

**SUBSTITUTE FOR
SENATE BILL NO. 1294**

A bill to amend 1980 PA 350, entitled
"The nonprofit health care corporation reform act,"
by amending the title and sections 218, 401e, and 414b (MCL
550.1218, 550.1401e, and 550.1414b), the title as amended by 1994
PA 169, section 218 as added by 2002 PA 559, section 401e as added
by 1996 PA 516, and section 414b as added by 2006 PA 413, and by
adding sections 201a, 220, 400, 401m, 410b, 501c, and 620 and part
6A.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

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TITLE

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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

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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 A NONPROFIT CORPORATION 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 ~~certain acts~~ and parts of acts.

SEC. 201A. NOTWITHSTANDING SECTION 201, A HEALTH CARE CORPORATION SHALL NOT BE FORMED IN THIS STATE ON OR AFTER THE EFFECTIVE DATE OF THIS SECTION.

Sec. 218. A health care corporation shall not do any of the following:

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

(b) ~~Dissolve~~, **EXCEPT AS OTHERWISE PROVIDED IN SECTION 220, DISSOLVE**, merge, consolidate, mutualize, or take any other action

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1 that results in a change in direct or indirect control of the
2 health care corporation or sell, transfer, lease, exchange, option,
3 or convey assets that results in a change in direct or indirect
4 control of the health care corporation.

5 SEC. 220. (1) NOTWITHSTANDING ANY PROVISION OF THIS ACT TO THE
6 CONTRARY, A HEALTH CARE CORPORATION MAY ESTABLISH, OWN, OPERATE,
7 AND MERGE WITH A NONPROFIT MUTUAL DISABILITY INSURER FORMED UNDER
8 CHAPTER 58 OF THE INSURANCE CODE OF 1956, 1956 PA 218, MCL 500.5800
9 TO 500.5840. THE SURVIVING ENTITY OF A MERGER DESCRIBED IN THIS
10 SUBSECTION IS THE NONPROFIT MUTUAL DISABILITY INSURER. A MERGER
11 DESCRIBED IN THIS SUBSECTION IS EXEMPT FROM THE APPLICATION OF
12 SECTIONS 1311 TO 1319 OF THE INSURANCE CODE OF 1956, 1956 PA 218,
13 MCL 500.1311 TO 500.1319.

14 (2) THE MERGER OF A HEALTH CARE CORPORATION WITH A NONPROFIT
15 MUTUAL DISABILITY INSURER IS EFFECTIVE UPON COMPLETION OF BOTH OF
16 THE FOLLOWING:

17 (A) THE ADOPTION OF A PLAN OF MERGER BY THE MAJORITY OF THE
18 BOARDS OF DIRECTORS OF BOTH THE HEALTH CARE CORPORATION AND THE
19 NONPROFIT MUTUAL DISABILITY INSURER. THE HEALTH CARE CORPORATION
20 SHALL INCLUDE IN THE PLAN OF MERGER THAT BEGINNING IN APRIL 2014
21 THE SURVIVING ENTITY OF A MERGER DESCRIBED IN SUBSECTION (1) SHALL
22 USE ITS BEST EFFORTS TO MAKE ANNUAL SOCIAL MISSION CONTRIBUTIONS IN
23 AN AGGREGATE AMOUNT <<OF UP TO \$1,500,000,000.00 OVER A PERIOD OF UP TO
24 18 YEARS BEGINNING IN APRIL 2014 TO THE MICHIGAN HEALTH AND WELLNESS
25 FOUNDATION CREATED UNDER PART 6A OF THIS ACT.>> IF
26 ADOPTED, THE BOARDS OF DIRECTORS SHALL SUBMIT THE PLAN OF MERGER TO
27 THE COMMISSIONER FOR HIS OR HER CONSIDERATION AS PROVIDED IN
SUBDIVISION (B).

1 (B) THE APPROVAL OF THE PLAN OF MERGER BY THE COMMISSIONER.
2 THE COMMISSIONER SHALL MAKE A DETERMINATION TO APPROVE OR
3 DISAPPROVE A PLAN OF MERGER WITHIN 90 DAYS OF RECEIPT OF THE PLAN,
4 AND THE COMMISSIONER SHALL NOT UNREASONABLY WITHHOLD APPROVAL OF A
5 PLAN OF MERGER SUBMITTED UNDER SUBDIVISION (A).

6 (3) NOTWITHSTANDING ANY OTHER PROVISION OF THIS ACT TO THE
7 CONTRARY, THE DIRECTORS OF A HEALTH CARE CORPORATION MAY SERVE AS
8 INCORPORATORS OF THE CORPORATE BODY OF, DIRECTORS OF, OR OFFICERS
9 OF THE NONPROFIT MUTUAL DISABILITY INSURER FORMED THROUGH A MERGER
10 DESCRIBED IN SUBSECTION (1).

