug benefits under part D of title XVIII of the social security act, 42 USC 1395w-101 to 1395w-154.

(n) "Paid claims" means actual payments, net of recoveries, made for the diagnosis of autism spectrum disorders and treatment of autism spectrum disorders whether made to a provider or reimbursed to an individual by a carrier, third party administrator, or excess loss or stop loss carrier. Paid claims do not include any of the following:

(*i*) Claims paid for services rendered to a nonresident of this state.

(*ii*) Claims paid for services rendered to a person covered under a health benefit plan for federal employees.

(*iii*) Claims paid for services rendered outside of this state to a person who is a resident of this state.

(*iv*) Claims paid under a federal employee health benefit program, medicare, medicare advantage plan, medicare part D, tricare, by the United States veterans administration, and for high-risk pools established pursuant to the federal act.

(*v*) Costs paid by an individual for cost-sharing requirements, including deductibles, coinsurance, or copays.

(*vi*) Claims paid by, or on behalf of, this state.

(*vii*) Claims paid that are covered by medicaid.

(*viii*) Claims paid for which the carrier or third party administrator has already been reimbursed or compensated, in whole or in part, through any increase in premiums or rates or from any other source.

(*ix*) Beginning January 1, 2014, claims paid for services that are included in the essential health benefits as required pursuant to the federal act.

(o) "Specialty prepaid health plan" means that term as described in section 109f of the social welfare act, 1939 PA 280, MCL 400.109f.

(p) "Third party administrator" means an entity that processes claims under a service contract and that may also provide 1 or more other administrative services under a service contract.

History: 2012, Act 101, Imd. Eff. Apr. 18, 2012.

Compiler's note: For transfer of autism coverage reimbursement program from department of licensing and regulatory affairs to department of insurance and financial services, see E.R.O. No. 2013-1, compiled at MCL 550.991.

550.1835 Autism coverage reimbursement program; creation; operation; development of application, approval, and compliance process; forms; approval or denial of application; limitation on amount of coverage; receipt of funding by third party administrator; increase in rates by carrier.

Sec. 5. (1) No later than 120 days after the effective date of this act, the department shall create and operate an autism coverage reimbursement program to encourage carriers to provide coverage for the diagnosis of autism spectrum disorders and treatment of autism spectrum disorders and, to the extent coverage for the diagnosis of autism spectrum disorders and treatment of autism spectrum disorders is required under section 416e of the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1416e, or section 3406s of the insurance code of 1956, 1956 PA 218, MCL 500.3406s, to offset any additional costs that may be incurred as a result of the mandate.

(2) The department shall develop the application, approval, and compliance process necessary to operate and manage this program. The department shall develop and implement the use of an application form to be used by carriers and third party administrators who seek reimbursement for the coverage of autism spectrum disorders. The program standards, guidelines, templates, and any other forms used by the department to implement this program shall be published and available on the department's website.

(3) Subject to the limitations provided under this section, the program shall, as approved by the department, reimburse carriers and third party administrators in an amount equal to the amount of paid claims that are paid 180 days after the effective date of this act by the carrier or third party administrator. A carrier or third party administrator shall apply, on the form prescribed by the department, for approval of funding associated with paid claims. As part of the application, the applicant shall include the results from a completed autism diagnostic observation schedule or the results from any other annual development evaluation and documentation verifying those paid claims for which they are seeking reimbursement under this program. In determining whether to approve an application for the reimbursement of paid claims under this section, the department may review whether the treatment for which the paid claims were paid is consistent with current protocols and cost-containment practices as described in section 416e of the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1416e, or section 3406s of the insurance code of 1956, 1956 PA 218, MCL 500.3406s. The department shall review and consider applications in the order in

which they are received and shall approve or deny an application within 30 days after receipt of the application.

(4) To the extent there is a cap on the amount of coverage mandated under section 416e of the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1416e, or section 3406s of the insurance code of 1956, 1956 PA 218, MCL 500.3406s, the department shall not approve more than the mandated amount to any carrier or third party administrator that seeks reimbursement under this act for paid claims.

(5) If a third party administrator receives any funding under this program, the third party administrator shall apply that funding to the benefit of the carrier covering the claim upon which the funding was received.

(6) If the department determines at the end of the fiscal year that a carrier was not fully reimbursed for paid claims paid due to a shortfall in the reimbursement fund for the fiscal year, and the carrier increases its rates in the following year to cover the total amount of such unreimbursed paid claims, the rate increase shall not be considered reimbursement or compensation for paid claims paid under section 3(n)(*viii*), if the commissioner determines that such rate increase is a reasonable recoupment of the amount of such unreimbursed paid claims.

History: 2012, Act 101, Imd. Eff. Apr. 18, 2012.

Compiler's note: For transfer of autism coverage reimbursement program from department of licensing and regulatory affairs to department of insurance and financial services, see E.R.O. No. 2013-1, compiled at MCL 550.991.

550.1837 Autism coverage fund; creation within state treasury; investment; credit of interest and earnings; administration of fund by department for auditing purposes; expenditures; reimbursement; insufficient money in fund; notice of insufficient funds; money in fund at close of fiscal year; payment of claim approved under MCL 550.1835; reimbursement to carrier or third party administrator; formula.

Sec. 7. (1) The autism coverage fund is created within the state treasury.

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

(3) The department is the administrator of the fund for auditing purposes. The department shall expend money from the fund, on appropriation, only for the purpose of creating, operating, and funding the program.

(4) Except as otherwise provided in subsection (7), the department shall reimburse carriers and third party administrators from the fund in the order in which the applications are approved under the program. If there is insufficient money in the fund to reimburse a carrier or third party administrator for paid claims approved under section 5, reimbursement must not be made. However, applications that are approved but not reimbursed may be paid if revenues of the fund become available.

(5) The department shall develop and implement a process to notify carriers, third party administrators, and the legislature that funds in this program may be insufficient to cover future claims when the department reasonably believes that within 60 days the funds in the program will be insufficient to pay claims. The process shall, at a minimum, do all of the following:

(a) Identify a specific date by which carriers and third party administrators will no longer receive reimbursement for claims submitted to the program.

(b) Outline a clear process indicating the order in which claims pending with the program will be paid.

(c) Outline a clear process indicating the order in which claims that were pending with the program when funds became insufficient will be paid if funds subsequently become available.

(6) Money in the fund at the close of the fiscal year shall remain in the fund and shall not lapse to the general fund.

(7) Subject to subsection (8), from money appropriated to the fund in calendar year 2016, the department shall reimburse a carrier or third party administrator for a paid claim approved under section 5 pursuant to the formula under subsection (8) if the following conditions are met:

(a) The carrier or third party administrator submits its application under section 5 before May 1, 2016.

(b) The services for which the carrier or third party administrator is seeking reimbursement were provided before January 1, 2016.

(c) The department has not already fully reimbursed the carrier or third party administrator for the paid claim.

(d) The department approves the paid claim of the carrier or third party administrator before August 1, 2016.

(8) The department shall reimburse a carrier or third party administrator under subsection (7) pursuant to the following formula:

(a) First, divide the money appropriated to the fund in calendar year 2016 by the total paid claims approved

under section 5 that meet the conditions under subsection (7).

(b) Second, multiply the calculation under subdivision (a) by the amount of the carrier's or third party administrator's paid claims approved under section 5 that meet the conditions of subsection (7).

History: 2012, Act 101, Imd. Eff. Apr. 18, 2012;—Am. 2016, Act 310, Imd. Eff. Oct. 6, 2016.

Compiler's note: For transfer of autism coverage reimbursement program from department of licensing and regulatory affairs to department of insurance and financial services, see E.R.O. No. 2013-1, compiled at MCL 550.991.

