HOUSE BILL No. 4854

June 15, 1993, Introduced by Reps. Saunders, Berman, Anthony, Rivers and Kilpatrick and referred to the Committee on Insurance.

A bill to amend sections 102, 104, 105, 108, 201, 205, 207, 401, 403, 404, 501, 502, 504, 511, 515, 518, 608, 609, and 610 of Act No. 350 of the Public Acts of 1980, entitled as amended "The nonprofit health care corporation reform act," section 105 as amended by Act No. 430 of the Public Acts of 1980, section 205 as amended by Act No. 74 of the Public Acts of 1991, section 207 as amended by Act No. 260 of the Public Acts of 1989, section 401 as amended by Act No. 66 of the Public Acts of 1984, section 502 as amended by Act No. 38 of the Public Acts of 1988, and sections 608 and 609 as amended by Act No. 61 of the Public Acts of 1991, being sections 550.1102, 550.1104, 550.1105, 550.1108, 550.1201, 550.1205, 550.1207, 550.1401, 550.1403, 550.1404, 550.1501, 550.1502, 550.1504, 550.1511, 550.1515, 550.1518, 550.1608, 550.1609, and 550.1610 of the Michigan

Compiled Laws; to add sections 202a, 211a, 401e, 401f, 503a, 505a, and 519; and to repeal certain parts of the act.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Section 1. Sections 102, 104, 105, 108, 201, 205, 207, 401, 403, 404, 501, 502, 504, 511, 515, 518, 608, 609, and 610 of Act No. 350 of the Public Acts of 1980, section 105 as amended by Act No. 430 of the Public Acts of 1980, section 205 as amended by Act No. 74 of the Public Acts of 1991, section 207 as amended by Act No. 260 of the Public Acts of 1989, section 401 as amended by Act No. 66 of the Public Acts of 1984, section 502 as amended by Act No. 38 of the Public Acts of 1988, and sections 608 and 609 as amended by Act No. 61 of the Public Acts of 1991, being sections 550.1102, 550.1104, 550.1105, 550.1108, 550.1201, 550.1205, 550.1207, 550.1401, 550.1403, 550.1404, 550.1501, 550.1502, 550.1504, 550.1511, 550.1515, 550.1518, 550.1608, 550.1609, and 550.1610 of the Michigan Compiled Laws, are amended and sections 202a, 211a, 401e, 401f, 503a, 505a, and 519 are added to read as follows:

Sec. 102. (1) It is the PRIMARY purpose of and intent of this act, and the policy of the legislature, TO PROVIDE THE OPPORTUNITY FOR ACCESS TO HIGH QUALITY HEALTH CARE SERVICES AT A FAIR AND REASONABLE COST. IT IS THE SECONDARY 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.

(4) IT IS THE PURPOSE OF AND INTENT OF THE AMENDATORY ACT THAT ADDED THIS SUBSECTION TO PRESERVE THE STATE'S INTEREST IN THE HEALTH AND WELFARE OF ITS CITIZENS BY PREVENTING A SINGLE HEALTH CARE CORPORATION FROM MONOPOLIZING THE HEALTH CARE MARKET, TO ELIMINATE THE RESULTING NEGATIVE EFFECTS OF A MONOPOLY ON THE STATE'S HEALTH CARE MARKET, TO RESTORE REASONABLE ACCESS TO HIGH

QUALITY HEALTH CARE AT REASONABLE COSTS, TO RETURN HEALTH CARE CORPORATIONS TO COMPLIANCE WITH THIS SECTION WHICH PROVIDES THAT HEALTH CARE CORPORATIONS SHALL BE REGULATED AND SUPERVISED BY THE COMMISSIONER OF INSURANCE, AND TO RETURN EXISTING HEALTH CARE CORPORATIONS TO COMPLIANCE WITH THE ORIGINAL LEGISLATIVE INTENT WHICH PROVIDED FOR CHARITABLE, BENEVOLENT, TAX-EXEMPT INSTITUTIONS, ESTABLISHED TO PROMOTE AN APPROPRIATE DISTRIBUTION OF HEALTH CARE SERVICES FOR THE BENEFIT OF ALL RESIDENTS OF THE STATE.

