

SENATE BILL No. 234

February 27, 2003, Introduced by Senators HAMMERSTROM, JACOBS, CHERRY,
PATTERSON, ALLEN and GOSCHKA and referred to the Committee on Health Policy.

A bill to amend 1980 PA 350, entitled
"The nonprofit health care corporation reform act,"
by amending sections 107, 201, 204, 206, 207, 211, 401, 502, 602,
608, 609, 610, 611, 612, 613, and 614 (MCL 550.1107, 550.1201,
550.1204, 550.1206, 550.1207, 550.1211, 550.1401, 550.1502,
550.1602, 550.1608, 550.1609, 550.1610, 550.1611, 550.1612,
550.1613, and 550.1614), 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, section 608 as
amended by 1991 PA 73, and section 609 as amended by 1991 PA 61,
and by adding sections 204a, 205a, 422c, 608a, 608b, 608c, 608d,
and 620; and to repeal acts and parts of acts.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

1 Sec. 107. (1) "Participating provider" means a provider
2 that has entered into a participating contract with a health care

1 corporation and that meets the standards set by the corporation
2 for that class of providers.

3 (2) "Participating contract" means an agreement, contract, or
4 other arrangement under which a provider agrees to accept the
5 payment of the health care corporation as payment in full for
6 health care services or parts of health care services covered
7 under a certificate, as provided for in section 502(1).

8 (3) "Person" means an individual, corporation, partnership,
9 organization, **limited liability company**, or association.

10 (4) "Personal data" means a document incorporating medical or
11 surgical history, care, treatment, or service; or any similar
12 record, including an automated or computer accessible record,
13 relative to a member, which is maintained or stored by a health
14 care corporation.

15 (5) "Proposed rate" means any of the following:

16 (a) A proposed increase or decrease in the rates to be
17 charged to nongroup subscribers.

18 (b) For group subscribers, any proposed changes in the
19 methodology or definitions of any rating system, formula,
20 component, or factor subject to prior approval by the
21 commissioner.

22 (c) A proposed increase or decrease in deductible amounts or
23 coinsurance percentages.

24 (d) A proposed extension of benefits, additional benefits, or
25 a reduction or limitation in benefits.

26 ~~(e) A review pursuant to section 608(2).~~

27 (6) "Provider class" means classes of providers, as defined

1 in section 105(4), that have a provider contract or a
2 reimbursement arrangement with a health care corporation to
3 render health care services to subscribers, as those classes are
4 established by the corporation.

5 (7) "Provider class plan" or "plan" means a document
6 containing a reimbursement arrangement and objectives for a
7 provider class, and, in the case of those providers with which a
8 health care corporation contracts, provisions that are included
9 in that contract.

10 (8) "Provider contract" or "contract" means an agreement
11 between a provider and a health care corporation that contains
12 provisions to implement the provider class plan.

13 Sec. 201. (1) A health care corporation shall not be
14 incorporated in this state except under this act.

15 (2) Not less than 7 persons, all of whom shall be residents
16 of this state, may form a health care corporation under this act
17 for the purpose of providing 1 or more health care benefits at
18 the expense of the corporation to persons or groups of persons
19 who become subscribers to the plan, under certificates ~~which~~
20 **that** will entitle each subscriber to certain health care services
21 by providers with which the corporation has contracted for that
22 purpose.

23 (3) A certificate shall not provide for the payment of cash
24 or any other material benefit to a subscriber or the estate of a
25 subscriber on account of death, illness, or injury except where
26 payment is made to a subscriber for health care services by a
27 provider who has not entered into a participating contract with

1 the corporation or to reimburse a subscriber who has made, or is
2 obligated to make, payment directly to a provider.

3 (4) A health care corporation ~~shall~~ **is** not ~~be~~ subject to
4 the laws of this state with respect to insurance corporations,
5 except as provided in this act. A health care corporation
6 ~~shall~~ **is** not ~~be~~ subject to the laws of this state with
7 respect to corporations generally.

8 (5) A health care corporation subject to this act is
9 declared to be a charitable and benevolent institution, and its
10 funds, ~~and~~ property, ~~shall be~~ **and activities are** exempt from
11 taxation by this state or any political subdivision of this
12 state.

13 (6) A person shall not act as a health care corporation or
14 issue a certificate except as authorized by and pursuant to a
15 certificate of authority granted to the person by the
16 commissioner pursuant to this act.