550.1838 University autism programs and autism family assistance services; appropriation; reimbursement.

Sec. 8. In addition to any other use for money in the fund under section 7, for the 2014-2015 fiscal year only, up to $8,500,000.00 may be expended from the fund, upon appropriation, for university autism programs and autism family assistance services as specified in section 1902 of article IV of 2014 PA 252. It is the intent of the legislature that for the 2015-2016 fiscal year, $5,500,000.00 or the amount expended from the fund under this section if less than $5,500,000.00 will be appropriated to reimburse the fund for the expenditures authorized for the 2014-2015 fiscal year under this section.

History: Add. 2014, Act 401, Imd. Eff. Dec. 29, 2014;—Am. 2015, Act 8, Imd. Eff. Apr. 1, 2015.

550.1839 Annual report.

Sec. 9. The department shall submit an annual report to the state budget director and the senate and house of representatives standing committees on appropriations not later than April 1 of each year that includes, but is not limited to, all of the following:

(a) The total number of applications received under this program in the immediately preceding calendar year.

(b) The number of applications approved and the total amount of funding awarded under this program in the immediately preceding calendar year.

(c) The amount of administrative costs used to administer the program in the immediately preceding calendar year.

History: 2012, Act 101, Imd. Eff. Apr. 18, 2012.

Compiler's note: For transfer of autism coverage reimbursement program from department of licensing and regulatory affairs to department of insurance and financial services, see E.R.O. No. 2013-1, compiled at MCL 550.991.

550.1841 Implementation of program.

Sec. 11. (1) The department shall not implement the program under this act until the legislature has appropriated sufficient funds to cover the same.

(2) Not more than 1% of the annual appropriation made to the autism coverage fund may be used for the purpose of administering the program authorized under this act.

History: 2012, Act 101, Imd. Eff. Apr. 18, 2012.

Compiler's note: For transfer of autism coverage reimbursement program from department of licensing and regulatory affairs to department of insurance and financial services, see E.R.O. No. 2013-1, compiled at MCL 550.991.

HEALTH CARE SHARING MINISTRIES FREEDOM TO SHARE ACT
Act 530 of 2012

AN ACT to recognize the operation of health care sharing ministries by eligible entities; and to provide that entities that establish and operate health care sharing ministries are not engaging in the business of insurance.

History: 2012, Act 530, Eff. Jan. 1, 2013.

The People of the State of Michigan enact:

550.1861 Short title.

Sec. 1. This act shall be known and may be cited as the "health care sharing ministries freedom to share act".

History: 2012, Act 530, Eff. Jan. 1, 2013.

550.1863 Definitions.

Sec. 3. As used in this act:

(a) "Eligible entity" means a faith-based, nonprofit entity that maintains tax-exempt status under section 501(c) of the internal revenue code, 26 USC 501.

(b) "Health care sharing ministry" or "ministry" means a program established by an eligible entity for the sharing of finances and health care in compliance with this act.

History: 2012, Act 530, Eff. Jan. 1, 2013.

550.1865 Health care sharing ministry; establishment; operation; business of insurance prohibited.

Sec. 5. An eligible entity may establish and operate a health care sharing ministry under this act. An eligible entity that establishes and operates a health care sharing ministry in compliance with this act is not engaged in the business of insurance in this state and the entity and ministry are not subject to the insurance laws of this state.

History: 2012, Act 530, Eff. Jan. 1, 2013.

550.1867 Health care sharing ministry; requirements.

Sec. 7. To be considered a health care sharing ministry under this act, the ministry shall meet all of the following requirements:

(a) Limit participation in the ministry to individuals who are of a similar faith.

(b) Provide that the ministry act as a facilitator by matching its participants who have financial or medical needs with participants who have the ability to assist in meeting those needs according to criteria established for the ministry by the eligible entity.

(c) Provide for the financial or medical needs of a participant through voluntary contributions by its participants.

(d) Provide amounts that participants may contribute with no assumption of risk or promise to pay among its participants.

(e) Provide financial assistance to participants who have financial or medical needs with no assumption of risk or promise to pay by the ministry to its participants.

(f) Provide a monthly written statement to its participants that lists the total dollar amount of qualified financial or medical needs that were submitted to the ministry, as well as the amount actually published or assigned to participants for their contribution.

(g) Provide, in substantially similar form and language, the following written disclaimer on or accompanying all applications and guideline materials distributed by or on behalf of the ministry:

"Notice: The [insert name of eligible entity] that operates this health care sharing ministry is not an insurance company and the financial assistance provided through the ministry is not insurance and is not provided through an insurance company. Whether any participant in the ministry chooses to assist another participant who has financial or medical needs is totally voluntary. A participant will not be compelled by law to contribute toward the financial or medical needs of another participant. This document is not a contract of insurance or a promise to pay for the financial or medical needs of a participant by the ministry. A participant who receives assistance from the ministry for his or her financial or medical needs remains personally responsible for the payment of all of his or her medical bills and other obligations incurred in meeting his or her financial or medical needs.".

History: 2012, Act 530, Eff. Jan. 1, 2013.

550.1869 Effective date.

Sec. 9. This act takes effect January 1, 2013.

History: 2012, Act 530, Eff. Jan. 1, 2013.

PATIENT'S RIGHT TO INDEPENDENT REVIEW ACT
Act 251 of 2000

AN ACT to provide review of certain health care coverage adverse determinations made by health carriers; to prescribe eligibility, powers, and duties of certain independent review organizations; to prescribe the powers and duties of certain health carriers; to prescribe the powers and duties of certain persons; to prescribe the powers and duties of certain state officials; to provide for the reporting of certain information; to provide fees; and to provide penalties for violations of this act.

History: 2000, Act 251, Eff. Oct. 1, 2000.

The People of the State of Michigan enact:

550.1901 Short title.

Sec. 1. This act shall be known and may be cited as the "patient's right to independent review act".

History: 2000, Act 251, Eff. Oct. 1, 2000.

550.1903 Definitions.

Sec. 3. As used in this act:

(a) "Adverse determination" means a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay, or other health care service that is a covered benefit has been reviewed and, based on the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated. Failure to respond in a timely manner to a request for a determination is an adverse determination.

(b) "Ambulatory review" means utilization review of health care services performed or provided in an outpatient setting.

(c) "Authorized representative" means any of the following:

(*i*) A person to whom a covered person has given express written consent to represent the covered person in an external review.

(*ii*) A person authorized by law to provide substituted consent for a covered person.

(*iii*) If the covered person is unable to provide consent, a family member of the covered person or the covered person's treating health care professional.

(d) "Case management" means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other health conditions.

(e) "Certification" means a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay, or other health care service has been reviewed and, based on the information provided, satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, and effectiveness.

(f) "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by a health carrier to determine the necessity and appropriateness of health care services.

(g) "Concurrent review" means utilization review conducted during a patient's hospital stay or course of treatment.

(h) "Covered benefits" or "benefits" means those health care services to which a covered person is entitled under the terms of a health benefit plan.

(i) "Covered person" means a policyholder, subscriber, member, enrollee, or other individual participating in a health benefit plan.

(j) "Department" means the department of insurance and financial services.

(k) "Director" means the director of the department.

(*l*) "Discharge planning" means the formal process for determining, before discharge from a facility, the coordination and management of the care that a patient receives following discharge from the facility.

(m) "Disclose" means to release, transfer, or otherwise divulge protected health information to any person other than the individual who is the subject of the protected health information.

(n) "Evidence-based standard" means the conscientious, explicit, and judicious use of the current best evidence based on the overall systematic review of the research in making decisions about the care of individual patients.

(o) "Expedited internal grievance" means an expedited grievance under section 2213(1)(*l*) of the insurance code of 1956, 1956 PA 218, MCL 500.2213, or section 404(4) of the nonprofit health care corporation reform

act, 1980 PA 350, MCL 550.1404.

(p) "Facility" or "health facility" means:

(*i*) A facility or agency or a part of a facility or agency that is licensed or authorized under parts 201 to 217 of the public health code, 1978 PA 368, MCL 333.20101 to 333.21799e.