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 ~~24.315~~ 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~~ CONCERNING rates of pay, wages, hours of employment, or other conditions of employment ~~relative to~~ AFFECTING the employees ~~so~~ 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, including, SUBJECT TO SECTION 211A, a contract containing an administrative services only or cost-plus arrangement. 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 ~~169~~ 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.

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 AND, SUBJECT TO SECTION 211A, 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~~ 22205 of THE PUBLIC HEALTH CODE, Act

No. 368 of the Public Acts of 1978, being section ~~333.22104~~ 333.22205 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.

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).~~

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~~ THAT 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~~ IF 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.

(8) NOTWITHSTANDING ANY OTHER PROVISION OF THIS ACT, A HEALTH CARE CORPORATION IS SUBJECT TO PRIVATE CAUSES OF ACTION BY AGGRIEVED PERSONS, INCLUDING PROVIDERS AND SUBSCRIBERS, FOR VIOLATIONS OF THIS ACT. ATTORNEY FEES AND COSTS MAY BE AWARDED TO A PREVAILING PLAINTIFF. PRIVATE CAUSES OF ACTION FOR VIOLATIONS OF THIS ACT MAY INCLUDE, BUT ARE NOT LIMITED TO, ALL OF THE FOLLOWING:

(A) BAD FAITH CONDUCT OR RETALIATORY CONDUCT ON THE PART OF A HEALTH CARE CORPORATION IN EXERCISING ITS POWERS UNDER THIS ACT.

(B) WITHHOLDING PAYMENTS TO PROVIDERS OR SUBSCRIBERS IN VIOLATION OF THIS ACT.

(9) NOTWITHSTANDING ANY OTHER PROVISION OF THIS ACT, A HEALTH CARE CORPORATION SHALL NOT DIRECTLY OR INDIRECTLY OPERATE,

CONTROL, OR USE THE INFLUENCE OF AN INDEPENDENT COMMITTEE AS DEFINED IN SECTION 208 OF THE MICHIGAN CAMPAIGN FINANCE ACT, ACT NO. 388 OF THE PUBLIC ACTS OF 1976, BEING SECTION 169.208 OF THE MICHIGAN COMPILED LAWS, OR A POLITICAL COMMITTEE AS DEFINED IN SECTION 11 OF ACT NO. 388 OF THE PUBLIC ACTS OF 1976, BEING SECTION 169.211 OF THE MICHIGAN COMPILED LAWS. A HEALTH CARE CORPORATION WHO VIOLATES THIS SUBSECTION MAY BE SUBJECT TO A CIVIL FINE OF NOT MORE THAN $10,000.00 FOR EACH VIOLATION.

SEC. 202A. NOTWITHSTANDING ANY OTHER PROVISION OF THIS ACT, A HEALTH CARE CORPORATION SHALL NOT SERVE AS A FISCAL INTERMEDIARY FOR THE FEDERAL MEDICARE PROGRAM. THIS SECTION SHALL TAKE EFFECT UPON THE EXPIRATION OF THE CONTRACT THAT IS IN EXISTENCE ON THE EFFECTIVE DATE OF THIS SECTION THAT PERMITS THE HEALTH CARE CORPORATION TO ACT AS FISCAL INTERMEDIARY FOR THE FEDERAL MEDICARE PROGRAM.

Sec. 205. (1) A health care corporation shall record or estimate liabilities at reasonable values, neither excessive nor inadequate, and in accordance with sound actuarial practices and generally accepted accounting principles, to provide for the payment of all debts of the corporation. The assets of the corporation shall be valued in accordance with sound actuarial practices and generally accepted accounting principles. The commissioner shall disapprove the amount of any assets or liabilities that violate this subsection. The commissioner shall have the authority to disapprove the creation of any new liability that is properly includable in the contingency reserves. A liability shall

be considered to be a new liability if the liability was not in existence on or before December 31, 1978.

(2) At all times while engaged in business, a health care corporation shall maintain a contingency reserve that, on a projected basis, progresses toward the target contingency reserve level established pursuant to this section. Until a target contingency reserve level is established pursuant to this section, the corporation shall maintain a contingency reserve in the form and amount determined by the commissioner, or 11.5% of the previous year's total incurred claims and incurred expenses, whichever is greater.

