HOUSE SUBSTITUTE FOR

SENATE BILL NO. 460

A bill to amend 1956 PA 218, entitled

"The insurance code of 1956,"

by amending section 3406q (MCL 500.3406q), as added by 2002 PA 538, and by adding chapter 37.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Sec. 3406q. (1) An expense-incurred hospital, medical, or surgical policy or certificate delivered, issued for delivery, or renewed in this state that provides pharmaceutical coverage and a health maintenance organization contract **that provides pharmaceutical coverage** shall provide coverage for an off-label use of a federal food and drug administration approved drug and the reasonable cost of supplies medically necessary to administer the drug.

(2) Coverage for a drug under subsection (1) applies if all of the following conditions are met:

(a) The drug is approved by the federal food and drug administration.

(b) The drug is prescribed by an allopathic or osteopathic physician for the treatment of either of the following:

(*i*) A life-threatening condition so long as the drug is medically necessary to treat that condition and the drug is on the plan formulary or accessible through the health plan's formulary procedures.

(*ii*) A chronic and seriously debilitating condition so long as the drug is medically necessary to treat that condition and the drug is on the plan formulary or accessible through the health plan's formulary procedures.

(c) The drug has been recognized for treatment for the condition for which it is prescribed by 1 of the following:

(*i*) The American medical association drug evaluations.

(*ii*) The American hospital formulary service drug information.

(*iii*) The United States pharmacopoeia dispensing information, volume 1, "drug information for the health care professional".

(*iv*) Two articles from major peer-reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal.

(3) Upon request, the prescribing allopathic or osteopathic physician shall supply to the insurer or health maintenance organization documentation supporting compliance with subsection

(2).

(4) This section does not prohibit the use of a copayment, deductible, sanction, or a mechanism for appropriately controlling the utilization of a drug that is prescribed for a use different from the use for which the drug has been approved by the food and drug administration. This may include prior approval or a drug utilization review program. Any copayment, deductible, sanction, prior approval, drug utilization review program, or mechanism described in this subsection shall not be more restrictive than for prescription coverage generally.

(5) As used in this section:

(a) "Chronic and seriously debilitating" means a disease or condition that requires ongoing treatment to maintain remission or prevent deterioration and that causes significant long-term morbidity.

(b) "Life-threatening" means a disease or condition where the likelihood of death is high unless the course of the disease is interrupted or that has a potentially fatal outcome where the end point of clinical intervention is survival.

(c) "Off-label" means the use of a drug for clinical indications other than those stated in the labeling approved by the federal food and drug administration.

CHAPTER 37

SMALL EMPLOYER GROUP HEALTH COVERAGE

Sec. 3701. As used in this chapter:

(a) "Actuarial certification" means a written statement by a member of the American academy of actuaries or another individual

acceptable to the commissioner that a small employer carrier is in compliance with the provisions of section 3705, based upon the person's examination, including a review of the appropriate records and the actuarial assumptions and methods used by the carrier in establishing premiums for applicable health benefit plans.

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

(c) "Base premium" means the lowest premium charged or that could be charged for a rating period under a rating system by a small group carrier to small employers for a health benefit plan in a geographic area.

(d) "Carrier" means a person that provides health benefits, coverage, or insurance in this state. For the purposes of this chapter, carrier includes a health insurance company authorized to do business in this state, a nonprofit health care corporation, a health maintenance organization, a multiple employer welfare arrangement, or any other person providing a plan of health benefits, coverage, or insurance subject to state insurance regulation.

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

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

(*i*) A group health plan.

(*ii*) A health benefit plan.

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

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

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

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

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

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

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

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

(g) "Eligible employee" means an employee who works on a full-time basis with a normal workweek of 30 or more hours. Eligible employee includes an employee who works on a full-time basis with a normal workweek of 20 to 30 hours, if an employer so chooses and if this eligibility criterion is applied uniformly among all of the employer's employees and without regard to health status-related factors.