(*ii*) A psychiatric hospital, psychiatric unit, partial hospitalization psychiatric program, or center for persons with disabilities operated by the department of health and human services or certified or licensed under the mental health code, 1974 PA 258, MCL 330.1001 to 330.2106.

(*iii*) A facility providing outpatient physical therapy services, including speech pathology services.

(*iv*) A kidney disease treatment center, including a freestanding hemodialysis unit.

(*v*) An ambulatory health care facility.

(*vi*) A tertiary health care service facility.

(*vii*) A substance use disorder services program licensed under part 62 of the public health code, 1978 PA 368, MCL 333.6230 to 333.6251.

(*viii*) An outpatient psychiatric clinic.

(*ix*) A home health agency.

(q) "Final adverse determination" means an adverse determination involving a covered benefit that has been upheld by a health carrier, or its designee utilization review organization, at the completion of the health carrier's internal grievance process procedures as set forth in section 2213 of the insurance code of 1956, 1956 PA 218, MCL 500.2213, or sections 404 or 407 of the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1404 and MCL 550.1407.

(r) "Health benefit plan" means a policy, contract, certificate, or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of covered health care services.

(s) "Health care professional" means an individual licensed, certified, registered, or otherwise authorized to engage in a health profession under parts 161 to 183 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18315.

(t) "Health care provider" or "provider" means a health care professional or a health facility.

(u) "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

(v) "Health carrier" means a person that is subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the director, 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 care corporation, a nonprofit dental care corporation operating under 1963 PA 125, MCL 550.351 to 550.373, or any other person providing a plan of health insurance, health benefits, or health services. Health carrier does not include a state department or agency administering a plan of medical assistance under the social welfare act, 1939 PA 280, MCL 400.1 to 400.119b.

(w) "Health information" means information or data, whether oral or recorded in any form or medium, and personal facts or information about events or relationships that relates to 1 or more of the following:

(*i*) The past, present, or future physical, mental, or behavioral health or condition of an individual or a member of the individual's family.

(*ii*) The provision of health care services to an individual.

(*iii*) Payment for the provision of health care services to an individual.

(x) "Independent review organization" means a person that conducts independent external reviews of adverse determinations.

(y) "Medical or scientific evidence" means evidence found in any of the following sources:

(*i*) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff.

(*ii*) Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia, and other medical literature that meet the criteria of the National Institutes of Health's United States National Library of Medicine for indexing in the former Index Medicus or its current online version, MEDLINE, and Elsevier B. V. for indexing in EMBASE.

(*iii*) Medical journals recognized by the secretary of the United States Department of Health and Human Services under 42 USC 1395x(t)(2)(B)(ii)(I).

(*iv*) The following standard reference compendia:

(A) The American Hospital Formulary Service drug information.

(B) Drug facts and comparisons.

(C) The American Dental Association's accepted dental therapeutics.

(D) The United States Pharmacopoeia drug information.

(*v*) Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including the following:

(A) The Agency for Healthcare Research and Quality.

(B) The National Institutes of Health.

(C) The National Cancer Institute.

(D) The National Academy of Sciences.

(E) The Centers for Medicare and Medicaid Services.

(F) The United States Food and Drug Administration.

(G) Any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health care services.

(*vi*) Any other medical or scientific evidence that is comparable to the sources listed in subparagraphs (*i*) to (*v*).

(z) "Person" means an individual or a corporation, partnership, association, joint venture, joint stock company, trust, unincorporated organization, or similar entity, or any combination of these.

(aa) "Prospective review" means utilization review conducted before an admission or a course of treatment.

(bb) "Protected health information" means health information that identifies an individual who is the subject of the information or with respect to which there is a reasonable basis to believe that the information could be used to identify an individual.

(cc) "Retrospective review" means a review of medical necessity conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment.

(dd) "Second opinion" means an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health service to assess the clinical necessity and appropriateness of the initial proposed health service.

(ee) "Utilization review" means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review.

(ff) "Utilization review organization" means a person that conducts utilization review, other than a health carrier performing a review for its own health plans.

History: 2000, Act 251, Eff. Oct. 1, 2000;—Am. 2006, Act 542, Imd. Eff. Dec. 29, 2006;—Am. 2016, Act 274, Eff. Sept. 29, 2016.

550.1905 Scope.

Sec. 5. (1) Except as otherwise provided in subsection (2), this act applies to all health carriers.

(2) This act does not apply to a policy or certificate that provides coverage only for specified accident or accident-only coverage, credit, disability income, hospital indemnity, long-term care insurance, as that term is defined in section 3901 of the insurance code of 1956, 1956 PA 218, MCL 500.3901, or any other limited supplemental benefit other than specified disease, dental, vision care, or care provided pursuant to a system of health care delivery and financing operating under section 3573 of the insurance code of 1956, 1956 PA 218, MCL 500.3573, Medicare supplement policy of insurance, coverage under a plan through Medicare, or the federal employees health benefits program, any coverage issued under 10 USC 1071 to 1110b, and any coverage issued as supplement to that coverage, any coverage issued as supplemental to liability insurance, worker's disability compensation or similar insurance, automobile medical-payment insurance, or any insurance under which benefits are payable with or without regard to fault, whether written on a group blanket or individual basis.

History: 2000, Act 251, Eff. Oct. 1, 2000;—Am. 2016, Act 274, Eff. Sept. 29, 2016.

550.1907 Right to request external review for adverse determination; written notice.

Sec. 7. (1) A health carrier shall provide written notice to a covered person of the internal grievance and external review processes at the time the health carrier sends written notice of an adverse determination.

(2) Except as provided in subsection (3)(a), a request for an external review under section 11 or 13 must not be made until the covered person has exhausted the health carrier's internal grievance process provided for by law.

(3) The written notice of the right to request an external review for an adverse determination issued before the service is provided to a covered person must include all of the following:

(a) A statement informing the covered person of all of the following:

(*i*) If the covered person has a medical condition such that the time frame for completion of an expedited

internal grievance would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, as substantiated by a physician either orally or in writing, the covered person or the covered person's authorized representative may file a request for an expedited external review under section 13 at the same time the covered person or the covered person's authorized representative files a request for an expedited internal grievance subject to section 13(3). A covered person who files a request under this subparagraph is considered to have exhausted the health carrier's internal grievance process for purposes of subsection (2).

(*ii*) The covered person or the covered person's authorized representative may file a grievance under the health carrier's internal grievance process, but if the health carrier has not issued a written decision to the covered person or the covered person's authorized representative within the required time and without the covered person or the covered person's authorized representative requesting or agreeing to a delay, the covered person or the covered person's authorized representative may file a request for external review under section 9 and is considered to have exhausted the health carrier's internal grievance process for purposes of subsection (2).

(*iii*) A health carrier may waive its internal grievance process and the requirement for a covered person to exhaust the process before filing a request for an external review or an expedited external review.

(*iv*) The covered person is considered to have exhausted a health carrier's internal grievance process if the health carrier has failed to comply with the requirements of the internal grievance process unless the failure or failures are based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the covered person.

(b) A copy of the description of both the standard and expedited external review procedures the health carrier is required to provide under section 25, highlighting the provisions in the external review procedures that give the covered person or the covered person's authorized representative the opportunity to submit additional information and including any forms used to process an external review.

(c) As part of any forms provided under subdivision (b), an authorization form, or other document approved by the director, by which the covered person, for purposes of conducting an external review under this act, authorizes the health carrier and health care provider to disclose protected health information, including medical records, concerning the covered person that are pertinent to the external review.

(4) The written notice of the right to request an external review for an adverse determination issued after the service was provided to the covered person must include the standard external review procedures information required under subsection (3) and be provided to the covered person in the manner prescribed by the director.

History: 2000, Act 251, Eff. Oct. 1, 2000;—Am. 2016, Act 274, Eff. Sept. 29, 2016.

550.1909 Written request to director; manner; electronic communication.

Sec. 9. (1) Except for a request for an expedited external review under section 13, all requests for external review must be made in writing to the director.