11 (4) A MERGER DESCRIBED IN SUBSECTION (1) IS THE DISSOLUTION OF
12 THE HEALTH CARE CORPORATION, AND THE SURVIVING NONPROFIT MUTUAL
13 DISABILITY INSURER ASSUMES THE PERFORMANCE OF ALL CONTRACTS AND
14 POLICIES OF THE MERGED HEALTH CARE CORPORATION THAT EXIST ON THE
15 DATE OF THE MERGER. HOWEVER, THE OFFICERS OF A HEALTH CARE
16 CORPORATION MAY PERFORM ANY ACT OR ACTS NECESSARY TO CLOSE THE
17 AFFAIRS OF THE MERGED HEALTH CARE CORPORATION AFTER THE DATE OF THE
18 MERGER.

19 SEC. 400. (1) NOTWITHSTANDING ANY PROVISION OF THIS ACT TO THE
20 CONTRARY, THIS SECTION APPLIES TO THE USE OF A MOST FAVORED NATION
21 CLAUSE IN A PROVIDER CONTRACT ON AND AFTER FEBRUARY 1, 2013.

22 (2) BEGINNING FEBRUARY 1, 2013, A HEALTH CARE CORPORATION
23 SHALL NOT USE A MOST FAVORED NATION CLAUSE IN ANY PROVIDER
24 CONTRACT, INCLUDING A PROVIDER CONTRACT IN EFFECT ON FEBRUARY 1,
25 2013, UNLESS THE MOST FAVORED NATION CLAUSE HAS BEEN FILED WITH AND
26 APPROVED BY THE COMMISSIONER. BEGINNING FEBRUARY 1, 2013, A HEALTH
27 CARE CORPORATION SHALL NOT ENFORCE A MOST FAVORED NATION CLAUSE IN

1 ANY PROVIDER CONTRACT WITHOUT THE PRIOR APPROVAL OF THE
2 COMMISSIONER.

3 (3) AS USED IN THIS SECTION, "MOST FAVORED NATION CLAUSE"
4 MEANS A CLAUSE THAT DOES ANY OF THE FOLLOWING:

5 (A) PROHIBITS, OR GRANTS A CONTRACTING HEALTH CARE CORPORATION
6 AN OPTION TO PROHIBIT, A PROVIDER FROM CONTRACTING WITH ANOTHER
7 PARTY TO PROVIDE HEALTH CARE SERVICES AT A LOWER RATE THAN THE
8 PAYMENT OR REIMBURSEMENT RATE SPECIFIED IN THE CONTRACT WITH THE
9 HEALTH CARE CORPORATION.

10 (B) REQUIRES, OR GRANTS A CONTRACTING HEALTH CARE CORPORATION
11 AN OPTION TO REQUIRE, A PROVIDER TO ACCEPT A LOWER PAYMENT OR
12 REIMBURSEMENT RATE IF THE PROVIDER AGREES TO PROVIDE HEALTH CARE
13 SERVICES TO ANY OTHER PARTY AT A LOWER RATE THAN THE PAYMENT OR
14 REIMBURSEMENT RATE SPECIFIED IN THE CONTRACT WITH THE HEALTH CARE
15 CORPORATION.

16 (C) REQUIRES, OR GRANTS A CONTRACTING HEALTH CARE CORPORATION
17 AN OPTION TO REQUIRE, TERMINATION OR RENEGOTIATION OF AN EXISTING
18 PROVIDER CONTRACT IF A PROVIDER AGREES TO PROVIDE HEALTH CARE
19 SERVICES TO ANY OTHER PARTY AT A LOWER RATE THAN THE PAYMENT OR
20 REIMBURSEMENT RATE SPECIFIED IN THE CONTRACT WITH THE HEALTH CARE
21 CORPORATION.

22 (D) REQUIRES A PROVIDER TO DISCLOSE, TO THE HEALTH CARE
23 CORPORATION OR ITS DESIGNEE, THE PROVIDER'S CONTRACTUAL PAYMENT OR
24 REIMBURSEMENT RATES WITH OTHER PARTIES.

25 Sec. 401e. (1) Except as OTHERWISE provided in this section, a
26 health care corporation that has issued a nongroup certificate
27 shall renew or continue in force the certificate at the option of

1 the individual.

2 (2) Except as **OTHERWISE** provided in this section, a health
3 care corporation that has issued a group certificate shall renew or
4 continue in force the certificate at the option of the sponsor of
5 the plan.

6 (3) Guaranteed renewal is not required in cases of fraud,
7 intentional misrepresentation of material fact, lack of payment, if
8 the health care corporation no longer offers that particular type
9 of coverage in the market, or if the individual or group moves
10 outside the service area.