17 (7) A health care corporation shall provide only the kinds
18 of health care benefits and certificates authorized by this act.
19 A health care corporation shall not make or issue a certificate
20 relative to health care benefits except as approved or otherwise
21 authorized under this act.

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

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

1 attached.

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

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

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

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

8 (f) A copy of the bylaws.

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

11 (2) The commissioner shall examine the statements and
12 documents filed under subsection (1), may conduct any
13 investigation ~~which~~ **that** he or she considers necessary, may
14 request additional oral and written information from the
15 incorporators, and may examine under oath any persons interested
16 in or connected with the proposed health care corporation. The
17 commissioner shall ascertain whether all of the following
18 conditions are met:

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

21 (b) The rates to be charged and the benefits to be provided
22 are adequate, equitable, and not excessive, as defined in section
23 609.

24 (c) The amount of money actually available for working
25 capital is sufficient to carry all acquisition costs and
26 operating expenses for a reasonable period of time from the date
27 of issuance of the certificate of authority, and is not less than

1 \$500,000.00 or a greater amount, if the commissioner considers it
2 necessary.

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

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

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

12 (a) Return to the incorporators 1 copy of the articles of
13 incorporation, certified for filing with the ~~chief officer~~
14 **director** of the department of ~~commerce~~ **consumer and industry**
15 **services** or of any other agency or department authorized by law
16 to administer ~~Act No. 284 of the Public Acts of 1972, as~~
17 ~~amended, being sections 450.1101 to 450.2099 of the Michigan~~
18 ~~Compiled Laws~~ **the business corporation act, 1972 PA 284,**
19 **MCL 450.1101 to 450.2098**, or his or her designated
20 representative, and 1 copy of the articles of incorporation
21 certified for the records of the corporation itself.

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

24 (c) Deliver to the corporation a certificate of authority to
25 commence business and to issue certificates ~~which~~ **that** have
26 been approved by the commissioner, or ~~which~~ **that** are exempted
27 from prior approval pursuant to section 607(2) or (7), entitling

1 subscribers to certain health care benefits.

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

11 (2) If a health care corporation files a risk-based capital
12 report that indicates that its surplus is less than the amount
13 determined adequate by the commissioner under subsection (1), the
14 health care corporation shall prepare and submit a plan for
15 remedying the deficiency in accordance with risk-based capital
16 requirements adopted by the commissioner. Among the remedies
17 that a health care corporation may employ are planwide viability
18 contributions to surplus by subscribers.

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

22 (a) If the health care corporation's surplus is less than
23 200% but more than 150% of the authorized control level under
24 risk-based capital requirements, the maximum contribution rate
25 shall be 0.5% of the rate charged to subscribers for the benefits
26 provided.

27 (b) If the health care corporation's surplus is 150% or less

1 than the authorized control level under risk-based capital
2 requirements, the maximum contribution rate shall be 1% of the
3 rate charged to subscribers for the benefits provided.

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

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

11 Sec. 205a. A health care corporation shall report financial
12 information in conformity with sound actuarial practices and
13 statutory accounting principles, including approved permitted
14 practices, in the same manner as designated by the commissioner
15 for other carriers pursuant to section 438(2) of the insurance
16 code of 1956, 1956 PA 218, MCL 500.438.

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

27 (2) The funds of a health care corporation shall be invested

1 only in securities permitted by the laws of this state for the
 2 investments of assets of life insurance companies, as described
 3 in chapter 9 of ~~Act No. 218 of the Public Acts of 1956, as~~
 4 ~~amended, being sections 500.901 to 500.947 of the Michigan~~
 5 ~~Compiled Laws~~ **the insurance code of 1956, 1956 PA 218,**
 6 **MCL 500.901 to 500.947.**

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

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

24 (b) Unsecured debt instruments ~~which~~ **that** are either
 25 convertible into equity or have equity acquisition rights. These
 26 debt instruments shall be subordinated by their terms to all
 27 borrowings of the issuer from other institutional lenders and

1 shall have no part amortized during the first 5 years.