(3) Within 30 days after the filing of a health care corporation's annual financial statement under section 602, the commissioner shall determine the target contingency reserve level for the corporation, expressed as a percentage of the total incurred claims and incurred expenses of the corporation for the previous calendar year. The target shall be equal to the adjustment factor established in subsection (7) multiplied by the sum of the risk factors weighted by the distribution of business of the corporation as of the previous December 31. The commissioner shall transmit a copy of the target to the corporation, rounded up to the nearest 1/10 of a percent.

(4) A health care corporation, for purposes of this section, shall define at least 5 lines of business and shall assign a risk factor to each line of business. The risk factors shall be established in accordance with sound actuarial practices, and the

health care corporation shall file these risk factors with the commissioner within 6 months after the following times:

(a) In the case of a health care corporation established under former Act No. 108 or 109 of the Public Acts of 1939, upon the effective date of this act.

(b) In the case of a health care corporation newly incorporated under this act, upon formation of the corporation.

(c) In the case of a health care corporation that has previously determined risk factors pursuant to this section, upon request of either the corporation or the commissioner, provided that the request is not made within 3 years after a previous determination of risk factors pursuant to this section, except as provided in subsection (8).

(5) Within 30 days after receipt of the risk factors filed pursuant to subsection (4), the commissioner shall do 1 of the following:

(a) Approve the factors and proceed under subsection (7).

(b) Define 1 or more additional lines of business, transmit the definitions to the health care corporation, and request that the corporation establish risk factors for those additional lines. The corporation shall then have 60 days to submit a risk factor for each line of business defined by either the commissioner or the corporation, which shall be approved or disapproved by the commissioner under this subsection. A health care corporation may revise a previously filed risk factor under this subsection.

(c) Disapprove the factors, and proceed under subsection (6).

(6) If the risk factors are disapproved by the commissioner pursuant to subsection (5)(c), the commissioner shall immediately notify the health care corporation of the disapproval. Within 6 months following notification, a panel of 3 actuaries, 1 appointed by the commissioner, 1 by the corporation, and 1 appointed by the 2 previously appointed actuaries, shall determine a risk factor for each line of business. The agreement of any 2 actuaries on the panel shall be sufficient for the determination of the risk factors, and the panel shall transmit a copy of the risk factors to both the commissioner and the corporation.

(7) Within 15 days after the determination of the risk factors under subsection (6), or the approval of the risk factors under subsection (5)(a), the commissioner shall calculate an adjustment factor, which shall be transmitted to the health care corporation and the legislature. The adjustment factor shall equal:

(a) In the case of a filing pursuant to subsection (4)(a), 11.5% divided by the sum of the risk factors weighted by the distribution of business of the corporation as of December 31, 1979.

(b) In the case of a filing pursuant to subsection (4)(b), 11.5% divided by the sum of the risk factors weighted by the distribution of business of the corporation as of 6 months following the formation of the corporation.

(c) In the case of a filing pursuant to subsection (4)(c), the current target contingency reserve level divided by the sum of the risk factors weighted by the distribution of business of the corporation as of the previous December 31.

(8) At any time the health care corporation and the commissioner, by mutual agreement, may enter into a stipulation setting forth lines of business, risk factors for each line of business, and an adjustment factor.

(9) The contingency reserve of a health care corporation shall not be less than 65%, or more than 120% of the target contingency reserve level. If the contingency reserve is above the required range at the end of a calendar year, the corporation shall implement adjustments as necessary to achieve the required range and shall file with the commissioner, for information, a description of the adjustments.

(10) The commissioner shall examine a health care corporation's annual financial statement filed in accordance with section 602 to determine, in accordance with generally accepted accounting principles, whether the contingency reserve is outside the required range described in subsection (9). If the contingency reserve is outside the required range at the end of 2 successive calendar years, the ~~corporation shall file a plan, for approval by the commissioner, to adjust the contingency reserve to a level within the required range. If the commissioner disapproves the corporation's plan, the commissioner shall formulate a plan and shall forward the plan to the corporation. The corporation shall begin implementation of the commissioner's plan~~

~~immediately upon receipt of the plan in writing.~~ COMMISSIONER SHALL ORDER 1 OR MORE OF THE FOLLOWING:

(A) THAT THE CORPORATION BE PLACED UNDER INDEPENDENT SUPERVISION.

(B) THAT THE CORPORATION BE PLACED UNDER OUTSIDE MANAGEMENT FOR ITS ACTIVITIES DEALING WITH CLAIMS PAYMENTS.