11 (4) **A HEALTH CARE CORPORATION SHALL NOT DISCONTINUE OFFERING A**
12 **PARTICULAR PLAN OR PRODUCT IN THE NONGROUP OR GROUP MARKET UNLESS**
13 **THE HEALTH CARE CORPORATION DOES ALL OF THE FOLLOWING:**

14 (A) **PROVIDES NOTICE TO THE COMMISSIONER AND TO EACH COVERED**
15 **INDIVIDUAL PROVIDED COVERAGE UNDER THE PLAN OR PRODUCT OF THE**
16 **DISCONTINUATION AT LEAST 90 DAYS BEFORE THE DATE OF THE**
17 **DISCONTINUATION.**

18 (B) **OFFERS TO EACH COVERED INDIVIDUAL PROVIDED COVERAGE UNDER**
19 **THE PLAN OR PRODUCT THE OPTION TO PURCHASE ANY OTHER PLAN OR**
20 **PRODUCT CURRENTLY BEING OFFERED IN THE NONGROUP MARKET BY THAT**
21 **HEALTH CARE CORPORATION WITHOUT EXCLUDING OR LIMITING COVERAGE FOR**
22 **A PREEXISTING CONDITION OR PROVIDING A WAITING PERIOD.**

23 (C) **ACTS UNIFORMLY WITHOUT REGARD TO ANY HEALTH STATUS FACTOR**
24 **OF ENROLLED INDIVIDUALS OR INDIVIDUALS WHO MAY BECOME ELIGIBLE FOR**
25 **COVERAGE IN MAKING THE DETERMINATION TO DISCONTINUE COVERAGE AND IN**
26 **OFFERING OTHER PLANS OR PRODUCTS.**

27 (5) **A HEALTH CARE CORPORATION SHALL NOT DISCONTINUE OFFERING**

1 ALL COVERAGE IN THE NONGROUP OR GROUP MARKET UNLESS THE HEALTH CARE
2 CORPORATION DOES ALL OF THE FOLLOWING:

3 (A) PROVIDES NOTICE TO THE COMMISSIONER AND TO EACH COVERED
4 INDIVIDUAL OF THE DISCONTINUATION AT LEAST 180 DAYS BEFORE THE DATE
5 OF THE EXPIRATION OF COVERAGE.

6 (B) DISCONTINUES ALL HEALTH BENEFIT PLANS ISSUED IN THE
7 NONGROUP OR GROUP MARKET FROM WHICH THE HEALTH CARE CORPORATION
8 WITHDREW AND DOES NOT RENEW COVERAGE UNDER THOSE PLANS.

9 (6) IF A HEALTH CARE CORPORATION DISCONTINUES COVERAGE UNDER
10 SUBSECTION (5), THE HEALTH CARE CORPORATION SHALL NOT PROVIDE FOR
11 THE ISSUANCE OF ANY HEALTH BENEFIT PLANS IN THE NONGROUP OR GROUP
12 MARKET FROM WHICH THE HEALTH CARE CORPORATION WITHDREW DURING THE
13 5-YEAR PERIOD BEGINNING ON THE DATE OF THE DISCONTINUATION OF THE
14 LAST PLAN NOT RENEWED UNDER THAT SUBSECTION.

15 SEC. 401M. UNTIL JANUARY 1, 2014, A HEALTH CARE CORPORATION
16 ESTABLISHED, MAINTAINED, OR OPERATING IN THIS STATE SHALL OFFER
17 HEALTH CARE BENEFITS TO ALL RESIDENTS OF THIS STATE REGARDLESS OF
18 HEALTH STATUS.

19 SEC. 410B. NOTWITHSTANDING SECTION 410A(8), FOR A CERTIFICATE
20 DELIVERED, ISSUED FOR DELIVERY, OR RENEWED IN THIS STATE ON OR
21 AFTER JANUARY 1, 2014, THE PREMIUM FOR A GROUP CONVERSION
22 CERTIFICATE UNDER SECTION 410A SHALL BE DETERMINED ONLY BY USING
23 THE RATING FACTORS SET FORTH IN SECTION 3474A OF THE INSURANCE CODE
24 OF 1956, 1956 PA 218, MCL 500.3474A.

25 Sec. 414b. (1) A health care corporation may offer group
26 wellness coverage. Wellness coverage may provide for an appropriate
27 rebate or reduction in premiums or for reduced copayments,

1 coinsurance, or deductibles, or a combination of these incentives,
2 for participation in any health behavior wellness, maintenance, or
3 improvement program offered by the employer. The employer shall
4 provide evidence of demonstrative maintenance or improvement of the
5 members' health behaviors as determined by assessments of agreed-
6 upon health status indicators between the employer and the health
7 care corporation. Any rebate or premium provided by the health care
8 corporation is presumed to be appropriate unless credible data
9 demonstrate otherwise, but shall not exceed ~~10%~~30% of paid
10 premiums. A health care corporation shall make available to
11 employers all wellness coverage plans that it markets to employers
12 in this state.

13 (2) A health care corporation may offer nongroup wellness
14 coverage. Wellness coverage may provide for an appropriate rebate
15 or reduction in premiums or for reduced copayments, coinsurance, or
16 deductibles, or a combination of these incentives, for
17 participation in any health behavior wellness, maintenance, or
18 improvement program approved by the health care corporation. The
19 member shall provide evidence of demonstrative maintenance or
20 improvement of the individual's or family's health behaviors as
21 determined by assessments of agreed-upon health status indicators
22 between the member and the health care corporation. Any rebate of
23 premium provided by the health care corporation is presumed to be
24 appropriate unless credible data demonstrate otherwise, but shall
25 not exceed ~~10%~~30% of paid premiums. A health care corporation
26 shall make available to individuals all wellness coverage plans
27 that it markets to individuals in this state.

