SUBSTITUTE FOR

SENATE BILL NO. 234
(As amended May 28, 2003)

A bill to amend 1980 PA 350, entitled

"The nonprofit health care corporation reform act,"

by amending sections 204, 206, 207, 211, 401, 502, 602, 606, and 609 (MCL 550.1204, 550.1206, 550.1207, 550.1211, 550.1401, 550.1502, 550.1602, 550.1606, and 550.1609), section 207 as amended by 1999 PA 210, section 211 as amended by 1993 PA 127, section 401 as amended by 2000 PA 26, section 502 as amended by 1998 PA 446, and section 609 as amended by 1991 PA 61, and by adding sections 204a, 205a, 219, and 401j; and to repeal acts and parts of acts.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

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Sec. 204. (1) Before entering into contracts or securing applications of subscribers, the persons incorporating a health care corporation shall file all of the following in the office of the commissioner:

(a) Three copies of the articles of incorporation, with the certificate of the attorney general required under section 202(3) attached.

(b) A statement showing in full detail the plan upon which the corporation proposes to transact business.

(c) A copy of all certificates to be issued to subscribers.

(d) A copy of the financial statements of the corporation.

(e) Proposed advertising to be used in the solicitation of certificates for subscribers.

(f) A copy of the bylaws.

(g) A copy of all proposed contracts and reimbursement methods.

(2) The commissioner shall examine the statements and documents filed under subsection (1), may conduct any investigation ~~which~~ **that** he or she considers necessary, may request additional oral and written information from the incorporators, and may examine under oath any persons interested in or connected with the proposed health care corporation. The

commissioner shall ascertain whether all of the following conditions are met:

(a) The solicitation of certificates will not work a fraud upon the persons solicited by the corporation.

(b) The rates to be charged and the benefits to be provided are adequate, equitable, and not excessive, as defined in section 609.

(c) The amount of money actually available for working capital is sufficient to carry all acquisition costs and operating expenses for a reasonable period of time from the date of issuance of the certificate of authority, and is not less than $500,000.00 or a greater amount, if the commissioner considers it necessary.

(d) The amounts contributed as the working capital of the corporation are payable only out of amounts in excess of minimum required reserves of the corporation.

(e) Adequate and ~~reasonable reserves are provided, as defined in section 205~~ **unimpaired surplus is provided, as determined under section 204a**.

(3) If the commissioner finds that the conditions prescribed in subsection (2) are met, the commissioner shall do all of the following:

(a) Return to the incorporators 1 copy of the articles of incorporation, certified for filing with the ~~chief officer~~ **director** of the department of ~~commerce~~ **consumer and industry services** or of any other agency or department authorized by law to administer ~~Act No. 284 of the Public Acts of 1972, as~~

~~amended, being sections 450.1101 to 450.2099 of the Michigan Compiled Laws~~ **the business corporation act, 1972 PA 284, MCL 450.1101 to 450.2098**, or his or her designated representative, and 1 copy of the articles of incorporation certified for the records of the corporation itself.

(b) Retain 1 copy of the articles of incorporation for the commissioner's office files.

(c) Deliver to the corporation a certificate of authority to commence business and to issue certificates ~~which~~ **that** have been approved by the commissioner, or ~~which~~ **that** are exempted from prior approval pursuant to section 607(2) or ~~(7)~~ **(8)**, entitling subscribers to certain health care benefits.

Sec. 204a. (1) A health care corporation shall possess and maintain unimpaired surplus in an amount determined adequate by the commissioner to comply with section 403 of the insurance code of 1956, 1956 PA 218, MCL 500.403. The commissioner shall follow the risk-based capital requirements as developed by the national association of insurance commissioners in order to determine whether a health care corporation is in adequate compliance with section 403 of the insurance code of 1956, 1956 PA 218, MCL 500.403.

(2) If a health care corporation files a risk-based capital report that indicates that its surplus is less than the amount determined adequate by the commissioner under subsection (1), the health care corporation shall prepare and submit a plan for remedying the deficiency in accordance with risk-based capital requirements adopted by the commissioner. Among the remedies

that a health care corporation may employ are planwide viability contributions to surplus by subscribers.