(C) THAT THE CORPORATION SHALL NOT WRITE ANY NEW HEALTH CARE COVERAGE.

(D) THAT THE CORPORATION BE DISSOLVED AND LIQUIDATED.

(11) Contributions to the contingency reserve shall consist of 2 contribution components. The first is the contribution for risk which shall be actuarially determined as a normal part of the rate-making process. The second is the contribution for plan-wide viability. Both components shall be considered contributions to the contingency reserve and shall be taken into consideration in determining compliance with this section.

(12) With respect to contributions for plan-wide viability, those contributions shall be made in accordance with the following:

(a) For contributions by small group and nongroup subscribers, if the contingency reserve is below 65% of the target, the contribution rate shall be 1% of the rate established pursuant to part 6; if the contingency reserve is between 65% and 95% of the target, the contribution rate shall be 0.5% of the rate established pursuant to part 6; if the contingency reserve is greater than 95% of the target, the contribution rate shall be 0%.

(b) For contributions by medium group and large group subscribers, if the contingency reserve is below 65% of the target, the contribution rate shall be 1% of the rate established pursuant to part 6; if the contingency reserve is between 65% and 105% of the target, the contribution shall be 0.5% of the rate established pursuant to part 6; if the contingency reserve is greater than 105% of the target, the contribution rate shall be 0%.

(c) At any time the corporation and the commissioner, by mutual agreement, may enter into a stipulation setting forth uniform adjustments to the contributions established in subdivisions (a) and (b).

(13) As used in this section:

(a) "Actuary" means a person who has the professional designation of a fellow of the society of actuaries, or a fellow of the society of casualty actuaries.

(b) "Distribution of business" means the percentage of a health care corporation's total business attributable to a given line of business, based on dollar amount of incurred claims and incurred expenses.

(c) "Risk factor" means the relative probability of loss associated with a given line of business, expressed as a percentage of incurred claims and incurred expenses for a calendar year.

(14) Arrangements for health benefit programs authorized under section 207(1)(f) shall not be included under this section

unless, as part of the arrangement, contributions are made to the contingency reserve.

(15) The costs of a panel established under subsection (6) shall be split equally between a health care corporation and the commissioner, except that both the corporation and the commissioner shall pay the full costs associated with their appointed actuary.

(16) Provisions in this section concerning contributions to the contingency reserve do not apply to the Michigan Caring Program created in section 436.

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~~ SUBJECT TO SECTION 211A, 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~~ SUBJECT TO SECTION 211A, 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~~ SUBJECT TO SECTION 211A, FOR the purpose of administering any publicly supported health benefit plan, subcontract with any organization ~~which~~ 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~~ SUBJECT TO SECTION 211A, 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, ~~42 U.S.C. 1395c to 1395w~~ CHAPTER 531, 49 STAT. 620, 42 U.S.C. 1395c TO 1395i, 1395i-2 TO 1395i-4, 1395j TO 1395t, 1395u TO 1395w-2, AND 1395w-4; for the federal medicaid program established under title XIX of the social security act,

~~42 U.S.C. 1396 to 1396k; for the child health act of 1967, 42 U.S.C. 701 to 716~~ CHAPTER 531, 49 STAT. 620, 42 U.S.C. 1396 TO 1396f AND 1396i TO 1396u; UNDER TITLE V OF THE SOCIAL SECURITY ACT, CHAPTER 531, 49 STAT. 620, 42 U.S.C. 701 TO 703, 704, AND 705 TO 709; 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~~ SUBJECT TO SECTION 211A, PROVIDE administrative services only and cost-plus arrangements for any health benefit plan established by a subscriber group, subject to the requirements of section 211.

(h) Establish, own, and operate a health maintenance organization, subject to the requirements of the public health code, Act No. 368 of the Public Acts of 1978, as amended, being sections 333.1101 to 333.25211 of the Michigan Compiled Laws.

(i) Guarantee loans for the education of persons who are planning to enter or have entered a profession that is licensed, or 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, 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) 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, Act No. 218 of the Public Acts of 1956, being sections 500.106 and 500.110 of the Michigan Compiled Laws, whether engaged in a similar or different

business, or governmental or other activity, including banking corporations or trust companies, IF LOCATED WITHIN THE UNITED STATES. 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~~ AN insurer LOCATED WITHIN THE UNITED STATES, 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*) Will not result in the health care corporation owning or controlling 10% or more of the voting securities of the insurer.