(h) "Geographic area" means an area in this state that includes not less than 1 entire county, established by a carrier pursuant to section 3705 and used for adjusting premiums for a health benefit plan subject to this chapter. In addition, if the geographic area includes 1 entire county and additional counties or portions of counties, the counties or portions of counties must be contiguous with at least 1 other county or portion of another county in that geographic area.

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

(*i*) Any plan, fund, or program that would not be, but for section 2721(e) of subpart 4 of part A of title XXVII of the public health service act, chapter 373, 110 Stat. 1967, 42

U.S.C. 300gg-21, an employee welfare benefit plan and that is established or maintained by a partnership, to the extent that the plan, fund, or program provides medical care, including items and services paid for as medical care, to present or former partners in the partnership, or to their dependents, as defined under the terms of the plan, fund, or program, directly or through insurance, reimbursement or otherwise, shall be treated, subject to subparagraph (*ii*), as an employee welfare benefit plan that is a group health plan.

(*ii*) The term "employer" also includes the partnership in relation to any partner.

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

(j) "Health benefit plan" or "plan" means an expense-incurred hospital, medical, or surgical policy or certificate, nonprofit health care corporation certificate, or health maintenance organization contract. Health benefit plan does not include accident-only, credit, dental, or disability income insurance; long-term care insurance; coverage issued as a supplement to liability insurance; coverage only for a specified disease or

illness; worker's compensation or similar insurance; or automobile medical-payment insurance.

(k) "Index rate" means the arithmetic average during a rating period of the base premium and the highest premium charged or that could be charged for each health benefit plan offered by each small employer carrier [to each small employer or sole proprietor] in a geographic area.

(*l*) "Nonprofit health care corporation" means a nonprofit health care corporation operating pursuant to the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1101 to 550.1704.

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

(n) "Rating period" means the calendar period for which premiums established by a small employer carrier are assumed to be in effect, as determined by the small employer carrier.

(o) "Small employer" means any person, firm, corporation, partnership, limited liability company, or association actively engaged in business who, on at least 50% of its working days during the preceding and current calendar years, employed at least 2 but not more than 50 eligible employees. In determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for state taxation purposes shall be considered 1 employer.

(p) "Small employer carrier" means either of the following:

(*i*) A carrier that offers health benefit plans covering the employees of a small employer.

(*ii*) A carrier under section 3703(3).

(q) "Sole proprietor" means an individual who is a sole proprietor or sole shareholder in a trade or business through which he or she earns at least 50% of his or her taxable income as defined in section 30 of the income tax act of 1967, 1967 PA 281, MCL 206.30, excluding investment income, and for which he or she has filed the appropriate internal revenue service form 1040, schedule C or F, for the previous taxable year; who is a resident of this state; and who is actively employed in the operation of the business, working at least 30 hours per week in at least 40 weeks out of the calendar year.

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

Sec. 3703. (1) This chapter applies to any health benefit plan that provides coverage to a small employer if either of the following is met:

(a) Any portion of the premium or benefits is paid by or on behalf of the small employer or through salary deductions by the small employer.

(b) An eligible employee or dependent is reimbursed for any

portion of the premium, through wage adjustments or otherwise, by or on behalf of the small employer.

(2) Except as provided in subsection (1), this chapter does not apply to individual health insurance policies that are subject to policy form and premium approval by the commissioner.

(3) A nonprofit health care corporation shall make available upon request a health benefit plan to a sole proprietor. This chapter does apply to a nonprofit health care corporation providing a health benefit plan to a sole proprietor and to any other small employer carrier that elects to provide a health benefit plan to a sole proprietor.

[Sec. 3704. Notwithstanding section 3501, a health maintenance organization is not required to offer basic health services as defined in section 3501 in a health benefit plan under this chapter. A health maintenance organization shall make available upon request a health benefit plan that covers at a minimum physician services, inpatient services, outpatient services, ambulance services, and diagnostic lab and x-ray services. All health benefit plans offered by a health maintenance organization shall include preventative health services.]