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

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

(b) If the health care corporation's surplus is 150% or less than the authorized control level under risk-based capital requirements, the maximum contribution rate shall be 1% of the rate charged to subscribers for the benefits provided.

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

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

(5) Subject to this subsection, a health care corporation shall not maintain surplus in an amount that equals or is greater than 200% of the authorized control level under risk-based capital requirements multiplied by 5. If a health care corporation files a risk-based capital report that indicates that its surplus is more than the allowable maximum surplus permitted

under this subsection for 2 successive calendar years, the health care corporation shall file a plan for approval by the commissioner to adjust its surplus to a level below the allowable maximum surplus. If the commissioner disapproves the health care corporation's plan, the commissioner shall formulate an alternate plan and forward the alternate plan to the health care corporation. The health care corporation shall begin implementation of the plan immediately upon receipt of approval of its plan by the commissioner or upon receipt of the commissioner's alternate plan.

Sec. 205a. A health care corporation shall report financial information in conformity with sound actuarial practices and statutory accounting principles in the same manner as designated by the commissioner for other carriers pursuant to section 438(2) of the insurance code of 1956, 1956 PA 218, MCL 500.438. Approved permitted practices may be used by a health care corporation until January 1, 2007 to effectuate the transfer to statutory accounting principles required by this section.

Sec. 206. (1) The funds and property of a health care corporation shall be acquired, held, and disposed of only for the lawful purposes of the corporation and for the benefit of the subscribers of the corporation as a whole. A health care corporation shall only transact ~~such~~ business, receive, collect, and disburse ~~such~~ money, and acquire, hold, protect, and convey ~~such~~ property, ~~as are~~ **that is** properly within the scope of the purposes of the corporation as specifically set forth in section 202(1)(d), for the benefit of the subscribers of

the corporation as a whole, and consistent with this act.

(2) The funds of a health care corporation shall be invested only in securities permitted by the laws of this state for the investments of assets of life insurance companies, as described in chapter 9 of ~~Act No. 218 of the Public Acts of 1956, as amended, being sections 500.901 to 500.947 of the Michigan Compiled Laws~~ **the insurance code of 1956, 1956 PA 218, MCL 500.901 to 500.947**.

(3) Without regard to the limitation in subsection (2), up to 2% of the assets of the health care corporation may be invested in venture-type investments. For purposes of calculating ~~the contingency reserve pursuant to section 205~~ **adequate and unimpaired surplus under section 204a**, a venture-type investment shall be carried on the books of a health care corporation at the original acquisition cost, and losses may only be realized as an offset against gains from venture-type investments. All venture-type investments under this subsection shall provide employment or capital investment primarily within this state. Each investment under this subsection ~~shall be~~ **is** subject to prior approval by the board of directors. As used in this subsection, "venture-type investments" include:

(a) Common stock, preferred stock, limited partnerships, or similar equity interests acquired from the issuer subject to a provision barring resale without consent of the issuer for 5 years from the date of acquisition by the corporation.

(b) Unsecured debt instruments ~~which~~ **that** are either convertible into equity or have equity acquisition rights. These

debt instruments shall be subordinated by their terms to all borrowings of the issuer from other institutional lenders and shall have no part amortized during the first 5 years.

(4) A health care corporation shall not market or transact, as defined in sections 402a and 402b of ~~Act No. 218 of the Public Acts of 1956, being sections 500.402a and 500.402b of the Michigan Compiled Laws~~ **the insurance code of 1956, 1956 PA 218, MCL 500.402a and 500.402b**, any type of insurance described in chapter 6 of ~~Act No. 218 of the Public Acts of 1956, as amended, being sections 500.600 to 500.644 of the Michigan Compiled Laws~~ **the insurance code of 1956, 1956 PA 218, MCL 500.600 to 500.644**. This subsection shall not be construed to prohibit the provision of prepaid health care benefits.

Sec. 207. (1) A health care corporation, subject to any limitation provided in this act, in any other statute of this state, or in its articles of incorporation, may do any or all of the following:

(a) Contract to provide computer services and other administrative consulting services to 1 or more providers or groups of providers, if the services are primarily designed to result in cost savings to subscribers.