(2) A written notice required to be provided under this act must be provided in a culturally and linguistically appropriate manner, as required under 45 CFR 147.136(b)(2)(*ii*)(E).

(3) A health carrier may satisfy a requirement for the delivery of a notice to a covered person under this act by complying with 29 CFR 2520.104b-1(c) with respect to the use of electronic communication.

History: 2000, Act 251, Eff. Oct. 1, 2000;—Am. 2016, Act 274, Eff. Sept. 29, 2016.

550.1911 Request for external review; commencement; preliminary review; notice of acceptance; duties of director; incomplete request; nonacceptance; assignment of independent review organization; duty of health carrier to provide documents; reconsideration by health carrier of its adverse determination; recommendation; considerations; review by director; notice of decision.

Sec. 11. (1) Not later than 60 days or, after December 31, 2016, 120 days after the date of receipt of a notice of an adverse determination or final adverse determination under section 7, a covered person or the covered person's authorized representative may file a request for an external review with the director. Upon receipt of a request for an external review, the director immediately shall notify and send a copy of the request to the health carrier that made the adverse determination or final adverse determination that is the subject of the request.

(2) Not later than 5 business days after the date of receipt of a request for an external review, the director shall complete a preliminary review of the request to determine all of the following:

(a) Whether the individual is or was a covered person in the health benefit plan at the time the health care service was requested or, for a retrospective review, was a covered person in the health benefit plan at the

time the health care service was provided.

(b) Whether the health care service that is the subject of the adverse determination or final adverse determination reasonably appears to be a covered service under the covered person's health benefit plan.

(c) Whether the covered person has exhausted the health carrier's internal grievance process, unless the covered person is not required to exhaust the health carrier's internal grievance process.

(d) Whether the covered person has provided all the information and forms required by the director that are necessary to process an external review, including the health information release form.

(e) Whether the health care service that is the subject of the adverse determination or final adverse determination appears to involve issues of medical necessity or clinical review criteria.

(3) If a request for an external review involves issues of experimental or investigational service or treatment, not later than 5 business days after the date of receipt of a request for an external review, the director shall complete a preliminary review of the request to determine all of the following:

(a) Whether the individual is or was a covered person in the health benefit plan at the time the health care service was requested or, for a retrospective review, was a covered person in the health benefit plan at the time the health care service was provided.

(b) Whether the recommended or requested health care service or treatment that is the subject of the adverse determination or final adverse determination is both of the following:

(*i*) A covered benefit under the covered person's health benefit plan except for the health carrier's determination that the service or treatment is experimental or investigational for a particular medical condition.

(*ii*) Not explicitly listed as an excluded benefit under the covered person's health benefit plan with the health carrier.

(c) Whether the covered person's treating provider with the authority to treat under the public health code, 1978 PA 368, MCL 333.1101 to 333.25211, has certified that 1 or more of the following situations are applicable:

(*i*) Standard health care services or treatments have not been effective in improving the condition of the covered person.

(*ii*) Standard health care services or treatments are not medically appropriate for the covered person.

(*iii*) There is no available standard health care service or treatment covered by the health carrier that is more beneficial than the recommended or requested health care service or treatment described in subdivision (d).

(d) Whether the covered person's treating provider with the authority to treat under the public health code, 1978 PA 368, MCL 333.1101 to 333.25211, has done either of the following:

(*i*) Recommended a health care service or treatment that the treating provider certifies, in writing, is likely to be more beneficial to the covered person, in the treating provider's opinion, than any available standard health care services or treatments.

(*ii*) If the treating provider is a licensed, board certified or board eligible physician qualified to practice in the area of medicine appropriate to treat the covered person's condition, certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested by the covered person that is the subject of the adverse determination or final adverse determination is likely to be more beneficial to the covered person than any available standard health care services or treatments.

(e) Whether the covered person has exhausted the health carrier's internal grievance process, unless the covered person is not required to exhaust the health carrier's internal grievance process under this act.

(f) Whether the covered person has provided all the information and forms required by the director that are necessary to process an external review, including the health information release form.

(4) Upon completion of a preliminary review under subsection (2) or (3), the director immediately shall provide a written notice to the covered person and, if applicable, the covered person's authorized representative as to whether the request is complete and whether it has been accepted for external review.

(5) On accepting a request for external review, the director shall do both of the following:

(a) Include in the written notice under subsection (4) a statement that the covered person or the covered person's authorized representative may submit to the director in writing within 7 business days following the date of the notice additional information and supporting documentation that the reviewing entity will consider when conducting the external review.

(b) Immediately notify the health carrier in writing of the acceptance of the request for external review.

(6) If a request is not accepted for external review because the request is not complete, the director shall inform the covered person and, if applicable, the covered person's authorized representative what information or materials are needed to make the request complete. The covered person or, if applicable, the covered person's authorized representative shall provide the information or materials identified by the director within

30 days after receiving the notification. If a request is not accepted for external review, the director shall provide written notice to the covered person, if applicable, the covered person's authorized representative, and the health carrier of the reasons for its nonacceptance.

(7) If a request is accepted for external review and appears to involve issues of medical necessity or clinical review criteria, the director shall assign an independent review organization at the time the request is accepted for external review. The assigned independent review organization must be approved under this act to conduct external reviews. The assigned independent review organization shall provide a written recommendation to the director on whether to uphold or reverse the adverse determination or the final adverse determination.

(8) If a request is accepted for external review, does not appear to involve issues of medical necessity or clinical review criteria, and appears to only involve purely contractual provisions of a health benefit plan, such as covered benefits or accuracy of coding, the director may keep the request and conduct his or her own external review or may assign an independent review organization as provided in subsection (7) at the time the request is accepted for external review. Except as otherwise provided in subsection (18), if the director keeps a request, he or she shall review the request and issue a decision upholding or reversing the adverse determination or final adverse determination within the same time limits and subject to all other requirements of this act for requests assigned to an independent review organization. If at any time during the director's review of a request it is determined that a request does appear to involve issues of medical necessity or clinical review criteria, the director shall immediately assign the request to an independent review organization approved under this act to conduct external reviews.

(9) In reaching a recommendation, the reviewing entity is not bound by any decisions or conclusions reached during the health carrier's utilization review process or the health carrier's internal grievance process.

(10) Not later than 7 business days after the date of the notice under subsection (5)(b), the health carrier or its designee utilization review organization shall provide to the reviewing entity the documents and any information considered in making the adverse determination or the final adverse determination. Except as provided in subsection (11), the reviewing entity shall not delay the external review because of failure by the health carrier or its designee utilization review organization to provide the documents and information within 7 business days.

(11) Upon receipt of a notice from the assigned independent review organization that the health carrier or its designee utilization review organization has failed to provide the documents and information within 7 business days, the director may terminate the external review and make a decision to reverse the adverse determination or final adverse determination and shall immediately notify the assigned independent review organization, the covered person, if applicable, the covered person's authorized representative, and the health carrier of his or her decision.

(12) The reviewing entity shall review all of the information and documents received under subsection (10) and any other information submitted in writing by the covered person or the covered person's authorized representative under subsection (5)(a) that has been forwarded by the director. Upon receipt of any information submitted by the covered person or the covered person's authorized representative under subsection (5)(a), at the same time the director forwards the information to the independent review organization, the director shall forward the information to the health carrier.

(13) The health carrier may reconsider its adverse determination or final adverse determination that is the subject of the external review. Reconsideration by the health carrier of its adverse determination or final adverse determination does not delay or terminate the external review. The external review may only be terminated if the health carrier decides, upon completion of its reconsideration, to reverse its adverse determination or final adverse determination and provide coverage or payment for the health care service that is the subject of the adverse determination or final adverse determination. Immediately upon making the decision to reverse its adverse determination or final adverse determination, the health carrier shall notify the covered person, if applicable the covered person's authorized representative, if applicable the assigned independent review organization, and the director in writing of its decision. The reviewing entity shall terminate the external review upon receipt of the notice from the health carrier.