Sec. 3705. (1) For adjusting premiums for health benefit plans subject to this chapter, a carrier may establish up to 10 geographic areas in this state. A nonprofit health care corporation shall establish geographic areas that cover all counties in this state.

[(2) Except as otherwise provided in subsection (3), the premiums for a health benefit plan under this chapter are subject to the following:

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(a) For a nonprofit health care corporation, only industry and age may be used for determining the premiums in a geographic area for a small employer or sole proprietor located in that

geographic area and the premiums charged during a rating period to small employers and sole proprietors located in that

geographic area with the same or similar coverage shall not vary from the index rate by more than 35% of the index rate.

(b) For a health maintenance organization, only industry, age, gender, group size, and duration of coverage may be used for determining the premiums in a geographic area for a small employer or sole proprietor located in that geographic area and the premiums charged during a rating period to small employers and sole proprietors located in that geographic area with the same or similar coverage shall not vary from the index rate by more than 35% of the index rate.

(c) For a small employer carrier other than a nonprofit health care corporation or health maintenance organization, industry, age, gender, and group size may be used for determining the premiums in a geographic area for a small employer or sole proprietor located in that geographic area, except that, effective March 1, 2008, the maximum premium differential for age for a health benefit plan in a geographic area shall be 5 to 1. In addition, claims experience, health status, and duration of coverage may also be used for determining the premiums in a geographic area, but the premiums charged during a rating period to small employers and sole proprietors located in that geographic area with the same or similar coverage for claims experience, health status, and duration of coverage characteristics shall not vary from the index rate by more than 35% of the index rate.

[(3) This subsection applies beginning on the effective date of this chapter and continuing until the next renewal period for a health benefit

plan following February 29, 2008 at which time subsection (2) shall apply.] The premiums for a plan described in this subsection are subject to the following:

(a) For a nonprofit health care corporation, industry and age may only be used if the result is to lower the premium in a health benefit plan in a geographic area for a small employer or sole proprietor located in that geographic area. This subdivision only applies during a health benefit plan renewal period that ends before March 1, 2005.

(b) For a renewal occurring on or after March 1, 2005 and through February 28, 2006, as follows:

(*i*) For a nonprofit health care corporation, only industry and age may be used for determining the premiums in a geographic area for a small employer or sole proprietor located in that geographic area and the premiums charged during a rating period to small employers and sole proprietors located in that geographic area with the same or similar coverage shall not be higher than 10% above the index rate nor lower than 20% below the index rate.

(*ii*) For a health maintenance organization, only industry, age, gender, group size, and duration of coverage may be used for determining the premiums in a geographic area for a small employer or sole proprietor located in that geographic area and the premiums charged during a rating period to small employers and sole proprietors located in that geographic area with the same or similar coverage shall not vary from the index rate by more than 70% of the index rate.

(*iii*) For a small employer carrier other than a nonprofit health care corporation or health maintenance organization, industry, age, gender, and group size may be used for determining the premiums in a geographic area for a small employer or sole proprietor located in that geographic area. In addition, claim experience, health status, and duration of coverage may also be used for determining the premiums in a geographic area, but the premiums charged during a rating period to small employers and sole proprietors with the same or similar coverage for claims experience, health status, and duration of coverage characteristics shall not vary from the index rate by more than 70% of the index rate.

(c) For a renewal occurring on or after March 1, 2006 and through February 28, 2007, as follows:

(*i*) For a nonprofit health care corporation, only industry and age may be used for determining the premiums for a small employer or sole proprietor located in that geographic area and the premiums charged during a rating period to small employers and sole proprietors located in that geographic area with the same or similar coverage shall not be higher than 20% above the index rate nor lower than 30% below the index rate.

(*ii*) For a health maintenance organization, only industry, age, gender, group size, and duration of coverage may be used for determining the premiums in a geographic area for a small employer or sole proprietor located in that geographic area and the premiums charged during a rating period to small employers and sole proprietors located in that geographic area with the

same or similar coverage shall not vary from the index rate by more than 60% of the index rate.