(b) Engage in experimental health care projects to explore more efficient and economical means of implementing the corporation's programs, or the corporation's goals as prescribed in section 504 and the purposes of this act, to develop incentives to promote alternative methods and alternative providers, including nurse midwives, nurse anesthetists, and

nurse practitioners, for delivering health care, including preventive care and home health care.

(c) For the purpose of providing health care services to employees of this state, the United States, or an agency, instrumentality, or political subdivision of this state or the United States, or for the purpose of providing all or part of the costs of health care services to disabled, aged, or needy persons, contract with this state, the United States, or an agency, instrumentality, or political subdivision of this state or the United States.

(d) For the purpose of administering any publicly supported health benefit plan, accept and administer funds, directly or indirectly, made available by a contract authorized under subdivision (c), or made available by or received from any private entity.

(e) For the purpose of administering any publicly supported health benefit plan, subcontract with any organization that has contracted with this state, the United States, or an agency, instrumentality, or political subdivision of this state or the United States, for the administration or furnishing of health services or any publicly supported health benefit plan.

(f) Provide administrative services only and cost-plus arrangements for the federal medicare program established by parts A and B of title XVIII of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. ~~1395 to 1395b, 1395b-2, 1395b-6 to 1395b-7,~~ 1395c to 1395i, 1395i-2 to 1395i-5, 1395j to 1395t, 1395u to 1395w, **and** 1395w-2 to 1395w-4; ~~, 1395w-21 to 1395w-28,~~

~~1395x to 1395yy, and 1395bbb to 1395ggg;~~ for the federal medicaid program established under title XIX of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1396 to ~~1396f, 1396g-1 to~~ 1396r-6, and 1396r-8 to 1396v; for title V of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 701 to 704 and 705 to 710; for the program of medical and dental care established by the military medical benefits amendments of 1966, Public Law 85-861, 80 Stat. 862; for the Detroit maternity and infant care--preschool, school, and adolescent project; and for any other health benefit program established under state or federal law.

(g) Provide administrative services only and cost-plus arrangements for any noninsured health benefit plan, subject to the requirements of sections 211 and 211a.

(h) Establish, own, and operate a health maintenance organization, subject to the requirements of the ~~public health code, 1978 PA 368, MCL 333.1101 to 333.25211~~ **insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302**.

(i) Guarantee loans for the education of persons who are planning to enter or have entered a profession that is licensed, certified, or registered under parts 161 to 182 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18237, and has been identified by the commissioner, with the consultation of the office of health and medical affairs in the department of management and budget, as a profession whose practitioners are in insufficient supply in this state or specified areas of this state and who agree, as a condition of receiving a guarantee of a

loan, to work in this state, or an area of this state specified in a listing of shortage areas for the profession issued by the commissioner, for a period of time determined by the commissioner.

(j) Receive donations to assist or enable the corporation to carry out its purposes, as provided in this act.

(k) Bring an action against an officer or director of the corporation.

(*l*) Designate and maintain a registered office and a resident agent in that office upon whom service of process may be made.

(m) Sue and be sued in all courts and participate in actions and proceedings, judicial, administrative, arbitrative, or otherwise, in the same cases as natural persons.

(n) Have a corporate seal, alter the seal, and use it by causing the seal or a facsimile to be affixed, impressed, or reproduced in any other manner.

(o) ~~Invest~~ **Subject to chapter 9 of the insurance code of 1956, 1956 PA 218, MCL 500.901 to 500.947, invest** and reinvest its funds and, for investment purposes only, purchase, take, receive, subscribe for, or otherwise acquire, own, hold, vote, employ, sell, lend, lease, exchange, transfer, or otherwise dispose of, mortgage, pledge, use, and otherwise deal in and with, bonds and other obligations, shares, or other securities or interests issued by entities other than domestic, foreign, or alien insurers, as defined in sections 106 and 110 of the insurance code of 1956, 1956 PA 218, MCL 500.106 and 500.110, whether engaged in a similar or different business, or

governmental or other activity, including banking corporations or trust companies. However, a health care corporation may purchase, take, receive, subscribe for, or otherwise acquire, own, hold, vote, employ, sell, lend, lease, exchange, transfer, or otherwise dispose of bonds or other obligations, shares, or other securities or interests issued by a domestic, foreign, or alien insurer, so long as the activity meets all of the following:

(*i*) Is determined by the attorney general to be lawful under section 202.