2 (4) A health care corporation shall not market or transact,
3 as defined in sections 402a and 402b of ~~Act No. 218 of the~~
4 ~~Public Acts of 1956, being sections 500.402a and 500.402b of the~~
5 ~~Michigan Compiled Laws~~ **the insurance code of 1956, 1956 PA 218,**
6 **MCL 500.402a and 500.402b**, any type of insurance described in
7 chapter 6 of ~~Act No. 218 of the Public Acts of 1956, as amended,~~
8 ~~being sections 500.600 to 500.644 of the Michigan Compiled Laws~~
9 **the insurance code of 1956, 1956 PA 218, MCL 500.600 to 500.644.**

10 This subsection shall not be construed to prohibit the provision
11 of prepaid health care benefits.

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

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

20 (b) Engage in experimental health care projects to explore
21 more efficient and economical means of implementing the
22 corporation's programs, or the corporation's goals as prescribed
23 in section 504 and the purposes of this act, to develop
24 incentives to promote alternative methods and alternative
25 providers, including nurse midwives, nurse anesthetists, and
26 nurse practitioners, for delivering health care, including
27 preventive care and home health care.

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

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

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

20 (f) Provide administrative services only and cost-plus
 21 arrangements for the federal medicare program established by
 22 parts A and B of title XVIII of the social security act, chapter
 23 531, 49 Stat. 620, 42 U.S.C. ~~1395 to 1395b, 1395b-2, 1395b-6 to~~
 24 ~~1395b-7,~~ 1395c to 1395i, 1395i-2 to 1395i-5, 1395j to 1395t,
 25 1395u to 1395w, **and** 1395w-2 to 1395w-4; ~~—, 1395w-21 to 1395w-28,~~
 26 ~~1395x to 1395yy, and 1395bbb to 1395ggg;~~ for the federal
 27 medicaid program established under title XIX of the social

1 security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1396 to
 2 ~~1396f, 1396g-1 to~~ 1396r-6 ~~—~~ and 1396r-8 to 1396v; for title V
 3 of the social security act, chapter 531, 49 Stat. 620,
 4 42 U.S.C. 701 to 704 and 705 to 710; for the program of medical
 5 and dental care established by the military medical benefits
 6 amendments of 1966, Public Law 85-861, 80 Stat. 862; for the
 7 Detroit maternity and infant care--preschool, school, and
 8 adolescent project; and for any other health benefit program
 9 established under state or federal law.

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

13 (h) Establish, own, and operate a health maintenance
 14 organization, subject to the requirements of the ~~public health~~
 15 ~~code, 1978 PA 368, MCL 333.1101 to 333.25211~~ **insurance code of**
 16 **1956, 1956 PA 218, MCL 500.100 to 500.8302.**

17 (i) Guarantee loans for the education of persons who are
 18 planning to enter or have entered a profession that is licensed,
 19 certified, or registered under parts 161 to 182 of the public
 20 health code, 1978 PA 368, MCL 333.16101 to 333.18237, and has
 21 been identified by the commissioner, with the consultation of the
 22 office of health and medical affairs in the department of
 23 management and budget, as a profession whose practitioners are in
 24 insufficient supply in this state or specified areas of this
 25 state and who agree, as a condition of receiving a guarantee of a
 26 loan, to work in this state, or an area of this state specified
 27 in a listing of shortage areas for the profession issued by the

1 commissioner, for a period of time determined by the
2 commissioner.

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

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

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

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

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

15 (o) Invest and reinvest its funds and ~~—, for investment~~
16 ~~purposes only,~~ purchase, take, receive, subscribe for, or
17 otherwise acquire, own, hold, vote, employ, sell, lend, lease,
18 exchange, transfer, or otherwise dispose of, mortgage, pledge,
19 use, and otherwise deal in and with, bonds and other obligations,
20 shares, or other securities or interests issued by **other** entities
21 ~~other than domestic, foreign, or alien insurers, as defined in~~
22 ~~sections 106 and 110 of the insurance code of 1956, 1956 PA 218,~~
23 ~~MCL 500.106 and 500.110,~~ whether engaged in a similar or
24 different business, or governmental or other activity, including
25 banking corporations or trust companies. ~~However, a health care~~
26 ~~corporation may purchase, take, receive, subscribe for, or~~
27 ~~otherwise acquire, own, hold, vote, employ, sell, lend, lease,~~

1 ~~exchange, transfer, or otherwise dispose of bonds or other~~
2 ~~obligations, shares, or other securities or interests issued by a~~
3 ~~domestic, foreign, or alien insurer, so long as the activity~~
4 ~~meets all of the following:~~