(*iii*) For a small employer carrier other than a nonprofit health care corporation or health maintenance organization, industry, age, gender, and group size may be used for determining the premiums in a geographic area for a small employer or sole proprietor located in that geographic area. In addition, claim experience, health status, and duration of coverage may also be used for determining the premiums in a geographic area, but the premiums charged during a rating period to small employers and sole proprietors with the same or similar coverage for claims experience, health status, and duration of coverage characteristics shall not vary from the index rate by more than 60% of the index rate.

(d) For a renewal occurring on or after March 1, 2007 and through February 29, 2008, as follows:

(*i*) For a nonprofit health care corporation, only industry and age may be used for determining the premiums in a geographic area for a small employer or sole proprietor located in that geographic area and the premiums charged during a rating period to small employers and sole proprietors located in that geographic area with the same or similar coverage shall not be higher than 30% above the index rate nor lower than 35% below the index rate.

(*ii*) For a health maintenance organization, only industry, age, gender, group size, and duration of coverage may be used for determining the premiums in a geographic area for a small

employer or sole proprietor located in that geographic area and the premiums charged during a rating period to small employers and sole proprietors located in that geographic area with the same or similar coverage shall not vary from the index rate by more than 50% of the index rate.

(*iii*) For a small employer carrier other than a nonprofit health care corporation or health maintenance organization, industry, age, gender, and group size may be used for determining the premiums in a geographic area for a small employer or sole proprietor located in that geographic area. In addition, claim experience, health status, and duration of coverage may also be used for determining the premiums in a geographic area, but the premiums charged during a rating period to small employers and sole proprietors with the same or similar coverage for claims experience, health status, and duration of coverage characteristics shall not vary from the index rate by more than 50% of the index rate.

(4) For a sole proprietor, a small employer carrier may charge an additional amount of up to 25% above the premiums in subsections (2) and (3).

(5) Except as provided in subsection (3), the percentage increase in the premium charged to a small employer for a new rating period shall not exceed the sum of the following:

(a) The percentage change in the base premium for the health benefit plan measured from the first day of the prior rating period to the first day of the new rating period. For a health benefit plan for which the small employer carrier is not issuing

new policies, the carrier shall use the percentage change in the base premium.

(b) An adjustment as follows:

(*i*) For a nonprofit health care corporation, an adjustment not to exceed 35% annually, and adjusted pro rata for rating periods of less than 1 year, due to industry and age of the small employer's employees or the employees' dependents or of the sole proprietor or the sole proprietor's dependents.

(*ii*) For a health maintenance organization, an adjustment not to exceed 35% annually, and adjusted pro rata for rating periods of less than 1 year, due to industry, age, gender, group size, and duration of coverage of the small employer's employees or the employees' dependents or of the sole proprietor or the sole proprietor's dependents.

(*iii*) For a small employer carrier other than a nonprofit health care corporation or health maintenance organization, [an adjustment not to exceed 35% annually, and adjusted pro rata for rating periods of less than 1 year, due to industry, age, gender, and group size of the small employer's employees or the employees' dependents or of the sole proprietor or the sole proprietor's dependents and] an adjustment not to exceed 15% annually, and adjusted pro rata for rating periods of less than 1 year, due to claims experience, health status, and duration of coverage of the small employer's employees or employees' dependents or of the sole proprietor or the sole proprietor's dependents.

(c) Any adjustment due to change in coverage.

(6) Beginning 1 year after the effective date of this chapter, if a small employer or sole proprietor had been self-insured for health benefits immediately preceding application for a health benefit plan subject to this chapter, a carrier may charge an additional premium of up to 33% above the

premium in subsection (2) or (3) for no more than 2 years.

(7) Notwithstanding subsection (2) or (3), health benefit plan options, number of family members covered, and medicare eligibility may be used in establishing a small employer's or sole proprietor's premium.

(8) A small employer carrier shall apply all rating factors consistently with respect to all small employers and sole proprietors in a geographic area. Except as provided in subsection (7), a small employer carrier shall bill a small employer group only with a composite rate and shall not bill so that 1 or more employees in the small employer group are charged a higher premium than another employee in that small employer group.