(14) In addition to the documents and information provided under subsection (10), the reviewing entity, to the extent the information or documents are available and the reviewing entity considers them appropriate, shall consider the following in reaching a recommendation:

(a) The covered person's pertinent medical records.

(b) The attending health care professional's recommendation.

(c) Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, the covered person, the covered person's authorized representative, or the covered person's treating provider.

(d) The terms of coverage under the covered person's health benefit plan with the health carrier.

(e) The most appropriate practice guidelines, which may include generally accepted practice guidelines, evidence-based practice guidelines, or any other practice guidelines developed by the federal government or national or professional medical societies, boards, and associations.

(f) Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization.

(15) If a request for an external review involves issues of experimental or investigational service or treatment, in addition to the documents and information provided under subsections (10) and (14), the reviewing entity, in reaching a recommendation, shall consider whether either of the following applies:

(a) The recommended or requested health care service or treatment has been approved by the United States Food and Drug Administration, if applicable, for the condition.

(b) Medical or scientific evidence or evidence-based standards demonstrate that the expected benefits of the recommended or requested health care service or treatment are more likely than not to be more beneficial to the covered person than the benefits of any available standard health care service or treatment and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments.

(16) The assigned independent review organization shall provide its recommendation to the director within 14 days after the assignment by the director of the request for an external review. The independent review organization shall include in its recommendation all of the following:

(a) A general description of the reason for the request for external review.

(b) The date the independent review organization received the assignment from the director to conduct the external review.

(c) The date the external review was conducted.

(d) The date of its recommendation.

(e) The principal reason or reasons for its recommendation.

(f) The rationale for its recommendation.

(g) References to the evidence or documentation, including the practice guidelines, considered in reaching its recommendation.

(17) Upon receipt of the assigned independent review organization's recommendation under subsection (16), the director immediately shall review the recommendation to ensure that it is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier.

(18) The director shall provide written notice to the covered person, if applicable the covered person's authorized representative, and the health carrier of the decision to uphold or reverse the adverse determination or the final adverse determination within 7 business days after the date of receipt of the selected independent review organization's recommendation. If the director has kept a request for review, the director shall provide written notice to the covered person, if applicable the covered person's authorized representative, and the health carrier of his or her decision within 14 days after the decision to keep the request. The director shall include in a notice under this subsection all of the following:

(a) The principal reason or reasons for the decision, including, as an attachment to the notice or in any other manner the director considers appropriate, the information provided as determined by the reviewing entity under subsection (16).

(b) If appropriate, the principal reason or reasons why the director did not follow the assigned independent review organization's recommendation.

(19) Upon receipt of a notice of a decision under subsection (18) reversing the adverse determination or final adverse determination, the health carrier immediately shall approve the coverage that was the subject of the adverse determination or final adverse determination.

History: 2000, Act 251, Eff. Oct. 1, 2000;—Am. 2000, Act 398, Imd. Eff. Jan. 8, 2001;—Am. 2016, Act 274, Eff. Sept. 29, 2016.

550.1913 Expedited external review.

Sec. 13. (1) Except as provided in subsection (12), a covered person or the covered person's authorized representative may make a request for an expedited external review with the director within 10 days after the covered person receives an adverse determination if both of the following apply:

(a) The adverse determination involves a medical condition of the covered person for which the time frame for completion of an expedited internal grievance would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function as substantiated by a physician either orally or in writing.

(b) The covered person or the covered person's authorized representative has filed a request for an expedited internal grievance.

(2) When the director receives a request for an expedited external review, the director immediately shall notify and provide a copy of the request to the health carrier that made the adverse determination or final adverse determination. If the director determines the request meets the reviewability requirements under section 11(2) or (3), the director shall assign an independent review organization that has been approved under this act to conduct the expedited external review and to provide a written recommendation to the director on whether to uphold or reverse the adverse determination or final adverse determination.

(3) If a covered person has not completed the health carrier's expedited internal grievance process, the independent review organization shall determine immediately after receipt of the assignment to conduct the expedited external review whether the covered person will be required to complete the expedited internal grievance before conducting the expedited external review. If the independent review organization determines that the covered person must first complete the expedited internal grievance process, the independent review organization immediately shall notify the covered person and, if applicable, the covered person's authorized representative of this determination and that it will not proceed with the expedited external review until the covered person completes the expedited internal grievance.

(4) In reaching a recommendation, an assigned independent review organization is not bound by any decisions or conclusions reached during the health carrier's utilization review process or the health carrier's internal grievance process.

(5) Not later than 12 hours after a health carrier receives a notice under subsection (2), the health carrier or its designee utilization review organization shall provide or transmit all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization electronically or by telephone, facsimile, or any other available expeditious method.

(6) In addition to the documents and information provided or transmitted under subsection (5), the assigned independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider the following in reaching a recommendation:

(a) The covered person's pertinent medical records.

(b) The attending health care professional's recommendation.

(c) Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, the covered person's authorized representative, or the covered person's treating provider.

(d) The terms of coverage under the covered person's health benefit plan with the health carrier.

(e) The most appropriate practice guidelines, which may include generally accepted practice guidelines, evidence-based practice guidelines, or any other practice guidelines developed by the federal government or national or professional medical societies, boards, and associations.

(f) Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization in making adverse determinations.

(7) If a request for an external review involves issues of experimental or investigational service or treatment, in addition to the documents and information provided under subsections (5) and (6), the assigned independent review organization, in reaching a recommendation, shall consider whether either of the following applies:

(a) The recommended or requested health care service or treatment has been approved by the United States Food and Drug Administration, if applicable, for the condition.

(b) Medical or scientific evidence or evidence-based standards demonstrate that the expected benefits of the recommended or requested health care service or treatment are more likely than not to be more beneficial to the covered person than the benefits of any available standard health care service or treatment and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments.

(8) An assigned independent review organization shall provide its recommendation to the director as expeditiously as the covered person's medical condition or circumstances require, but not more than 36 hours after the date the director received the request for an expedited external review.

(9) Upon receipt of an assigned independent review organization's recommendation, the director immediately shall review the recommendation to ensure that it is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier.

(10) As expeditiously as the covered person's medical condition or circumstances require, but not more than 24 hours after receiving the recommendation of the assigned independent review organization, the director shall complete the review of the independent review organization's recommendation and notify the covered person, if applicable, the covered person's authorized representative, and the health carrier of the decision to uphold or reverse the adverse determination or final adverse determination. If the notice under this

subsection is not in writing, within 2 days after the date of providing the notice, the director shall provide written confirmation of the decision to the covered person, if applicable, the covered person's authorized representative, and the health carrier and include the information required in section 11(18).

(11) Upon receipt of a notice of a decision under subsection (10) reversing the adverse determination or final adverse determination, the health carrier immediately shall approve the coverage that was the subject of the adverse determination or final adverse determination.

(12) An expedited external review must not be provided for retrospective adverse determinations or retrospective final adverse determinations.

History: 2000, Act 251, Eff. Oct. 1, 2000;—Am. 2000, Act 398, Imd. Eff. Jan. 8, 2001;—Am. 2016, Act 274, Eff. Sept. 29, 2016.

550.1915 Decision as final administrative remedy; other remedies.

Sec. 15. (1) An external review decision and an expedited external review decision are the final administrative remedies available under this act. A person aggrieved by an external review decision or an expedited external review decision may seek judicial review no later than 60 days from the date of the decision in the circuit court for the county where the covered person resides or in the circuit court of Ingham county.

(2) Subsection (1) does not preclude a health carrier from seeking other remedies available under applicable state law.

(3) Subsection (1) does not preclude a covered person from seeking other remedies available under applicable federal or state law.

(4) A covered person or the covered person's authorized representative may not file a subsequent request for external review involving the same adverse determination or final adverse determination for which the covered person has already received an external review decision under this act.