Nothing in this subdivision shall be interpreted as expanding the lawful purposes of a health care corporation under this act. Except where expressly authorized by statute, a health care corporation shall not indirectly engage in any investment activity ~~which~~ THAT it may not engage in directly. A health care corporation shall not guarantee or become surety upon a bond or other undertaking securing the deposit of public money.

(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 ~~which~~ THAT do not significantly affect rates charged to subscribers.

(t) Participate with others in any joint venture ~~with respect to any transaction which~~ 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) OWN OR OPERATE A SUBSIDIARY WITH THE PRIOR APPROVAL OF THE COMMISSIONER AND ATTORNEY GENERAL, WHICH SHALL NOT BE GIVEN UNTIL AFTER A PUBLIC HEARING. A HEALTH CARE CORPORATION SHALL ONLY OWN OR OPERATE A SUBSIDIARY THAT ENHANCES THE CORPORATION'S

ABILITY TO PROVIDE THE GREATEST POSSIBLE ACCESS TO QUALITY HEALTH CARE TO THE GREATEST NUMBER OF MICHIGAN CITIZENS.

(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 OWN OR OPERATE ANY OFF-SHORE CAPTIVE INSURERS OR CASUALTY INSURERS INCLUDING PROFESSIONAL LIABILITY INSURERS.

SEC. 211A. (1) A HEALTH CARE CORPORATION SHALL NOT ENTER INTO ANY CONTRACTS CONTAINING AN ADMINISTRATIVE SERVICES ONLY OR COST PLUS ARRANGEMENT. A HEALTH CARE CORPORATION SHALL TERMINATE ALL EXISTING ADMINISTRATIVE SERVICES ONLY OR COST PLUS ARRANGEMENTS BY NO LATER THAN 1 YEAR AFTER THE EFFECTIVE DATE OF THIS SECTION OR THE NEXT RENEWAL DATE FOR THE ADMINISTRATIVE SERVICES ONLY OR COST PLUS ARRANGEMENT, WHICHEVER IS SOONER.

(2) A HEALTH CARE CORPORATION SHALL NOTIFY ALL PARTICIPATING PROVIDERS AND PROVIDERS WHO PARTICIPATE ON AN INDIVIDUAL CASE OR SERVICE BASIS, AND WHO RECEIVE REIMBURSEMENT PURSUANT TO AN ADMINISTRATIVE SERVICES ONLY OR COST PLUS ARRANGEMENT, THAT THE APPLICABLE COVERAGE IS PURSUANT TO AN ADMINISTRATIVE SERVICES ONLY OR COST PLUS ARRANGEMENT AND THE DATE THAT IT WILL TERMINATE OR NOT BE RENEWED.

(3) A HEALTH CARE CORPORATION SHALL PROVIDE EACH SUBSCRIBER WHOSE CONTRACT FOR HEALTH CARE BENEFITS CONTAINS AN ADMINISTRATIVE SERVICES ONLY OR COST PLUS ARRANGEMENT WITH A NEW IDENTIFICATION CARD BY NO LATER THAN 60 DAYS AFTER THE EFFECTIVE DATE OF THIS SECTION. THE IDENTIFICATION CARD SHALL CLEARLY DESIGNATE THAT THE COVERAGE IS PURSUANT TO AN ADMINISTRATIVE SERVICES ONLY OR COST PLUS ARRANGEMENT.

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 ~~which~~ 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.

(4) Nothing in subsection (3) shall 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 ~~which~~ 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.

(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, ACT NO. 64 OF THE PUBLIC ACTS OF 1984, BEING SECTIONS 550.251 TO 550.255 OF THE MICHIGAN COMPILED LAWS.

(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.~~

(7) ~~(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 ~~which~~ THAT is to be used for acute care.

SEC. 401E. NOTWITHSTANDING ANY OTHER PROVISION OF THIS ACT, A HEALTH CARE CORPORATION SHALL NOT DO THE FOLLOWING:

(A) REFUSE TO PAY OR REFUSE TO REIMBURSE FOR COVERED SERVICES PERFORMED BY A HEALTH CARE PROVIDER ACTING WITHIN THE SCOPE OF HIS OR HER LICENSURE.