Sec. 3706. (1) A small employer carrier may apply an open enrollment period for sole proprietors. If a small employer carrier applies an open enrollment period for sole proprietors, the open enrollment period shall be offered at least annually and shall be at least 1 month long.

(2) A small employer carrier is not required to offer or provide to a sole proprietor all health benefit plans available to small employers who are not sole proprietors. However, a small employer carrier is required to offer to all sole proprietors all health benefit plans in a geographic area that are available to any sole proprietor in that geographic area.

(3) A small employer carrier may exclude or limit coverage for a sole proprietor for a condition only if the exclusion or limitation relates to a condition for which medical advice,

diagnosis, care, or treatment was recommended or received within 6 months before enrollment and the exclusion or limitation does not extend for more than 6 months after the effective date of the health benefit plan.

(4) A small employer carrier shall not impose a preexisting condition exclusion for a sole proprietor that relates to pregnancy as a preexisting condition or with regard to a child who is covered under any creditable coverage within 30 days of birth, adoption, or placement for adoption, provided that the child does not experience a significant break in coverage and provided that the child was adopted or placed for adoption before attaining 18 years of age. A period of creditable coverage under this subsection shall not be counted for enrollment of an individual under a health benefit plan if, after this period and before the enrollment date, there was a 63-day period during all of which the individual was not covered under any creditable coverage.

Sec. 3707. (1) As a condition of transacting business in this state with small employers, every small employer carrier shall make available to small employers all health benefit plans it markets to small employers in this state. A small employer carrier shall be considered to be marketing a health benefit plan if it offers that plan to a small employer not currently receiving a health benefit plan from that small employer carrier. A small employer carrier shall issue any health benefit plan to any small employer that applies for the plan and agrees to make the required premium payments and to satisfy the other

reasonable provisions of the health benefit plan not inconsistent with this chapter.

(2) Except as otherwise provided in this subsection, a small employer carrier shall not offer or sell to small employers a health benefit plan that contains a waiting period applicable to new enrollees or late enrollees. However, a small employer carrier may offer or sell to small employers other than sole proprietors a health benefit plan that provides for an affiliation period of time that must expire before coverage becomes effective for a new enrollee or a late enrollee if all of the following are met:

(a) The affiliation period is applied uniformly to all new and late enrollees and dependents of the new and late enrollees of the small employer and without regard to any health status-related factor.

(b) The affiliation period does not exceed 60 days for new enrollees and does not exceed 90 days for late enrollees.

(c) The small employer carrier does not charge any premiums for the enrollee during the affiliation period.

(d) The coverage issued is not effective for the enrollee during the affiliation period.

Sec. 3708. (1) A health benefit plan offered to a small employer by a small employer carrier shall provide for the acceptance of late enrollees subject to this chapter.

(2) A small employer carrier shall permit an employee or a dependent of the employee, who is eligible, but not enrolled, to enroll for coverage under the terms of the small employer health

benefit plan during a special enrollment period if all of the following apply:

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

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

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

is effective not later than the first day of the first calendar month beginning after the date the completed request for enrollment is received.

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

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

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

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

dependent shall be effective as follows:

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

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

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

Sec. 3709. (1) Except as provided in this section, requirements used by a small employer carrier in determining whether to provide coverage to a small employer shall be applied uniformly among all small employers applying for coverage or receiving coverage from the small employer carrier. If a small employer carrier waives a minimum participation rule for a small employer, the carrier cannot later enforce that minimum participation rule for that small employer.

(2) A small employer carrier may deny coverage to a small employer if the small employer fails to enroll enough of its employees to meet the minimum participation rules established by the carrier pursuant to sound underwriting requirements. A minimum participation rule may require a small employer to enroll a certain number or percentage of employees with the small employer carrier as a condition of coverage. A minimum participation rule is subject to the following:

(a) For a small employer of 10 or fewer eligible employees, may require enrollment of up to 100% of the small employer's employees seeking health care coverage through the small employer.