History: 2000, Act 251, Eff. Oct. 1, 2000;—Am. 2000, Act 398, Imd. Eff. Jan. 8, 2001.

550.1917 Approved independent review organizations; application; form; fee; expiration; termination; updated list.

Sec. 17. (1) The director shall approve independent review organizations eligible to be assigned to conduct external reviews under this act to ensure that an independent review organization satisfies the minimum standards established under section 19.

(2) The director shall develop an application form for initially approving and for reapproving independent review organizations to conduct external reviews.

(3) Any independent review organization wishing to be approved to conduct external reviews under this act shall submit the application form developed under subsection (2) and include with the form all documentation and information necessary for the director to determine if the independent review organization satisfies the minimum qualifications established under section 19. The director may charge an application fee that independent review organizations shall submit to the director with an application for approval or reapproval.

(4) An approval under this section is effective for 2 years, unless the director determines before expiration of the approval that the independent review organization is not satisfying the minimum standards established under section 19. If the director determines that an independent review organization no longer satisfies the minimum standards established under section 19, the director shall terminate the approval of the independent review organization and remove the independent review organization from the list of independent review organizations approved to conduct external reviews under this act that is maintained by the director under subsection (5).

(5) The director shall maintain and periodically update a list of approved independent review organizations.

History: 2000, Act 251, Eff. Oct. 1, 2000;—Am. 2016, Act 274, Eff. Sept. 29, 2016.

550.1919 Approved independent review organization; requirements.

Sec. 19. (1) To be approved under section 17 to conduct external reviews, an independent review organization must do all of the following:

(a) Have and maintain written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process under sections 11 and 13 that include, at a minimum, a quality assurance mechanism in place that does all of the following:

(*i*) Ensures that external reviews are conducted within the specified time frames and required notices are provided in a timely manner.

(*ii*) Ensures the selection of qualified and impartial clinical peer reviewers to conduct external reviews on

behalf of the independent review organization and suitable matching of reviewers to specific cases.

(*iii*) Ensures the confidentiality of medical and treatment records and clinical review criteria.

(*iv*) Ensures that any person employed by or under contract with the independent review organization adheres to the requirements of this act.

(b) Agree to maintain and provide to the director the information required in section 23.

(c) Be accredited by a nationally recognized private accrediting organization approved by the director.

(2) A clinical peer reviewer assigned by an independent review organization to conduct external reviews must be a physician or other appropriate health care professional who meets all of the following minimum qualifications:

(a) Is an expert in the treatment of the covered person's medical condition that is the subject of the external review.

(b) Is knowledgeable about the recommended health care service or treatment because he or she devoted in the immediately preceding year a majority of his or her time in an active clinical practice within the medical specialty most relevant to the subject of the review.

(c) Holds a nonrestricted license in a state of the United States and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review.

(d) Has no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional competence or moral character.

(3) An independent review organization may not own or control, be a subsidiary of or in any way be owned or controlled by, or exercise control with a health benefit plan, a national, state, or local trade association of health benefit plans, or a national, state, or local trade association of health care providers.

(4) An independent review organization selected to conduct the external review and any clinical peer reviewer assigned by the independent organization to conduct the external review must not have a material professional, familial, or financial conflict of interest with any of the following:

(a) The health carrier that is the subject of the external review.

(b) The covered person whose treatment is the subject of the external review or the covered person's authorized representative.

(c) Any officer, director, or management employee of the health carrier that is the subject of the external review.

(d) The health care provider, the health care provider's medical group, or independent practice association recommending the health care service or treatment that is the subject of the external review.

(e) The facility at which the recommended health care service or treatment would be provided.

(f) The developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of the external review.

(5) In determining whether an independent review organization or a clinical peer reviewer of the independent review organization has a material professional, familial, or financial conflict of interest for purposes of subsection (4), the director shall take into consideration situations in which the independent review organization to be assigned to conduct an external review of a specified case or a clinical peer reviewer to be assigned by the independent review organization to conduct an external review of a specified case may have an apparent professional, familial, or financial relationship or connection with a person described in subsection (4), but that the characteristics of that relationship or connection are such that they are not a material professional, familial, or financial conflict of interest that results in the disapproval of the independent review organization or the clinical peer reviewer from conducting the external review.

History: 2000, Act 251, Eff. Oct. 1, 2000;—Am. 2016, Act 274, Eff. Sept. 29, 2016.

550.1921 Independent review organization; liability for damages.

Sec. 21. An independent review organization or clinical peer reviewer working on behalf of an independent review organization is not liable in damages to any person for any opinions rendered during or upon completion of an external review conducted under this act, unless the opinion was rendered in bad faith or involved gross negligence.

History: 2000, Act 251, Eff. Oct. 1, 2000.

550.1923 Maintenance of records; report to director.

Sec. 23. (1) An independent review organization assigned to conduct an external review under section 11 or 13 shall maintain for 3 years written records in the aggregate and by health carrier on all requests for

external review for which it conducted an external review during a calendar year. Each independent review organization required to maintain written records on all requests for external review for which it was assigned to conduct an external review shall submit to the director, at least annually, a report in the format specified by the director.

(2) The report to the director under subsection (1) must include in the aggregate and for each health carrier all of the following:

(a) The total number of requests for external review.

(b) The number of requests for external review resolved and, of those resolved, the number resolved upholding the adverse determination or final adverse determination and the number resolved reversing the adverse determination or final adverse determination.

(c) The average length of time for resolution.

(d) A summary of the types of coverages or cases for which an external review was sought, as provided in the format required by the director.

(e) The number of external reviews under section 11(13) that were terminated as the result of a reconsideration by the health carrier of its adverse determination or final adverse determination after the receipt of additional information from the covered person or the covered person's authorized representative.

(f) Any other information the director may request or require.

(3) A health carrier shall maintain for 3 years written records in the aggregate and for each type of health benefit plan offered by the health carrier on all requests for external review that are filed with the health carrier or that the health carrier receives notice of from the director under this act. A health carrier required to maintain written records on all requests for external review shall submit to the director, at least annually, a report in the format specified by the director.

(4) The report to the director under subsection (3) must include in the aggregate and by type of health benefit plan all of the following:

(a) The total number of requests for external review.

(b) From the number of requests for external review that are filed directly with the health carrier, the number of requests accepted for a full external review.

(c) The number of requests for external review resolved and, of those resolved, the number resolved upholding the adverse determination or final adverse determination and the number resolved reversing the adverse determination or final adverse determination.

(d) The average length of time for resolution.

(e) A summary of the types of coverages or cases for which an external review was sought, as provided in the format required by the director.

(f) The number of external reviews under section 11(13) that were terminated as the result of a reconsideration by the health carrier of its adverse determination or final adverse determination after the receipt of additional information from the covered person or the covered person's authorized representative.

(g) Any other information the director may request or require.

History: 2000, Act 251, Eff. Oct. 1, 2000;—Am. 2000, Act 398, Imd. Eff. Jan. 8, 2001;—Am. 2016, Act 274, Eff. Sept. 29, 2016.

550.1925 Description of internal grievance and external review procedures; inclusion with materials provided to covered persons.

Sec. 25. (1) A health carrier shall include a description of the internal grievance and external review procedures in or attached to the policy, certificate, membership booklet, outline of coverage, or other evidence of coverage it provides to covered persons.

(2) The description under subsection (1) must include all of the following:

(a) A statement informing the covered person of his or her right to file a request for an internal grievance and external review of an adverse determination.

(b) The director's toll-free telephone number and address.

(c) A statement informing the covered person that, when filing a request for an external review, the covered person will be required to authorize the release of any medical records that may be required to be reviewed to reach a decision on the external review.

History: 2000, Act 251, Eff. Oct. 1, 2000;—Am. 2016, Act 274, Eff. Sept. 29, 2016.

550.1927 Rules.

Sec. 27. The director may promulgate rules under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, necessary to carry out this act.