(B) REFUSE PARTICIPATION TO A LICENSED HEALTH CARE PROVIDER BECAUSE THE PROVIDER IS NOT AFFILIATED WITH ANOTHER HEALTH CARE PROVIDER.

SEC. 401F. IF A HEALTH CARE CORPORATION GROUP OR NONGROUP CERTIFICATE PROVIDES FOR HEALTH CARE BENEFITS FOR A HEALTH CARE SERVICE AND REQUIRES PRIOR APPROVAL OR AUTHORIZATION, ONCE THAT APPROVAL OR AUTHORIZATION IS GIVEN BY THE CORPORATION THOSE BENEFITS OR REIMBURSEMENT FOR THE PROVISION OF THE SERVICE SHALL NOT BE DENIED BECAUSE THE SERVICE WAS RENDERED BY A LICENSED HEALTH CARE PROVIDER SO LONG AS THE PROVIDER WAS OPERATING WITHIN THE SCOPE OF PRACTICE OF HIS OR HER LICENSURE.

Sec. 403. (1) A health care corporation, on a timely basis, shall pay to a member, TO A NONPARTICIPATING PROVIDER AT A MEMBER'S DIRECTION, or TO a participating provider benefits as are entitled and provided under the applicable certificate. ~~When~~ IF not paid on a timely basis, benefits payable to a member shall bear simple interest from a date ~~60~~ 30 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.

(2) A health care corporation shall specify in writing the materials ~~which~~ 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~~ 30 days after receipt of the claim form by the corporation.

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, shall be entitled to a ~~private informal managerial level conference with the corporation, and to a~~ review before the commissioner. ~~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 include all of the following:~~

~~(a) 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.~~

~~(b) A method for resolving the dispute promptly and informally, while protecting the interests of both the person and the corporation.~~

~~(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 shall be entitled to a determination of the matter by the commissioner.~~

~~(4)~~ The commissioner shall ~~by rule~~ establish AN INFORMAL REVIEW HEARING PURSUANT TO THE ADMINISTRATIVE PROCEDURES ACT. ~~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.~~

(2) ~~(5)~~ If either the health care corporation or the person disagrees with a determination of the commissioner under this section, the commissioner, if requested to do so by either party, shall proceed to hear the matter as a contested case under the administrative procedures act.

Sec. 501. (1) A health care corporation subject to this act may enter into contracts with health care facilities IF APPROVED BY THE COMMISSIONER. THE COMMISSIONER HAS 90 DAYS AFTER SUBMISSION OF A PROPOSED CONTRACT BY THE HEALTH CARE CORPORATION TO APPROVE OR REJECT THE PROPOSED CONTRACT. IF THE COMMISSIONER REJECTS THE PROPOSED CONTRACT, THE COMMISSIONER SHALL STATE HIS OR HER REASONS FOR REJECTION IN WRITING. THE HEALTH CARE CORPORATION MAY ASK THE COMMISSIONER TO REVIEW HIS OR HER REJECTION AFTER THE CORPORATION HAS CORRECTED PROBLEMS CITED BY THE COMMISSIONER. THE COMMISSIONER SHALL REVIEW THE REJECTED PROPOSED CONTRACT WITHIN 30 DAYS OF A REQUEST TO REVIEW. IF THE COMMISSIONER AGAIN REJECTS THE PROPOSED CONTRACT, THE HEALTH CARE CORPORATION MAY AGAIN CORRECT AND REQUEST REVIEW OR MAY APPEAL THE COMMISSIONER'S DECISION PURSUANT TO THE ADMINISTRATIVE PROCEDURES ACT.

(2) Contracts entered into under this section shall be subject to the provisions of sections 504 to 518.

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 ~~which~~ THAT the professional health care providers 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 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. ~~Until January 1, 1993, as used in this subdivision, provider does not include a person licensed as a dentist under part 166 of the public health code, Act No. 368 of the Public Acts of 1978, being sections 333.16601 to 333.16648 of the Michigan Compiled Laws.~~

(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, handicap, or lawful occupation of the member entitled to health care benefits.