(b) For a small employer of 11 to 25 eligible employees, may require enrollment of up to 75% of the small employer's employees seeking health care coverage through the small employer.

(c) For a small employer of 26 to 40 eligible employees, may require enrollment of up to 65% of the small employer's employees seeking health care coverage through the small employer.

(d) For a small employer of 41 to 50 eligible employees, may require enrollment of up to 50% of the small employer's employees seeking health care coverage through the small employer.

Sec. 3711. (1) Except as provided in this section, a small employer carrier that offers health coverage in the small employer group market in connection with a health benefit plan shall renew or continue in force that plan at the option of the small employer or sole proprietor.

(2) Guaranteed renewal under subsection (1) is not required in cases of: fraud or intentional misrepresentation of the small employer or, for coverage of an insured individual, fraud or misrepresentation by the insured individual or the individual's representative; lack of payment; noncompliance with minimum participation or employer contribution requirements; if the small employer carrier no longer offers that particular type of coverage in the market; or if the sole proprietor or small employer moves outside the geographic area.

Sec. 3712. (1) If a small employer carrier decides to discontinue offering all small employer health benefit plans in a geographic area, all of the following apply:

(a) The small employer carrier shall provide notice to the

commissioner and to each small employer covered by the small employer carrier in the geographic area of the discontinuation at least 180 days prior to the date of the discontinuation of the coverage.

(b) All small employer health benefit plans issued or delivered for issuance in the geographic area are discontinued and all current health benefit plans in the geographic area are not renewed.

(c) The small employer carrier shall not issue or deliver for issuance any small employer health benefit plans in the geographic area for 5 years beginning on the date the last small employer health benefit plan in the geographic area is not renewed under subdivision (b).

(d) The small employer carrier shall not issue or deliver for issuance for 5 years any small employer health benefit plans in an area that was not a geographic area where the small employer carrier was issuing or delivering for issuance small employer health benefit plans on the date notice was given under subdivision (a). The 5-year period under this subdivision begins on the date notice was given under subdivision (a).

(2) A nonprofit health care corporation shall not cease to renew all health benefit plans in a geographic area.

Sec. 3713. Each small employer carrier shall provide all of the following to a small employer upon request and upon entering into a contract with the small employer:

(a) The extent to which premiums for a specific small employer are established or adjusted due to any permitted

characteristic and rating factors of the small employer's employees and the employees' dependents.

(b) The provisions concerning the carrier's right to change premiums, permitted characteristics, and any rating factors under this chapter that affect changes in premiums.

(c) The provisions relating to renewability of coverage.

Sec. 3715. (1) Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(2) Each small employer carrier shall file each March 1 with the commissioner an actuarial certification that the carrier is in compliance with this section and that the rating methods of the carrier are actuarially sound. A copy of the actuarial certification shall be retained by the carrier at its principal place of business.

(3) A small employer carrier shall make the information and documentation described in subsection (1) available to the commissioner upon request. The information and documentation described in subsection (1) are not subject to disclosure under the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246, to persons outside of the office of financial and insurance services unless agreed to by the small employer carrier or as ordered by a court of competent jurisdiction.

(4) This section is in addition to, and not in substitution of, the applicable filing provisions in this act and in the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1101 to 550.1704.

[Sec. 3716. This chapter does not apply to a health benefit plan covering an employee of a small employer that is a high deductible plan, as defined in section 220 of the internal revenue code of 1986, issued in conjunction with an Archer medical savings account or with a health reimbursement arrangement.]

Sec. 3717. [(1)] Upon a [request] for suspension by the small employer carrier and a finding by the commissioner after consulting with the attorney general that either the suspension is reasonable in light of the financial condition of the carrier or that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance, the commissioner may suspend all or any part of section 3705 as to The premiums applicable to 1 or more small employers for 1 or more rating periods and may suspend section 3712(1)(c) or (d).