(*ii*) Is approved in writing by the commissioner as being in the best interests of the health care corporation and its subscribers.

(*iii*) ~~Will~~ **For an activity that occurred before the effective date of the amendatory act that added subparagraph (*iv*), will** not result in the health care corporation owning or controlling 10% or more of the voting securities of the insurer **or will not otherwise result in the health care corporation having control of the insurer<<,>> either before or after the effective date of the amendatory act that added subparagraph (*iv*)**. ~~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 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.~~ **As used**

in this subparagraph and subparagraph (*iv*), "control" means that term as defined in section 115 of the insurance code of 1956, 1956 PA 218, MCL 500.115.

(*iv*) Beginning on the effective date of the amendatory act that added this subparagraph, will not result in the health care corporation owning or controlling part or all of the insurer unless the transaction satisfies chapter 13 of the insurance code of 1956, 1956 PA 218, MCL 500.1301 to 500.1379, and the insurer being acquired is only authorized to sell disability insurance as defined under section 606 of the insurance code of 1956, 1956 PA 218, MCL 500.606, or under a statute or regulation in the insurer's domiciliary jurisdiction that is substantially similar to section 606 of the insurance code of 1956, 1956 PA 218, MCL 500.606.

(p) Purchase, receive, take by grant, gift, devise, bequest or otherwise, lease, or otherwise acquire, own, hold, improve, employ, use and otherwise deal in and with, real or personal property, or an interest therein, wherever situated.

(q) Sell, convey, lease, exchange, transfer or otherwise dispose of, or mortgage or pledge, or create a security interest in, any of its property, or an interest therein, wherever situated.

(r) Borrow money and issue its promissory note or bond for the repayment of the borrowed money with interest.

(s) Make donations for the public welfare, including hospital, charitable, or educational contributions that do not significantly affect rates charged to subscribers.

(t) Participate with others in any joint venture with respect to any transaction that the health care corporation would have the power to conduct by itself.

(u) Cease its activities and dissolve, subject to the commissioner's authority under section 606(2).

(v) Make contracts, transact business, carry on its operations, have offices, and exercise the powers granted by this act in any jurisdiction, to the extent necessary to carry out its purposes under this act.

(w) Have and exercise all powers necessary or convenient to effect any purpose for which the corporation was formed.

(x) Notwithstanding subdivision (o) or any other provision of this act, establish, own, and operate a domestic stock insurance company only for the purpose of acquiring, owning, and operating the state accident fund pursuant to chapter 51 of the insurance code of 1956, 1956 PA 218, MCL 500.5100 to 500.5114, so long as all of the following are met:

(*i*) For insurance products and services the insurer whether directly or indirectly only transacts worker's compensation insurance and employer's liability insurance, transacts disability insurance limited to replacement of loss of earnings, and acts as an administrative services organization for an approved self-insured worker's compensation plan or a disability insurance plan limited to replacement of loss of earnings and does not transact any other type of insurance notwithstanding the authorization in chapter 51 of the insurance code of 1956, 1956 PA 218, MCL 500.5100 to 500.5114. This subparagraph does not

preclude the insurer from providing either directly or indirectly noninsurance products and services as otherwise provided by law.

(*ii*) The activity is determined by the attorney general to be lawful under section 202.

(*iii*) The health care corporation does not directly or indirectly subsidize the use of any provider or subscriber information, loss data, contract, agreement, reimbursement mechanism or arrangement, computer system, or health care provider discount to the insurer.

(*iv*) Members of the board of directors, employees, and officers of the health care corporation are not, directly or indirectly, employed by the insurer unless the health care corporation is fairly and reasonably compensated for the services rendered to the insurer if those services were paid for by the health care corporation.

(*v*) Health care corporation and subscriber funds are used only for the acquisition from the state of Michigan of the assets and liabilities of the state accident fund.

(*vi*) Health care corporation and subscriber funds are not used to operate or subsidize in any way the insurer including the use of such funds to subsidize contracts for goods and services. This subparagraph does not prohibit joint undertakings between the health care corporation and the insurer to take advantage of economies of scale or arm's-length loans or other financial transactions between the health care corporation and the insurer.