(2) A contract entered into pursuant to 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 prior to August 27, 1985 and ~~which~~ 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 AND ANY PROVISION IN A PARTICIPATING CONTRACT TO THAT EFFECT IS NULL AND VOID. 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 ~~shall~~ DOES not apply to limitations in benefits contained in certificates, to the reimbursement provisions of a provider contract or reimbursement arrangement, ~~nor~~ 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 ~~which~~ THAT are overutilized, including those services rendered, ordered, or prescribed to an extent ~~which~~ THAT is greater than reasonably necessary. THE DETERMINATION OF THE MEDICAL NECESSITY OF ANY MEDICAL TREATMENT OR ORDER OF GOODS OR SERVICES FROM ANY ANCILLARY OR OUTSIDE SUPPLIER OR PROVIDER SHALL BE THE RESPONSIBILITY OF THE TREATING PHYSICIAN AND SHALL BE PRESUMED TO BE REIMBURSABLE. A HEALTH CARE CORPORATION SHALL ASSERT ITS RIGHT TO REFUSE TO REIMBURSE A CLAIM FOR RECOVERY BASED ON LACK OF MEDICAL NECESSITY WITHIN THE SAME TIME PERIODS AS THOSE FIXED BY THE CORPORATION FOR SUBMISSION OF CLAIMS OR LOSE THE RIGHT TO REFUSE REIMBURSEMENT.

(4) A health care corporation may provide to a member, upon request, a list of providers with whom the corporation contracts AND A VERIFIED LIST OF THE PROVIDER'S SPECIFICATIONS, 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~~ THAT can be publicly displayed, to providers who participate on all claims for covered health care services rendered to subscribers.

(6) This section shall not be construed to 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 shall be subject to the provisions of sections 504 to 518.

(8) A health care corporation shall not deny participation to a freestanding medical or 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, Act No. 368 of the Public Acts of 1978, being sections 333.20801 to 333.20821 of the Michigan Compiled Laws, and complies with part ~~221~~ 222 of the public health code, Act No. 368 of the Public Acts of 1978, as amended, being sections ~~333.22101 to 333.22181~~ 333.22201 TO 333.22260 of the Michigan Compiled Laws.

SEC. 503A. NOTWITHSTANDING ANY OTHER PROVISION OF THIS ACT, A HEALTH CARE CORPORATION SHALL REIMBURSE FOR HEALTH CARE BENEFITS RECEIVED AT A REASONABLE RATE BASED ON THE AVERAGE REIMBURSEMENT RATE FOR THE SAME HEALTH CARE SERVICE BY THE SAME CLASS OF PROVIDERS IN ILLINOIS, INDIANA, OHIO, PENNSYLVANIA, AND WISCONSIN.

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. THE NUMBER OF PROVIDERS SHALL BE INDEPENDENTLY VERIFIED AND REPORTED ANNUALLY TO THE COMMISSIONER.

(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 AND THAT IS REASONABLE COMPARED TO REIMBURSEMENT AMOUNTS IN SURROUNDING STATES.

(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).

SEC. 505A. (1) A HEALTH CARE CORPORATION SHALL FURNISH TO THE COMMISSIONER BY DECEMBER 31 OF EACH YEAR THE NAMES AND, WHERE APPLICABLE, THE SPECIALTIES OF ALL PARTICIPATING PROVIDERS AND SHALL NAME THE PARTICIPATING PROVIDERS WHO ARE RESIDENTS.

(2) A HEALTH CARE CORPORATION SHALL NOT DISPARAGE IN ANY MANNER ANY PHYSICIAN WHO REFUSES TO PARTICIPATE WITH THE CORPORATION. A CORPORATION WHO VIOLATES THIS SUBSECTION MAY BE SUBJECT TO A CIVIL ACTION FOR DAMAGES.

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) OR MADE BY THE INDEPENDENT HEARING OFFICER PURSUANT TO SECTION 515(3). 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.

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. THERE SHALL BE A FAIR AND REASONABLE APPEALS PROCESS ESTABLISHED AND MAINTAINED BY THE HEALTH CARE CORPORATION FOR AGGRIEVED PERSONS THAT ASSURES DUE PROCESS AND IMPARTIAL DECISION MAKING, THAT ASSURES THAT ALL CONTRACTUAL OBLIGATIONS FOR COVERAGE ARE MET, AND THAT PROHIBITS DISCRIMINATION. The request for an appeal shall identify the issue or issues ~~which~~ THAT 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) ENUMERATING ANY DEFICIENCIES THAT HAVE BEEN FOUND IN THE PROVIDER CLASS PLAN.