1 (3) A health care corporation is not required to continue any
2 health behavior wellness, maintenance, or improvement program or to
3 continue any incentive associated with a health behavior wellness,
4 maintenance, or improvement program.

5 SEC. 501C. (1) BEGINNING JANUARY 1, 2014, A HEALTH CARE
6 CORPORATION SHALL ESTABLISH AND MAINTAIN A PROVIDER NETWORK IN A
7 MANNER THAT IS SUFFICIENT IN NUMBERS AND TYPES OF PROVIDERS AND
8 FACILITIES TO ENSURE THAT ALL COVERED HEALTH CARE SERVICES TO
9 MEMBERS WILL BE ACCESSIBLE WITHOUT UNREASONABLE DELAY. MEMBERS
10 SHALL HAVE ACCESS TO EMERGENCY SERVICES 24 HOURS PER DAY, 7 DAYS
11 PER WEEK. THE HEALTH CARE CORPORATION'S SERVICE AREA SHALL NOT BE
12 CREATED IN A MANNER THAT IS DESIGNED TO DISCRIMINATE AGAINST
13 INDIVIDUALS BECAUSE OF AGE, SEX, FAMILY STRUCTURE, ETHNICITY, RACE,
14 HEALTH CONDITION, EMPLOYMENT STATUS, OR SOCIOECONOMIC STATUS. A
15 HEALTH CARE CORPORATION SHALL ENSURE THAT ITS NETWORKS MEET THESE
16 REQUIREMENTS BY THE END OF THE FIRST YEAR OF INITIAL OPERATION OF
17 THE NETWORK AND AT ALL TIMES AFTER THE FIRST YEAR OF INITIAL
18 OPERATION.

19 (2) BEGINNING JANUARY 1, 2014, A HEALTH CARE CORPORATION SHALL
20 MAINTAIN CONTRACTS WITH THE NUMBER AND TYPES OF AFFILIATED
21 PROVIDERS THAT ARE SUFFICIENT TO ENSURE THAT COVERED SERVICES ARE
22 AVAILABLE TO ITS MEMBERS WITHOUT UNREASONABLE DELAY. THE
23 COMMISSIONER SHALL DETERMINE WHAT IS SUFFICIENT UNDER THIS
24 SUBSECTION AND AS MAY BE ESTABLISHED BY REFERENCE TO REASONABLE
25 CRITERIA USED BY THE HEALTH CARE CORPORATION, INCLUDING, BUT NOT
26 LIMITED TO, PROVIDER-MEMBER RATIOS BY SPECIALTY, PRIMARY CARE
27 PROVIDER-MEMBER RATIOS, GEOGRAPHIC ACCESSIBILITY, WAITING TIMES FOR

1 APPOINTMENTS WITH PARTICIPATING PROVIDERS, HOURS OF OPERATION, AND
2 THE VOLUME OF TECHNOLOGICAL AND SPECIALTY SERVICES AVAILABLE TO
3 SERVE THE NEEDS OF MEMBERS REQUIRING TECHNOLOGICALLY ADVANCED OR
4 SPECIALTY CARE.

5 (3) ON OR AFTER JANUARY 1, 2014, IF A HEALTH CARE CORPORATION
6 HAS AN INSUFFICIENT NUMBER OR TYPE OF PARTICIPATING PROVIDERS TO
7 PROVIDE A COVERED BENEFIT, THE HEALTH CARE CORPORATION SHALL ENSURE
8 THAT THE MEMBER OBTAINS THE COVERED HEALTH CARE SERVICE AT NO
9 GREATER COST TO THE MEMBER THAN IF THE COVERED HEALTH CARE SERVICE
10 WERE OBTAINED FROM A PARTICIPATING PROVIDER OR SHALL MAKE OTHER
11 ARRANGEMENTS ACCEPTABLE TO THE COMMISSIONER.

12 (4) BEGINNING JANUARY 1, 2014, A HEALTH CARE CORPORATION SHALL
13 ESTABLISH AND MAINTAIN ADEQUATE ARRANGEMENTS TO ENSURE REASONABLE
14 PROXIMITY OF PARTICIPATING PROVIDERS TO THE BUSINESS OR PERSONAL
15 RESIDENCE OF A MEMBER. IN DETERMINING WHETHER A HEALTH CARE
16 CORPORATION HAS COMPLIED WITH THIS SUBSECTION, THE COMMISSIONER
17 SHALL GIVE DUE CONSIDERATION TO THE RELATIVE AVAILABILITY OF HEALTH
18 CARE PROVIDERS IN THE SERVICE AREA.