(2) In order to ascertain the interests of senior citizens

regarding the provision of medicare supplemental coverage, as described in section 202(1)(d)(*v*), and to ascertain the interests of senior citizens regarding the administration of the federal medicare program when acting as fiscal intermediary in this state, as described in section 202(1)(d)(*vi*), a health care corporation shall consult with the office of services to the aging and with senior citizens' organizations in this state.

(3) An act of a health care corporation, otherwise lawful, is not invalid because the corporation was without capacity or power to do the act. However, the lack of capacity or power may be asserted:

(a) In an action by a director or a member of the corporate body against the corporation to enjoin the doing of an act.

(b) In an action by or in the right of the corporation to procure a judgment in its favor against an incumbent or former officer or director of the corporation for loss or damage due to an unauthorized act of that officer or director.

(c) In an action or special proceeding by the attorney general to enjoin the corporation from the transacting of unauthorized business, to set aside an unauthorized transaction, or to obtain other equitable relief.

Sec. 211. (1) Pursuant to section 207(1)(g), a health care corporation may enter into service contracts containing an administrative services only or cost-plus arrangement. Except as otherwise provided in this section, a corporation shall not enter into a service contract containing an administrative services only or cost-plus arrangement for a noninsured benefit plan

covering a group of less than 500 individuals, except that a health care corporation may continue an administrative services only or cost-plus arrangement with a group of less than 500, which arrangement is in existence in September of 1980. A corporation may enter into contracts containing an administrative services only or cost-plus arrangement for a noninsured benefit plan covering a group of less than 500 individuals if either the corporation makes arrangements for excess loss coverage or the sponsor of the plan that covers the individuals is liable for the plan's liabilities and is a sponsor of 1 or more plans covering a group of 500 or more individuals in the aggregate. The commissioner, upon obtaining the advice of the corporations subject to this act, shall establish the standards for the manner and amount of the excess loss coverage required by this subsection. It is the intent of the legislature that the excess loss coverage requirements be uniform as between corporations subject to this act and other persons authorized to provide similar services. The corporation shall offer in connection with a noninsured benefit plan a program of specific or aggregate excess loss coverage.

(2) Relative to actual administrative costs, fees for administrative services only and cost-plus arrangements shall be set in a manner that precludes cost transfers between subscribers subject to either of these arrangements and other subscribers of the health care corporation. Administrative costs for these arrangements shall be determined in accordance with the administrative costs allocation methodology and definitions filed

and approved under part 6, and shall be expressed clearly and accurately in the contracts establishing the arrangements, as a percentage of costs rather than charges. This subsection shall not be construed to prohibit the inclusion, in fees charged, of contributions to ~~the contingency reserve of the corporation, consistent with section 205~~ **adequate and unimpaired surplus as provided in section 204a**.

(3) Before a health care corporation may enter into contracts containing administrative services only or cost-plus arrangements pursuant to section 207(1)(g), the board of directors of the corporation shall approve a marketing policy ~~with respect to such~~ **for these** arrangements that is consistent with ~~the provisions of~~ this section. The marketing policy may contain other provisions as the board considers necessary. The marketing policy shall be carried out by the corporation consistent with this act.

(4) A corporation providing services under a contract containing an administrative services only or cost-plus arrangement in connection with a noninsured benefit plan shall provide in its service contract a provision that the person contracting for the services in connection with a noninsured benefit plan shall notify each covered individual **of** what services are being provided; the fact that individuals are not insured or are not covered by a certificate from the corporation, or are only partially insured or are only partially covered by a certificate from the corporation, as the case may be; which party is liable for payment of benefits; and of future changes in

benefits.

(5) A service contract containing an administrative services only arrangement between a corporation and a governmental entity not subject to the employee retirement income security act of 1974, Public Law 93-406, 88 Stat. 829, whose plan provides coverage under a collective bargaining agreement utilizing a policy or certificate issued by a carrier before the signing of the service contract, is void unless the governmental entity has provided the notice described in subsection (4) to the collective bargaining agent and to the members of the collective bargaining unit not less than 30 days before signing the service contract. The voiding of a service contract under this subsection shall not relieve the governmental entity of any obligations to the corporation under the service contract.