(C) ~~(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)~~ (3), 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~~ THAT the hearing officer determines should be retained as provided in section 506(4).

Sec. 518. (1) 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~~ THE COMMISSIONER MAY REVIEW

THE HEALTH CARE CORPORATION'S CONTINUED COMPLIANCE WITH SECTIONS 509 AND 516. IF THE COMMISSIONER DETERMINES THAT A HEALTH CARE CORPORATION HAS VIOLATED SECTION 509 OR 516, THE COMMISSIONER SHALL ORDER EITHER (A), (B), OR (C) AND IN ADDITION MAY ORDER (D), (E), OR (F):

(A) FOR AN INITIAL VIOLATION, A $10,000.00 CIVIL FINE PER VIOLATION.

(B) FOR A REPEAT VIOLATION, A $20,000.00 CIVIL FINE PER VIOLATION.

(C) FOR A WILLFUL OR GROSS VIOLATION, A $50,000.00 CIVIL FINE FOR AN INITIAL VIOLATION AND A $100,000.00 CIVIL FINE FOR A REPEAT VIOLATION.

(D) A CEASE AND DESIST ORDER.

(E) THAT A PROVIDER CONTRACT BE PLACED UNDER THE COMMISSIONER'S SUPERVISION.

(F) THAT THE CORPORATION CEASE DOING BUSINESS IN THIS STATE.

(2) PROVIDERS AND SUBSCRIBERS OF THE HEALTH CARE CORPORATION SHALL BE NOTIFIED OF ANY ORDERS ISSUED BY THE COMMISSIONER UNDER SUBSECTION (1).

(3) An appeal from a final determination of an independent hearing officer shall be conducted ONLY 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.

SEC. 519. A HEALTH CARE CORPORATION SHALL PUBLISH ANNUALLY A LIST OF ALL CONTRACTS THAT IT HAS ENTERED INTO WITH A VALUE OF

$1,000.00 OR MORE. THE LIST SHALL INCLUDE THE AMOUNT AND PURPOSE OF THE CONTRACT AND THE PARTIES SUBJECT TO THE CONTRACT. THE LIST SHALL BE PROVIDED TO THE GOVERNOR, THE SENATE AND HOUSE OF REPRESENTATIVES STANDING COMMITTEES ON INSURANCE AND HEALTH ISSUES, AND THE COMMISSIONER, AND UPON REQUEST TO PARTICIPATING PROVIDERS AND SUBSCRIBERS. A HEALTH CARE CORPORATION SHALL NOT ENTER INTO ANY CONTRACTS THAT ARE NOT DIRECTLY RELATED TO HEALTH CARE OR HEALTH RESEARCH.

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 AND SHALL BE COMMUNITY RATED. 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, SUBJECT TO SECTION 211A, 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. 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 REVIEW 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, SUBJECT TO SECTION 211A, 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 ~~when~~ 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.

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 the corporate contingency reserve that is consistent with the attainment or maintenance of the target contingency reserve level prescribed in section 205; 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 the elements listed above, 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

contingency reserve positions 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 contingency reserve positions 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. The Michigan caring program created in section 436 is not subject to any assessment or surcharge for cost transfer under this subsection.

(6) A RATE INCREASE SHALL NOT BE LEVIED TO MAKE UP FOR LOSSES FROM ILLEGAL ACTIVITIES OR FROM ACTIVITIES PERFORMED IN VIOLATION OF THIS ACT.

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 INCLUDING ALL AMOUNTS PAID FOR ADVERTISING AND SPONSORSHIP OF NONHEALTH RELATED ACTIVITIES AND ALL GRANTS AWARDED BY THE CORPORATION.

(d) Projected trend factors.

(e) Projected administrative expenses INCLUDING ALL AMOUNTS PAID FOR ADVERTISING AND SPONSORSHIP OF NONHEALTH RELATED ACTIVITIES AND ALL GRANTS AWARDED BY THE CORPORATION.

(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~~ THAT 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~~ THAT 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.

Section 2. Section 211 of Act No. 350 of the Public Acts of 1980, being section 550.1211 of the Michigan Compiled Laws, is repealed effective 1 year after the effective date of this amendatory act.