19 SEC. 620. (1) NOTWITHSTANDING ANY PROVISION OF THIS ACT TO THE
20 CONTRARY, A CERTIFICATE DELIVERED, ISSUED FOR DELIVERY, OR RENEWED
21 IN THIS STATE ON OR AFTER JANUARY 1, 2014 BY A HEALTH CARE
22 CORPORATION IS SUBJECT TO THE POLICY AND CERTIFICATE ISSUANCE AND
23 RATE FILING REQUIREMENTS OF THE INSURANCE CODE OF 1956, 1956 PA
24 218, MCL 500.100 TO 500.8302, INCLUDING THE RATING FACTOR
25 REQUIREMENTS OF SECTION 3474A OF THE INSURANCE CODE OF 1956, 1956
26 PA 218, MCL 500.3474A.

27 (2) FOR A CERTIFICATE DELIVERED, ISSUED FOR DELIVERY, OR

1 RENEWED IN THIS STATE ON OR AFTER JANUARY 1, 2014, SUBJECT TO THE
2 PRIOR APPROVAL OF THE COMMISSIONER, A HEALTH CARE CORPORATION MAY
3 ESTABLISH REASONABLE OPEN ENROLLMENT PERIODS.

4 (3) THE COMMISSIONER SHALL ESTABLISH MINIMUM STANDARDS FOR THE
5 FREQUENCY AND DURATION OF OPEN ENROLLMENT PERIODS ESTABLISHED UNDER
6 SUBSECTION (2). THE COMMISSIONER SHALL UNIFORMLY APPLY THE MINIMUM
7 STANDARDS FOR THE FREQUENCY AND DURATION OF OPEN ENROLLMENT PERIODS
8 ESTABLISHED UNDER THIS SUBSECTION TO ALL HEALTH CARE CORPORATIONS.

9 (4) A HEALTH CARE CORPORATION OFFERING COVERAGE DURING AN OPEN
10 ENROLLMENT PERIOD ESTABLISHED UNDER SUBSECTION (2) SHALL NOT DENY
11 OR CONDITION THE ISSUANCE OR EFFECTIVENESS OF A CERTIFICATE AND
12 SHALL NOT DISCRIMINATE IN THE PRICING OF THE CERTIFICATE ON THE
13 BASIS OF HEALTH STATUS, CLAIMS EXPERIENCE, RECEIPT OF HEALTH CARE,
14 OR MEDICAL CONDITION.

15 PART 6A

16 MICHIGAN HEALTH AND WELLNESS FOUNDATION

17 SEC. 651. AS USED IN THIS PART:

18 (A) "BOARD" MEANS THE MICHIGAN HEALTH AND WELLNESS FOUNDATION
19 BOARD CREATED IN SECTION 652.

20 (B) "EXECUTIVE DIRECTOR" MEANS THE EXECUTIVE DIRECTOR OF THE
21 FOUNDATION APPOINTED BY THE BOARD UNDER SECTION 654.

22 (C) "FOUNDATION" MEANS THE MICHIGAN HEALTH AND WELLNESS
23 FOUNDATION ORGANIZED AS A NONPROFIT CORPORATION UNDER SECTION 653.

24 SEC. 652. (1) THE MICHIGAN HEALTH AND WELLNESS FOUNDATION
25 BOARD IS CREATED TO ORGANIZE AND GOVERN THE FOUNDATION. THE BOARD
26 IS THE INCORPORATOR OF THE FOUNDATION FOR THE PURPOSES OF THE
27 NONPROFIT CORPORATION ACT, 1982 PA 162, MCL 450.2101 TO 450.3192.

1 (2) THE BOARD APPOINTED UNDER SUBSECTION (3) SHALL NOT
2 CURRENTLY BE OR WITHIN THE IMMEDIATELY PRECEDING 12 MONTHS HAVE
3 BEEN EMPLOYED BY A CARRIER, PRODUCER, HEALTH CARE PROVIDER, OR
4 THIRD PARTY ADMINISTRATOR OR BY AN AFFILIATE OR SUBSIDIARY OF A
5 CARRIER, PRODUCER, HEALTH CARE PROVIDER, OR THIRD PARTY
6 ADMINISTRATOR.

7 (3) SUBJECT TO THIS SUBSECTION, THE GOVERNOR SHALL APPOINT THE
8 MEMBERS OF THE BOARD WITH THE ADVICE AND CONSENT OF THE SENATE. ON
9 OR BEFORE THE EXPIRATION OF 60 DAYS AFTER THE EFFECTIVE DATE OF
10 THIS SECTION, THE GOVERNOR SHALL APPOINT THE FOLLOWING INITIAL
11 MEMBERS OF THE BOARD WITH THE ADVICE AND CONSENT OF THE SENATE:

12 (A) TWO MEMBERS FROM A LIST OF 5 OR MORE INDIVIDUALS
13 RECOMMENDED BY THE SENATE MAJORITY LEADER.