(6) Nothing in this section shall be construed to permit an actionable interference by a corporation with the rights and obligations of the parties under a collective bargaining agreement.

(7) An individual covered under a noninsured benefit plan for which services are provided under a service contract authorized under subsection (1) ~~shall~~ **is** not ~~be~~ liable for that portion of claims incurred and subject to payment under the plan if the service contract is entered into between an employer and a corporation, unless that portion of the claim has been paid directly to the covered individual.

(8) A corporation shall report with its annual statement the amount of business it has conducted as services provided under

subsection (1) that are performed in connection with a noninsured benefit plan, and the commissioner shall transmit annually this information to the state ~~commissioner of revenue~~ **treasurer**. The commissioner shall submit to the legislature on April 1, 1994, a report detailing the impact of this section on employers and covered individuals, and similar activities under other provisions of law, and in consultation with the ~~revenue commissioner~~ **state treasurer** the total financial impact on the state for the preceding legislative biennium.

(9) As used in this section, "noninsured benefit plan" or "plan" means a health benefit plan without coverage by a health care corporation, health maintenance organization, or insurer or the portion of a health benefit plan without coverage by a health care corporation, health maintenance organization, or insurer that has a specific or aggregate excess loss coverage.

Sec. 219. A nonprofit health care corporation is subject to chapter 37 of the insurance code of 1956, 1956 PA 218, MCL 500.3701 to 500.3723. To the extent that a provision of this act concerning health coverage, including, but not limited to, premiums, rates, filings, and coverages, conflicts with chapter 37 of the insurance code of 1956, 1956 PA 218, MCL 500.3701 to 500.3723, chapter 37 of the insurance code of 1956, 1956 PA 218, MCL 500.3701 to 500.3723, supersedes this act.

Sec. 401. (1) A health care corporation established, maintained, or operating in this state shall offer health care benefits to all residents of this state, and may offer other health care benefits as the corporation specifies with the

approval of the commissioner.

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

(3) A health care corporation shall not do any of the following:

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

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

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

(d) Rate, cancel benefits on, refuse to provide benefits for, or refuse to issue or continue a certificate solely because a subscriber or applicant is or has been a victim of domestic

violence. A health care corporation shall not be held civilly liable for any cause of action that may result from compliance with this subdivision. This subdivision applies to all health care corporation certificates issued or renewed on or after June 1, 1998. As used in this subdivision, "domestic violence" means inflicting bodily injury, causing serious emotional injury or psychological trauma, or placing in fear of imminent physical harm by threat or force a person who is a spouse or former spouse of, has or has had a dating relationship with, resides or has resided with, or has a child in common with the person committing the violence.

(e) Require a member or his or her dependent or an applicant for coverage or his or her dependent to do either of the following:

(*i*) Undergo genetic testing before issuing, renewing, or continuing a health care corporation certificate.

(*ii*) Disclose whether genetic testing has been conducted or the results of genetic testing or genetic information.

(4) Subsection (3) does not prevent a health care corporation from denying to a resident of this state coverage under a certificate for any of the following grounds:

(a) That the individual was not a member of a group that had contracted for coverage under this certificate.

(b) That the individual is not a member of a group with a size greater than a minimum size established for a certificate pursuant to sound underwriting requirements.

(c) That the individual does not meet requirements for

coverage contained in a certificate.

(d) <<For groups of under 100 subscribers and except>> as otherwise provided in section 3709 of the insurance code of 1956, 1956 PA 218, MCL 500.3709, that the group that the individual is a member of has failed to enroll enough of its eligible members with the health care corporation. This denial shall only be made if the health care corporation determines, using sound actuarial principles<<based on rating factors permitted under this act>>, that the portion of the group applying for coverage would be at least 50% more costly than the group as a whole. Not later than the close of business on the seventh business day after denying coverage under this subdivision, the health care corporation shall notify the commissioner of this denial and shall supply the information supporting the denial. The commissioner shall determine whether it will approve or disapprove the denial not later than the close of business on the seventh business day after receipt of the notice and shall promptly notify the health care corporation of his or her determination. The health care corporation or the employer may appeal the decision of the commissioner in circuit court.