5 ~~—— (i) Is determined by the attorney general to be lawful under~~
6 ~~section 202.~~

7 ~~—— (ii) Is approved in writing by the commissioner as being in~~
8 ~~the best interests of the health care corporation and its~~
9 ~~subscribers.~~

10 ~~—— (iii) Will not result in the health care corporation owning~~
11 ~~or controlling 10% or more of the voting securities of the~~
12 ~~insurer. Nothing in this subdivision shall be interpreted as~~
13 ~~expanding the lawful purposes of a health care corporation under~~
14 ~~this act. Except where expressly authorized by statute, a health~~
15 ~~care corporation shall not indirectly engage in any investment~~
16 ~~activity that it may not engage in directly. A health care~~
17 ~~corporation shall not guarantee or become surety upon a bond or~~
18 ~~other undertaking securing the deposit of public money.~~

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

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

27 (r) Borrow money and issue its promissory note or bond for

1 the repayment of the borrowed money with interest.

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

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

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

10 (v) Make contracts, transact business, carry on its
11 operations, have offices, and ~~exercise the powers granted by~~
12 ~~this act~~ **engage in any other lawful activity** in any
13 jurisdiction. ~~—, to the extent necessary to carry out its~~
14 ~~purposes under this act.~~

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

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

23 (i) For insurance products and services the insurer whether
24 directly or indirectly only transacts worker's compensation
25 insurance and employer's liability insurance, transacts
26 disability insurance limited to replacement of loss of earnings,
27 and acts as an administrative services organization for an

1 approved self-insured worker's compensation plan or a disability
2 insurance plan limited to replacement of loss of earnings and
3 does not transact any other type of insurance notwithstanding the
4 authorization in chapter 51 of the insurance code of 1956, 1956
5 PA 218, MCL 500.5100 to 500.5114. This subparagraph does not
6 preclude the insurer from providing either directly or indirectly
7 noninsurance products and services as otherwise provided by law.

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

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

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

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

24 (vi) Health care corporation and subscriber funds are not
25 used to operate or subsidize in any way the insurer including the
26 use of such funds to subsidize contracts for goods and services.
27 This subparagraph does not prohibit joint undertakings between

1 the health care corporation and the insurer to take advantage of
2 economies of scale or arm's-length loans or other financial
3 transactions between the health care corporation and the
4 insurer.

5 (2) In order to ascertain the interests of senior citizens
6 regarding the provision of medicare supplemental coverage, as
7 described in section 202(1)(d)(v), and to ascertain the interests
8 of senior citizens regarding the administration of the federal
9 medicare program when acting as fiscal intermediary in this
10 state, as described in section 202(1)(d)(vi), a health care
11 corporation shall consult with the office of services to the
12 aging and with senior citizens' organizations in this state.

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

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

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

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

27 **(4) A health care corporation may engage in any activity not**

1 prohibited by law. The absence of any specific grant of
2 authority in this act shall not be construed to prohibit a health
3 care corporation from engaging in any activity not otherwise
4 prohibited by law.

5 Sec. 211. (1) Pursuant to section 207(1)(g), a health care
6 corporation may enter into service contracts containing an
7 administrative services only or cost-plus arrangement. Except as
8 otherwise provided in this section, a corporation shall not enter
9 into a service contract containing an administrative services
10 only or cost-plus arrangement for a noninsured benefit plan
11 covering a group of less than 500 individuals, except that a
12 health care corporation may continue an administrative services
13 only or cost-plus arrangement with a group of less than 500,
14 which arrangement is in existence in September of 1980. A
15 corporation may enter into contracts containing an administrative
16 services only or cost-plus arrangement for a noninsured benefit
17 plan covering a group of less than 500 individuals if either the
18 corporation makes arrangements for excess loss coverage or the
19 sponsor of the plan that covers the individuals is liable for the
20 plan's liabilities and is a sponsor of 1 or more plans covering a
21 group of 500 or more individuals in the aggregate. The
22 commissioner, upon obtaining the advice of the corporations
23 subject to this act, shall establish the standards for the manner
24 and amount of the excess loss coverage required by this
25 subsection. It is the intent of the legislature that the excess
26 loss coverage requirements be uniform as between corporations
27 subject to this act and other persons authorized to provide

1 similar services. The corporation shall offer in connection with
2 a noninsured benefit plan a program of specific or aggregate
3 excess loss coverage.