14 (B) TWO MEMBERS FROM A LIST OF 5 OR MORE INDIVIDUALS
15 RECOMMENDED BY THE SPEAKER OF THE HOUSE OF REPRESENTATIVES.

16 (C) ONE MEMBER REPRESENTING THE INTERESTS OF MINOR CHILDREN.

17 (D) ONE MEMBER REPRESENTING THE INTERESTS OF SENIOR CITIZENS.

18 (E) TWO MEMBERS OF THE GENERAL PUBLIC.

19 (F) ONE MEMBER REPRESENTING THE BUSINESS COMMUNITY.

20 (G) ONE MEMBER REPRESENTING ORGANIZED LABOR.

21 (H) ONE MEMBER REPRESENTING SMALL BUSINESSES.

22 (I) ONE MEMBER FROM A LIST OF 3 OR MORE INDIVIDUALS
23 RECOMMENDED BY THE HOUSE MINORITY LEADER.

24 (J) ONE MEMBER FROM A LIST OF 3 OR MORE INDIVIDUALS
25 RECOMMENDED BY THE SENATE MINORITY LEADER.

26 (4) A VACANCY IN THE BOARD SHALL BE FILLED IN THE SAME MANNER
27 AS THE INITIAL APPOINTMENT OF THAT MEMBER UNDER SUBSECTION (3).

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1 EXCEPT AS OTHERWISE PROVIDED IN THIS SUBSECTION, A BOARD MEMBER
2 SHALL SERVE FOR A TERM OF 4 YEARS OR UNTIL A SUCCESSOR IS
3 APPOINTED, WHICHEVER IS LATER. FOR AN INITIAL MEMBER APPOINTED TO
4 THE BOARD UNDER SUBSECTION (3), 4 MEMBERS SHALL SERVE FOR 2-YEAR
5 TERMS, 4 MEMBERS SHALL SERVE FOR 3-YEAR TERMS, AND <<5>> MEMBERS SHALL
6 SERVE FOR 4-YEAR TERMS.

7 (5) SEVEN MEMBERS OF THE BOARD CONSTITUTE A QUORUM FOR THE
8 TRANSACTION OF BUSINESS AT A MEETING OF THE BOARD. AN AFFIRMATIVE
9 VOTE OF 7 BOARD MEMBERS IS NECESSARY FOR OFFICIAL ACTION OF THE
10 BOARD.

11 (6) THE BUSINESS THAT THE BOARD MAY PERFORM SHALL BE CONDUCTED
12 AT A MEETING OF THE BOARD THAT IS HELD IN THIS STATE, IS OPEN TO
13 THE PUBLIC, AND IS HELD IN A PLACE THAT IS AVAILABLE TO THE GENERAL
14 PUBLIC. HOWEVER, THE BOARD MAY ESTABLISH REASONABLE RULES AND
15 REGULATIONS TO MINIMIZE DISRUPTION OF A MEETING OF THE BOARD. AT
16 LEAST 10 DAYS AND NOT MORE THAN 60 DAYS BEFORE A MEETING, THE BOARD
17 SHALL PROVIDE PUBLIC NOTICE OF ITS MEETING AT ITS PRINCIPAL OFFICE
18 AND ON ITS INTERNET WEBSITE. THE BOARD SHALL INCLUDE IN THE PUBLIC
19 NOTICE OF ITS MEETING THE ADDRESS WHERE BOARD MINUTES REQUIRED
20 UNDER SUBSECTION (7) MAY BE INSPECTED BY THE PUBLIC. THE BOARD MAY
21 MEET IN A CLOSED SESSION FOR ANY OF THE FOLLOWING PURPOSES:

22 (A) TO CONSIDER THE HIRING, DISMISSAL, SUSPENSION, OR
23 DISCIPLINING OF BOARD MEMBERS OR ITS EMPLOYEES OR AGENTS.

24 (B) TO CONSULT WITH ITS ATTORNEY.

25 (C) TO COMPLY WITH STATE OR FEDERAL LAW, RULES, OR REGULATIONS
26 REGARDING PRIVACY OR CONFIDENTIALITY.

27 (7) THE BOARD SHALL KEEP MINUTES OF EACH MEETING. BOARD

1 MINUTES SHALL BE OPEN TO PUBLIC INSPECTION, AND THE BOARD SHALL
2 MAKE THE MINUTES AVAILABLE AT THE ADDRESS DESIGNATED ON THE PUBLIC
3 NOTICE OF ITS MEETING UNDER SUBSECTION (6). THE BOARD SHALL MAKE
4 COPIES OF THE MINUTES AVAILABLE TO THE PUBLIC AT THE REASONABLE
5 ESTIMATED COST FOR PRINTING AND COPYING. THE BOARD SHALL INCLUDE
6 ALL OF THE FOLLOWING IN ITS BOARD MINUTES:

7 (A) THE DATE, TIME, AND PLACE OF THE MEETING.

8 (B) BOARD MEMBERS WHO ARE PRESENT AND ABSENT.

9 (C) BOARD DECISIONS MADE AT A MEETING OPEN TO THE PUBLIC.