(5) A certificate may provide for the coordination of benefits, subrogation, and the nonduplication of benefits. Savings realized by the coordination of benefits, subrogation, and nonduplication of benefits shall be reflected in the rates for those certificates. If a group certificate issued by the corporation contains a coordination of benefits provision, the benefits shall be payable pursuant to the coordination of benefits act, 1984 PA 64, MCL 550.251 to 550.255.

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

(7) A health care corporation shall not directly reimburse a provider in this state who has not entered into a participating contract with the corporation.

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

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

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

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

(d) Follow generally accepted accounting principles and practices.

(e) Have a community advisory board.

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

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

(9) As used in this section:

(a) "Clinical purposes" includes all of the following:

(*i*) Predicted risk of diseases.

(*ii*) Identifying carriers for single-gene disorders.

(*iii*) Establishing prenatal and clinical diagnosis or prognosis.

(*iv*) Prenatal, newborn, and other carrier screening, as well as testing in high-risk families.

(*v*) Tests for metabolites if undertaken with high probability that an excess or deficiency of the metabolite indicates or suggests the presence of heritable mutations in single genes.

(*vi*) Other tests if their intended purpose is diagnosis of a presymptomatic genetic condition.

(b) "Genetic information" means information about a gene, gene product, or inherited characteristic derived from a genetic test.

(c) "Genetic test" means the analysis of human DNA, RNA, chromosomes, and those proteins and metabolites used to detect heritable or somatic disease-related genotypes or karyotypes for clinical purposes. A genetic test must be generally accepted in

the scientific and medical communities as being specifically determinative for the presence, absence, or mutation of a gene or chromosome in order to qualify under this definition. Genetic test does not include a routine physical examination or a routine analysis, including, but not limited to, a chemical analysis, of body fluids, unless conducted specifically to determine the presence, absence, or mutation of a gene or chromosome.

Sec. 401j. The rates charged to nongroup and group conversion subscribers for a certificate that includes prescription drug coverage pursuant to section 401i may include rate differentials based on age, with not more than 8 separate age bands. The health care corporation shall file its rates for the prescription drug coverage in this section in the same manner and under the same requirements as provided in section 607.

Sec. 502. (1) A health care corporation may enter into participating contracts for reimbursement with professional health care providers practicing legally in this state **for health care services or with health practitioners practicing legally in any other jurisdiction** for health care services that the professional health care providers **or practitioners** may legally perform. **<<A health care corporation shall not reimburse a health practitioner located out of state at a higher rate for the same health care services than it reimburses an in-state health care provider.>>** 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. As used in this subdivision, provider does not include a person licensed as a dentist under part 166 of the public health code, 1978 PA 368, MCL 333.16601 to 333.16648.

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

(2) A contract entered into 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 that continues to meet the standards set by the corporation for that class of providers.

(3) A health care corporation shall not restrict the methods of diagnosis or treatment of professional health care providers who treat members. Except as otherwise provided in section 502a, each member of the health care corporation shall at all times have a choice of professional health care providers. This subsection does not apply to limitations in benefits contained in certificates, to the reimbursement provisions of a provider contract or reimbursement arrangement, or to standards set by the

corporation for all contracting providers. A health care corporation may refuse to reimburse a health care provider for health care services that are overutilized, including those services rendered, ordered, or prescribed to an extent that is greater than reasonably necessary.

(4) A health care corporation may provide to a member, upon request, a list of providers with whom the corporation contracts, for the purpose of assisting a member in obtaining a type of health care service. However, except as otherwise provided in section 502a, an employee, agent, or officer of the corporation, or an individual on the board of directors of the corporation, shall not make recommendations on behalf of the corporation with respect to the choice of a specific health care provider. Except as otherwise provided in section 502a, an employee, agent, or officer of the corporation, or a person on the board of directors of the corporation who influences or attempts to influence a person in the choice or selection of a specific professional health care provider on behalf of the corporation, is guilty of a misdemeanor.

(5) A health care corporation shall provide a symbol of participation, which can be publicly displayed, to providers who participate on all claims for covered health care services rendered to subscribers.