[(2) A small employer carrier that is not a nonprofit health care corporation or health maintenance organization and whose capital and surplus as concerns policyholders as of December 31, 2003 as shown on the annual financial statement filed with the commissioner is $8,000,000.00 or less may be exempt from this chapter, if the carrier files with the commissioner a written request for an exemption and the commissioner, after reviewing the carrier's request and annual financial statement, determines an exemption is warranted.

(3) An exemption granted under subsection (2) is effective for 3 years, so long as the carrier experiences no disproportionate growth in premium volume in business written, or changes in the carrier's pattern, location, or contours of that insurance business which indicate that the carrier is utilizing its exemption to take unfair competitive advantage of competing carriers who do not qualify for the exemption. A carrier that meets the requirements of subsections (2) to (5) may reapply every 3 years to the commissioner for a subsection (2) exemption. The commissioner shall determine whether the continuation of the exemption is warranted.

(4) The commissioner shall not grant an exemption under subsection (2) to any carrier that directly, or indirectly through 1 or more intermediaries, controls, is controlled by, or is under common control with a carrier whose surplus as concerns policyholders is in excess of the amount stated in subsection (2).

(5) A carrier admitted to do business in this state after January 1, 2004 is not eligible for an exemption under subsection (2).

(6) This chapter does not apply to a health benefit plan covering an employee of a small employer that is a high deductible plan, as defined in section 220 of the internal revenue code of 1986, issued in conjunction with an Archer medical savings account or with a health reimbursement arrangement.]

Sec. 3718. A nonprofit health care corporation is subject to section 619 of the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1619.

Sec. 3721. (1) By March 1, 2006 and by each March 1 after 2006, the commissioner shall make a determination as to whether a reasonable degree of competition in the small employer carrier health market exists on a statewide basis. If the commissioner determines that a reasonable degree of competition in the small employer carrier health market does not exist on a statewide basis, the commissioner shall hold a public hearing and shall issue a report delineating specific classifications and kinds or types of insurance, if any, where competition does not exist and any suggested statutory or other changes necessary to increase or encourage competition. The report shall be based on relevant

economic tests, including, but not limited to, those in subsection (3). The findings in the report shall not be based on any single measure of competition, but appropriate weight shall be given to all measures of competition.

(2) If the results of the report issued under subsection (1) are disputed or if the commissioner determines that circumstances that the report was based on have changed, the commissioner shall issue a supplemental report to the report under subsection (1) that includes a certification of whether or not a reasonable degree of competition exists in the small employer carrier health market. The supplemental report and certification shall be issued not later than December 15 immediately following the release of the report under subsection (1) that this report supplements and shall be supported by substantial evidence.

(3) All of the following shall be considered by the commissioner for purposes of subsections (1) and (2):

(a) The extent to which any carrier controls all or a portion of the small employer carrier health benefit plan market.

(b) Whether the total number of carriers writing small employer health benefit plan coverage in this state is sufficient to provide multiple options to small employers.

(c) The disparity among small employer health benefit plan premiums and classifications to the extent that those classifications result in rate differentials.

(d) The availability of small employer health benefit plan coverage to small employers in all geographic areas and all types of business.

(e) The overall rate level that is not excessive, inadequate, or unfairly discriminatory.

(f) Any other factors the commissioner considers relevant.

(4) The reports and certifications required under subsections (1) and (2) shall be forwarded to the governor, the clerk of the house, the secretary of the senate, and all the members of the senate and house of representatives standing committees on insurance and health issues.

Sec. 3723. The provisions of this chapter apply to each health benefit plan for a small employer or sole proprietor that is delivered, issued for delivery, renewed, or continued in this state on or after the effective date of this chapter. For purposes of this section, the date a health benefit plan is continued is the first rating period that begins on or after the effective date of this chapter.

Enacting section 1. This amendatory act does not take effect unless Senate Bill No. 234 of the 92nd Legislature is enacted into law.

Enacting section 2. This amendatory act takes effect 6 months after the date this amendatory act is enacted.