10 (D) ALL ROLL CALL VOTES TAKEN AT THE MEETING.

11 (8) BOARD MEMBERS SHALL SERVE WITHOUT COMPENSATION. HOWEVER,
12 BOARD MEMBERS MAY BE REIMBURSED FOR THEIR ACTUAL AND NECESSARY
13 EXPENSES INCURRED IN THE PERFORMANCE OF THEIR OFFICIAL DUTIES AS
14 BOARD MEMBERS.

15 SEC. 653. (1) THE BOARD SHALL ORGANIZE A NONPROFIT
16 CORPORATION, ON A NONSTOCK, DIRECTORSHIP BASIS, UNDER THE NONPROFIT
17 CORPORATION ACT, 1982 PA 162, MCL 450.2101 TO 450.3192. THE
18 NONPROFIT CORPORATION SHALL BE KNOWN AS THE MICHIGAN HEALTH AND
19 WELLNESS FOUNDATION AND IS ORGANIZED TO RECEIVE AND ADMINISTER
20 FUNDS FOR THE PUBLIC WELFARE.

21 (2) THE FOUNDATION SHALL DO ALL OF THE FOLLOWING:

22 (A) PLAN, PROMOTE, COORDINATE, AND FUND PROGRAMS THAT WILL
23 BENEFIT THE HEALTH AND WELLNESS OF THE RESIDENTS OF THIS STATE.

24 (B) PROMOTE, THROUGH GRANTS TO PROGRAMS OR ENTITIES, THE
25 PROGRESS OF THE SCIENCE AND ART OF HEALTH CARE IN THIS STATE.

26 (C) IMPROVE ACCESS TO AND THE COST AND QUALITY OF HEALTH CARE
27 SERVICES IN THIS STATE.

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1 (D) PROMOTE WELLNESS AND IMPROVE THE PHYSICAL, MENTAL, AND
2 EMOTIONAL HEALTH OF RESIDENTS OF THIS STATE THROUGH DEVELOPMENT AND
3 SUPPORT OF PROGRAMS THAT PROMOTE A HEALTHIER LIFESTYLE AND
4 ENCOURAGE PROPER NUTRITION AND PHYSICAL ACTIVITY.

5 (E) SUPPORT PROGRAMS THAT ASSIST SENIOR CITIZENS AND
6 INDIVIDUALS WITH DISABILITIES TO LIVE HEALTHY AND INDEPENDENT
7 LIFESTYLES AND THAT PROTECT VULNERABLE INDIVIDUALS FROM ABUSE AND
8 NEGLECT.

9 (F) SOLICIT AND ACCEPT ANY GIFT, GRANT, LEGACY, OR ENDOWMENT
10 OF MONEY OR IN-KIND DONATIONS OF GOODS AND SERVICES FROM THE
11 FEDERAL GOVERNMENT, THIS STATE, OTHER STATE GOVERNMENT, LOCAL
12 GOVERNMENT, OR ANY PRIVATE SOURCE TO FURTHER ITS PURPOSES UNDER
13 THIS SECTION.

14 (G) PLAN, PROMOTE, COORDINATE, AND FUND PROGRAMS THAT ARE
15 DESIGNED TO PREVENT ILLNESS, DISABILITY, OR DEATH DUE TO FOODBORNE
16 DISEASE.

17 (H) SUPPORT PROGRAMS TO REDUCE INEFFICIENCIES IN THE HEALTH
18 CARE DELIVERY SYSTEM OF THIS STATE THROUGH THE USE OF TECHNOLOGY,
19 COLLABORATION OR COORDINATION OF ENTITIES PROVIDING HEALTH CARE
20 SERVICES, OR EDUCATION OF HEALTH CARE CONSUMERS.

<<(I) SUPPORT PROGRAMS THAT ASSIST MINOR CHILDREN TO LIVE HEALTHY
LIFESTYLES AND PROTECT MINOR CHILDREN FROM ABUSE AND NEGLECT.>>

21 (3) IN ADDITION TO THE POWERS AND DUTIES UNDER SUBSECTION (2),
22 THE FOUNDATION HAS THE POWER AND DUTIES OF A NONPROFIT CORPORATION
23 UNDER THE NONPROFIT CORPORATION ACT, 1982 PA 162, MCL 450.2101 TO
24 450.3192. IF A CONFLICT BETWEEN A POWER OR DUTY OF THE FOUNDATION
25 UNDER THIS SECTION CONFLICTS WITH A POWER OR DUTY UNDER OTHER STATE
26 LAW, THIS SECTION CONTROLS.