(6) This section does not impede the lawful operation of, or lawful promotion of, a health maintenance organization owned by a health care corporation.

(7) Contracts entered into under this section **with**

professional health care providers licensed in this state are subject to the provisions of sections 504 to 518.

(8) A health care corporation shall not deny participation to a freestanding surgical outpatient facility on the basis of ownership if the facility meets the reasonable standards set by the health care corporation for similar facilities, is licensed under part 208 of the public health code, 1978 PA 368, MCL 333.20801 to 333.20821, and complies with part 222 of the public health code, 1978 PA 368, MCL 333.22201 to 333.22260.

(9) Notwithstanding any other provision of this act, if a certificate provides for benefits for services that are within the scope of practice of optometry, a health care corporation is not required to provide benefits or reimburse for a practice of optometric service unless that service was included in the definition of practice of optometry under section 17401 of the public health code, 1978 PA 368, MCL 333.17401, as of May 20, 1992.

(10) Notwithstanding any other provision of this act, a health care corporation is not required to reimburse for services otherwise covered under a certificate if the services were performed by a member of a health care profession, which health care profession was not licensed or registered by this state on or before January 1, 1998 but that becomes a health care profession licensed or registered by this state after January 1, 1998. This subsection does not change the status of a health care profession that was licensed or registered by this state on or before January 1, 1998.

Sec. 602. (1) Not later than March 1 each year, subject to a 30-day extension ~~which~~ **that** may be granted by the commissioner, a health care corporation shall file in the office of the commissioner a sworn statement verified by at least 2 of the principal officers of the corporation showing its condition as of the preceding December 31. The statement shall be in a form ~~,~~ and contain those matters ~~, which~~ **that** the commissioner prescribes for a health care corporation, including those matters contained in section ~~205~~ **204a**. The statement shall include the number of members and the number of subscribers' certificates issued by the corporation and outstanding.

(2) The commissioner, by order, may require a health care corporation to submit statistical, financial, and other reports for the purpose of monitoring compliance with this act.

Sec. 606. (1) The commissioner shall have the same authority regarding the officers and directors of a health care corporation as the commissioner has with respect to the officers and directors of insurers under sections 249 and 250 of ~~Act No. 218 of the Public Acts of 1956, being sections 500.249 and 500.250 of the Michigan Compiled Laws~~ **the insurance code of 1956, 1956 PA 218, MCL 500.249 and 500.250**.

(2) The commissioner shall have the same authority with respect to the dissolution, taking over, or liquidation of corporations formed or doing business under this act as is provided in chapter ~~78 of Act No. 218 of the Public Acts of 1956, as amended, being sections 500.7800 to 500.7868 of the~~

~~Michigan Compiled Laws~~ **81 of the insurance code of 1956, 1956 PA 218, MCL 500.8101 to 500.8159**. For purposes of this subsection, a health care corporation shall be considered to be insolvent if its liabilities exceed its assets, unless otherwise defined in chapter ~~78 of Act No. 218 of the Public Acts of 1956, as amended~~ **81 of the insurance code of 1956, 1956 PA 218, MCL 500.8101 to 500.8159**.

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~~ **surplus that is consistent with the attainment or maintenance of adequate and unimpaired surplus as provided in section 204a**; and provision for adjustments due to prior experience of groups, as defined in the group rating system. A determination as to whether a rate is excessive relative to ~~the~~ **these** 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~~ **unimpaired surplus** of the health care corporation. To the extent that any of these elements are considered excessive, the provision in the rates for these elements shall be modified

accordingly.

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

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

(4) A rate is adequate if the rate is not unreasonably low relative to the elements prescribed in subsection (1), individually or collectively, based on reasonable evaluations of recent claim experience, projected trends in claim costs, the allocation of administrative expense budgets, and the present and anticipated ~~contingency reserve positions~~ **unimpaired surplus** of the health care corporation.

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

~~caring program created in section 436 is not subject to any assessment or surcharge for cost transfer under this subsection.~~

Enacting section 1. This amendatory act does not take effect unless Senate Bill No. 460 of the 92nd Legislature is enacted into law.

Enacting section 2. Section 205 of the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1205, is repealed.