History: 2000, Act 251, Eff. Oct. 1, 2000;—Am. 2016, Act 274, Eff. Sept. 29, 2016.

550.1929 Cease and desist order; additional orders; fines; hearing; injunction; creation of cancer clinical trials; disposition of funds.

Sec. 29. (1) If the commissioner finds that a violation of this act has occurred, the commissioner shall reduce the findings and decision to writing and shall issue and cause to be served upon the person charged with the violation a copy of the findings and an order requiring the person to cease and desist from the violation. In addition, the commissioner may order any of the following:

(a) Payment of a civil fine of not more than $1,000.00 for each violation. However, if the person knew or reasonably should have known that he or she was in violation of this act, the commissioner may order the payment of a civil fine of not more than $5,000.00 for each violation.

(b) The suspension, limitation, or revocation of the person's license or certificate of authority.

(2) If the commissioner finds that a health carrier has deliberately refused to pay for a covered benefit, the commissioner may order any of the following:

(a) For a first offense, payment of a civil fine of not more than $25,000.00 and recovery of the cost of the investigation.

(b) For a second offense, payment of a civil fine of not more than $50,000.00 and recovery of the cost of the investigation.

(c) For a third or subsequent offense or if the commissioner determines that the health carrier has deliberately engaged in a pattern of refusing to pay for a covered benefit, both of the following:

(*i*) The greater of the following:

(A) Payment of a civil fine of not more than $280,000.00.

(B) Payment of a civil fine which shall be the amount of the health carrier's total liability for the covered benefits denied.

(*ii*) Recovery of the cost of the investigation.

(3) A fine collected under this section shall be placed in the cancer clinical trials fund created in subsection (7).

(4) A person who violates any provision of this act shall be afforded an opportunity for a hearing before the commissioner pursuant to the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328. After notice and opportunity for hearing, the commissioner may by order reopen and alter, modify, or set aside, in whole or in part, an order issued under this section if, in the commissioner's opinion, conditions of fact or law have changed to require that action or the public interest requires that action.

(5) If a person knowingly violates a cease and desist order under this section and has been given notice and an opportunity for a hearing held pursuant to the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, the commissioner may order a civil fine of $10,000.00 for each violation, or a suspension, limitation, or revocation of a person's license, or both.

(6) The commissioner may apply to the Ingham county circuit court for an order of the court enjoining a violation of this act.

(7) The cancer clinical trials fund is created as a separate fund in the state treasury. The money in the fund shall be used as provided in this subsection. The state treasurer shall credit to the cancer clinical trials fund all fines collected under this section. The state treasurer may invest money in the fund in any manner authorized by law for the investment of state money, and earnings shall be credited to the fund. Money may be appropriated from the fund to hospitals, outpatient oncology centers, and other facilities located in this state involved in national institutes of health phase III or IV cancer clinical trials that apply for fund money to partially defray costs of patient participation in cancer clinical trials not covered by pharmaceutical manufacturers or health carriers. Money may be appropriated from the fund in amounts that shall not exceed $5,000.00 per facility per year. Money in the cancer clinical trials fund at the close of the fiscal year shall remain in the fund and shall not lapse to the general fund.

History: 2000, Act 251, Eff. Oct. 1, 2000.

CONTRACTS WITH STATE AND LOCAL GOVERNMENT SUBJECT TO PATIENT'S RIGHT TO INDEPENDENT REVIEW
Act 495 of 2006

AN ACT to provide that certain entities contracting with state and local units of government are subject to the patient's right to independent review act.

History: 2006, Act 495, Imd. Eff. Dec. 29, 2006.

The People of the State of Michigan enact:

550.1951 "Local unit of government" defined.

Sec. 1. As used in this act, "local unit of government" means any political subdivision of this state, including, but not limited to, school districts, community and junior colleges, state universities, cities, villages, townships, charter townships, counties, charter counties, authorities created by the state, and authorities created by other local units of government.

History: 2006, Act 495, Imd. Eff. Dec. 29, 2006.

550.1952 Entities contracting with state or local government for costs of health care services under self-funded plan; duties.

Sec. 2. (1) An entity that contracts with a state or local unit of government to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services provided under a self-funded plan established or maintained by that state or local unit of government for its employees shall do all of the following:

(a) Establish procedures and make available to persons covered by the plan internal reviews as though the entity were an insurer subject to section 2213 of the insurance code of 1956, 1956 PA 218, MCL 500.2213.

(b) Establish procedures and make available to persons covered by the plan external reviews in the same manner and subject to all the obligations, conditions, and consequences as though the entity were a health carrier under the patient's right to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929.

(2) The commissioner of the office of financial and insurance services shall provide external reviews under subsection (1)(b) to a person covered by the plan as though that person were a covered person under the patient's right to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929.

History: 2006, Act 495, Imd. Eff. Dec. 29, 2006.

550.1953 Exceptions.

Sec. 3. This act does not apply to a self-funded plan that provides coverage only for dental, vision care, or any other limited supplemental benefit.

History: 2006, Act 495, Imd. Eff. Dec. 29, 2006.

ELDER PRESCRIPTION INSURANCE COVERAGE ACT
Act 499 of 2000

AN ACT to create certain prescription programs relating to the elderly; to enhance access to prescription drugs to certain elderly residents of the state; to prescribe the powers and duties of certain state departments and agencies; and to repeal acts and parts of acts.

History: 2000, Act 499, Eff. Oct. 1, 2001.

The People of the State of Michigan enact:

550.2001 Short title; intent; establishment.

Sec. 1. (1) This act shall be known and may be cited as the "elder prescription insurance coverage act".

(2) It is the intent of the legislature that the EPIC program defray the cost of obtaining medically necessary prescription drugs by elderly Michigan residents under the conditions specified in this act.

(3) The elder prescription insurance coverage program is established within the department of community health.

History: 2000, Act 499, Eff. Oct. 1, 2001.

550.2002 Definitions.

Sec. 2. As used in this act:

(a) "Department" means the department of community health.

(b) "EPIC program" means the elder prescription insurance coverage program created in section 3 or any other state program, federal program, or combination of state programs and federal programs, providing services to the population specified in section 3.

(c) "Federal poverty guidelines" means the poverty guidelines updated annually in the federal register by the United States department of health and human services under authority of 42 U.S.C. 9902(2).

(d) "Household income" means all income received by all persons of a household in a tax year while members of a household.

(e) "Medicaid" means the program for medical assistance established under title XIX of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1396 to 1396f, 1396g-1 to 1396r-6, and 1396r-8 to 1396v, and administered by the department under the social welfare act, 1939 PA 280, MCL 400.1 to 400.119b.

(f) "MEPPS" means the Michigan emergency pharmaceutical program for seniors.

(g) "Michigan resident" means an individual who establishes residence for a period of 3 months in a settled or permanent home or domicile within the state with the intention of remaining in this state. An individual is a resident until the individual establishes a permanent residence outside this state.

(h) "Prescription" and "prescription drug" mean those terms as defined in section 17708 of the public health code, 1978 PA 368, MCL 333.17708.

History: 2000, Act 499, Eff. Oct. 1, 2001.

550.2003 EPIC program; provisions; eligibility requirements; enrollment; assessment for medicaid; “institution” explained; business with not more than 1 employee and less than $200,000.00 in assets.

Sec. 3. (1) The EPIC program shall provide prescription drug coverage, including related supplies as determined by the department in consultation with the advisory committee established in section 7, to each person to whom all of the following apply:

(a) The person is a noninstitutionalized Michigan resident 65 years of age or older.

(b) The person has a household income at or below 200% of the federal poverty guidelines.

(c) The person is not currently a medicaid recipient.

(d) Excluding medicare supplemental insurance or a federal program described in section 9(2), the person is not covered by other insurance that provides prescription drug coverage.