27 <<

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>> THE BOARD <<SHALL>> IMPLEMENT A PROGRAM THAT DISBURSES
FOUNDATION

MONEY TO SUBSIDIZE THE COST OF INDIVIDUAL MEDIGAP COVERAGE TO
SENIOR CITIZENS IN THIS STATE WHO DEMONSTRATE A FINANCIAL NEED IN
ORDER TO BE ABLE TO PURCHASE INDIVIDUAL MEDIGAP COVERAGE. TO
IMPLEMENT THE PROGRAM, THE BOARD SHALL DEVELOP A MEANS TEST TO
DETERMINE IF A SENIOR CITIZEN APPLICANT IS ELIGIBLE FOR THE MEDIGAP
COVERAGE SUBSIDY ALLOWED IN THIS SUBSECTION.

(5) EXCEPT AS OTHERWISE PROVIDED IN THIS SUBSECTION, <<BEGINNING
JANUARY 1, 2016>> THE BOARD
SHALL DISBURSE <<60%>> OF THE TOTAL AMOUNT OF FOUNDATION MONEY ELIGIBLE
FOR DISBURSEMENT UNDER SECTION 655(3) TO SUBSIDIZE THE COST OF
INDIVIDUAL MEDIGAP COVERAGE PURCHASED BY SENIOR CITIZENS IN THIS
STATE, SUBJECT TO THE MEANS TEST REQUIRED IN SUBSECTION (4). THIS
SUBSECTION DOES NOT APPLY AFTER DECEMBER 31, 2021 OR AFTER A
NONPROFIT MUTUAL DISABILITY INSURER DISCONTINUES OFFERING
SUPPLEMENTAL COVERAGE TO MEDICARE ENROLLEES AS PROVIDED IN SECTION
5805(3) OF THE INSURANCE CODE OF 1956, 1956 PA 218, MCL 500.5805,
WHICHEVER FIRST OCCURS.

SEC. 654. (1) THE BOARD SHALL APPOINT AN EXECUTIVE DIRECTOR OF
THE FOUNDATION. THE EXECUTIVE DIRECTOR IS THE CHIEF EXECUTIVE
OFFICER OF THE FOUNDATION AND SERVES AT THE PLEASURE OF THE BOARD.
THE EXECUTIVE DIRECTOR MAY EMPLOY STAFF AS NECESSARY WITH THE
APPROVAL OF THE BOARD. THE BOARD SHALL DETERMINE COMPENSATION FOR
THE EXECUTIVE DIRECTOR AND STAFF EMPLOYED UNDER THIS SUBSECTION.

(2) TO ENSURE EFFICIENT OPERATION OF THE FOUNDATION, THE
EXECUTIVE DIRECTOR MAY SEEK ASSISTANCE AND SUPPORT AS MAY BE

1 REQUIRED IN THE PERFORMANCE OF HIS OR HER DUTIES FROM APPROPRIATE
2 STATE DEPARTMENTS, AGENCIES, AND OFFICES. UPON REQUEST OF THE
3 EXECUTIVE DIRECTOR, THE STATE DEPARTMENT, AGENCY, OR OFFICE MAY
4 PROVIDE ASSISTANCE AND SUPPORT TO THE EXECUTIVE DIRECTOR.

5 (3) THE EXECUTIVE DIRECTOR SHALL DISPLAY ON THE FOUNDATION
6 INTERNET WEBSITE INFORMATION RELEVANT TO THE PUBLIC, AS DEFINED BY
7 THE BOARD, CONCERNING THE FOUNDATION'S OPERATIONS AND EFFICIENCIES,
8 AS WELL AS THE BOARD'S ASSESSMENTS OF THOSE ACTIVITIES.

9 SEC. 655. (1) THE BOARD SHALL PROVIDE FOR A SYSTEM OF
10 FINANCIAL ACCOUNTING, CONTROLS, AUDITS, AND REPORTS. THE BOOKS,
11 RECORDS, AND ACCOUNTS OF THE FOUNDATION ARE SUBJECT TO AUDIT.

12 (2) THE BOARD SHALL PROVIDE FOR THE INVESTMENT POLICY OF THE
13 FOUNDATION IN ITS BYLAWS. SUBJECT TO THE INVESTMENT POLICY OF THE
14 FOUNDATION, ALL MONEY RECEIVED BY THE FOUNDATION MAY BE INVESTED IN
15 BONDS OR OTHER OBLIGATIONS OF, OR GUARANTEED AS TO PRINCIPAL AND
16 INTEREST BY, THE UNITED STATES, THIS STATE, OR A POLITICAL
17 SUBDIVISION OF THIS STATE.

18 (3) NO MORE THAN 1/2 OF THE MONEY CONTRIBUTED TO THE
19 FOUNDATION EACH YEAR, INCLUDING ANY INTEREST AND EARNINGS BUT NOT
20 INCLUDING ANY UNREALIZED GAINS OR LOSSES ON THOSE CONTRIBUTIONS, IS
21 AVAILABLE FOR DISBURSEMENT BY THE FOUNDATION UPON BOARD APPROVAL.

22 (4) MONEY FROM THE FOUNDATION MAY BE USED AS MATCHING FUNDS
23 FOR A FEDERAL GRANT.

24 Enacting section 1. This amendatory act does not take effect
25 unless Senate Bill No. 1293 of the 96th Legislature is enacted into
26 law.