(2) The department shall give initial enrollment priority to applicants who in the 12 months preceding October 1, 2001 participated in the MEPPS. A second enrollment priority will be afforded to applicants with annual household incomes up to 150% of the federal poverty guidelines who received a senior prescription tax credit in former section 273 of the income tax act of 1967, 1967 PA 281. Enrollment in the EPIC program for eligible applicants who formerly participated in the MEPPS program shall take effect not later than October 1, 2001. Enrollment in the EPIC program for eligible applicants who formerly received a senior prescription tax credit shall take effect not later than December 1, 2001. Other applicants with incomes up to 200% of the federal poverty guidelines will be enrolled contingent upon available money.

(3) An individual or married couple meeting the basic eligibility criteria established in subsection (1) may apply for enrollment in the EPIC program as follows:

(a) Submit an annual application to the department, or the department's designee, that, at a minimum, attests to the age, residence, and household income of the individual applicant or couple, if married. A refundable administrative fee must be included with the application and shall be returned to an applicant who the department determines is not eligible for the EPIC program. The administrative fee is $25.00.

(b) Upon notification of eligibility, the enrollee may access the EPIC program by meeting the cost-sharing obligation through a copayment on each prescription that does not exceed 20% of the cost of the prescription being purchased, with a maximum monthly copayment amount calculated based on 1 of the following:

(*i*) If the applicant's household income is at or below 100% of the federal poverty guidelines, the monthly copayment is 1/12 of 1% of household income as established during the annual application process.

(*ii*) If the applicant's household income is at or below 125% but greater than 100% of the federal poverty guidelines, the monthly copayment is 1/12 of 2% of household income as established during the annual application process.

(*iii*) If the applicant's household income is at or below 150% but greater than 125% of the federal poverty guidelines, the monthly copayment is 1/12 of 3% of household income as established during the annual application process.

(*iv*) If the applicant's household income is at or below 175% but greater than 150% of the federal poverty guidelines, the monthly copayment is 1/12 of 4% of household income as established during the annual application process.

(*v*) If the applicant's household income is at or below 200% but greater than 175% of the federal poverty guidelines, the monthly copayment is 1/12 of 5% of household income as established during the annual application process.

(4) Subsequent to enrollment in the EPIC program, an applicant who has a household income at or below 100% of the federal poverty guidelines shall be referred to the local family independence agency for assessment of eligibility for medicaid. Nothing in this subsection shall be construed as mandating that an applicant found eligible for medicaid must enroll in that program in lieu of enrollment in the EPIC program.

(5) For the purpose of determining eligibility under this section, an institution is a facility in which an individual resides and receives medical care through the facility, including prescription drugs. An institution may include a hospital, nursing home, convalescent center, mental health or psychiatric facility, or jail, prison, or other correctional facility. An adult foster care home, a home for the aged, or an assisted living facility is not an institution for purposes of determining eligibility under this section.

(6) For an owner of a sole proprietorship whose business has not more than 1 employee and has less than $200,000.00 in assets or for the owner of a family-owned farm with less than $200,000.00 in assets, household income for the purposes of determining income eligibility under this section shall be determined after excluding business or farm expenses deducted for federal tax purposes.

History: 2000, Act 499, Eff. Oct. 1, 2001;—Am. 2004, Act 57, Imd. Eff. Apr. 12, 2004.

550.2004 Expedited enrollment process; temporary eligibility card or voucher; eligibility requirements.

Sec. 4. (1) The department shall establish an expedited enrollment process or provide an emergency voucher if an otherwise eligible EPIC applicant immediately needs to obtain a medically necessary prescription.

(2) The department shall give an applicant enrolled under subsection (1) a temporary EPIC program eligibility card or an emergency voucher that is valid for up to 90 days from the issue date.

(3) Eligibility requirements for emergency vouchers shall not be more restrictive than the requirements established for the Michigan emergency pharmaceutical program for seniors previously funded in the annual appropriation for the department.

History: 2000, Act 499, Eff. Oct. 1, 2001.

550.2005 Brand name drug; copayment.

Sec. 5. Except as otherwise specified in this section, if an enrollee chooses to have a prescription filled with a brand name drug when a recognized generic drug is available, a copayment is required. For the initial year of operation, the copayment amount is $15.00. For subsequent years, the amount of a copayment applied under this section may be established by the legislature. Nothing in this section shall be construed as allowing therapeutic substitution. The department shall develop a mechanism, with the advice of the advisory committee established in section 7, that will specify when drugs should be dispensed as written and not subject to the $15.00 copayment. These recommendations shall be presented to the senate and house of

representatives appropriations committees not later than September 1, 2001.

History: 2000, Act 499, Eff. Oct. 1, 2001.

550.2006 Program benefits; duties of department.

Sec. 6. In providing program benefits, the department may do all of the following:

(a) Enter into a contract with a private individual, corporation, or agency to manage the EPIC program. A contract entered into under this subdivision shall be awarded through a competitive bidding process.

(b) Use procedures and rebate amounts specified under section 1927 of title XIX of the social security act, 42 U.S.C. 1396r-8, to secure quarterly rebates from pharmaceutical manufacturers for outpatient drugs dispensed to participants in EPIC.

(c) For products distributed by the pharmaceutical manufacturers not providing quarterly rebates as listed in subdivision (b), require preauthorization.

History: 2000, Act 499, Eff. Oct. 1, 2001.

550.2007 Other senior focused entities; utilization and assistance; establishment of advisory committee.

Sec. 7. (1) To assist in implementing this act, the department may utilize the office of services to the aging, area agencies on aging, senior citizens centers, or other senior focused entities, to provide outreach, enrollment assistance, and education services to potentially eligible seniors for both the EPIC and medicaid programs.

(2) To assist in determining the coverage appropriate under the provisions of this act, the department shall establish an advisory committee. The committee shall consist of consumer representatives, members with knowledge in the areas of pharmacology, geriatrics, development and review of budgetary issues and practice, and policy development, and 1 member of each appropriations committee, or his or her designee, as appointed by the respective chairpersons of the senate and house of representatives appropriations committees. The advisory committee shall meet at least once each year.

History: 2000, Act 499, Eff. Oct. 1, 2001.

550.2008 Reports.

Sec. 8. The department shall provide quarterly reports to the senate and house appropriations committees, and the senate and house fiscal agencies, that include quantified data as to the number of program applicants and enrollees, the amount of expenditures, and the number of enrollees subsequently found eligible for medicaid. Each report shall also contain an estimate of whether or not the current rate of expenditures will exceed the existing amount of money appropriated for the EPIC program in the current fiscal year. If the estimate indicates that the program would end the year in deficit, the department and the department of management and budget shall take 1 or more of the following actions:

(a) Request a supplemental appropriation for the EPIC program.

(b) Request a transfer of spending authority from any surplus appropriation within the department.

(c) Suspend further enrollment in the EPIC program.

(d) Increase copayments for new applicants. In no case shall an adjustment in program cost sharing result in a cost to an eligible senior in excess of 5% of the eligible senior's household income.

History: 2000, Act 499, Eff. Oct. 1, 2001.

550.2009 Program not as entitlement; limitation on benefits; EPIC as payer of last resort; use of automated system; pharmacy dispensing fee.

Sec. 9. (1) The program created by this act is not an entitlement. Benefits are limited to the level supported by the money explicitly appropriated in this or other acts for the EPIC program.

(2) Except as allowed in section 3(4), the EPIC program is a payer of last resort. If the federal government establishes a pharmaceutical assistance program that covers EPIC eligible seniors under medicare or another program, the EPIC program shall cover only eligible costs not covered by the federal program. This subsection does not require payment by a local prescription drug discount program or a local emergency prescription drug assistance program for a prescription drug covered under the EPIC program.

(3) The EPIC program shall utilize an automated pharmacy claims adjudication and prospective drug utilization review system. This automated system shall contain those edits necessary to reduce the risk of adverse drug reactions in the enrolled population.

(4) The pharmacy dispensing fee payable under the EPIC program shall be equal to the current medicaid dispensing fee.

History: 2000, Act 499, Eff. Oct. 1, 2001.