4 (2) Relative to actual administrative costs, fees for
5 administrative services only and cost-plus arrangements shall be
6 set in a manner that precludes cost transfers between subscribers
7 subject to either of these arrangements and other subscribers of
8 the health care corporation. Administrative costs for these
9 arrangements shall be determined in accordance with the
10 administrative costs allocation methodology and definitions filed
11 and approved under part 6, and shall be expressed clearly and
12 accurately in the contracts establishing the arrangements, as a
13 percentage of costs rather than charges. This subsection shall
14 not be construed to prohibit the inclusion, in fees charged, of
15 contributions to ~~the contingency reserve of the corporation,~~
16 ~~consistent with section 205-~~ **adequate and unimpaired surplus as**
17 **provided in section 204a.**

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

27 (4) A corporation providing services under a contract

1 containing an administrative services only or cost-plus
2 arrangement in connection with a noninsured benefit plan shall
3 provide in its service contract a provision that the person
4 contracting for the services in connection with a noninsured
5 benefit plan shall notify each covered individual **of** what
6 services are being provided; the fact that individuals are not
7 insured or are not covered by a certificate from the corporation,
8 or are only partially insured or are only partially covered by a
9 certificate from the corporation, as the case may be; which party
10 is liable for payment of benefits; and of future changes in
11 benefits.

12 (5) A service contract containing an administrative services
13 only arrangement between a corporation and a governmental entity
14 not subject to the employee retirement income security act of
15 1974, Public Law 93-406, 88 Stat. 829, whose plan provides
16 coverage under a collective bargaining agreement utilizing a
17 policy or certificate issued by a carrier before the signing of
18 the service contract, is void unless the governmental entity has
19 provided the notice described in subsection (4) to the collective
20 bargaining agent and to the members of the collective bargaining
21 unit not less than 30 days before signing the service contract.
22 The voiding of a service contract under this subsection shall not
23 relieve the governmental entity of any obligations to the
24 corporation under the service contract.

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

1 agreement.

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

9 (8) A corporation shall report with its annual statement the
10 amount of business it has conducted as services provided under
11 subsection (1) that are performed in connection with a noninsured
12 benefit plan, and the commissioner shall transmit annually this
13 information to the state ~~commissioner of revenue~~ **treasurer**.
14 The commissioner shall submit to the legislature on April 1,
15 1994, a report detailing the impact of this section on employers
16 and covered individuals, and similar activities under other
17 provisions of law, and in consultation with the ~~revenue~~
18 ~~commissioner~~ **state treasurer** the total financial impact on the
19 state for the preceding legislative biennium.

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

26 Sec. 401. (1) A health care corporation established,
27 maintained, or operating in this state shall offer health care

1 benefits to all residents of this state, and may offer other
2 health care benefits as the corporation specifies with the
3 approval of the commissioner.

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

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

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

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

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

27 (d) Rate, cancel benefits on, refuse to provide benefits for,

1 or refuse to issue or continue a certificate solely because a
2 subscriber or applicant is or has been a victim of domestic
3 violence. A health care corporation shall not be held civilly
4 liable for any cause of action that may result from compliance
5 with this subdivision. This subdivision applies to all health
6 care corporation certificates issued or renewed on or after
7 June 1, 1998. As used in this subdivision, "domestic violence"
8 means inflicting bodily injury, causing serious emotional injury
9 or psychological trauma, or placing in fear of imminent physical
10 harm by threat or force a person who is a spouse or former spouse
11 of, has or has had a dating relationship with, resides or has
12 resided with, or has a child in common with the person committing
13 the violence.

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

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

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

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

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

26 (b) That the individual is not a member of a group with a
27 size greater than a minimum size established for a certificate

1 pursuant to sound underwriting requirements.

2 (c) That the individual does not meet requirements for
3 coverage contained in a certificate.

4 (d) That the group the individual is a member of has failed
5 to enroll enough of its eligible members to meet the minimum
6 participation rules established by the health care corporation
7 pursuant to sound underwriting requirements. A minimum
8 participation rule may require a group to enroll a certain number
9 or percentage of its members with the health care corporation or
10 its subsidiary health maintenance organization as a condition of
11 coverage. A minimum participation rule for groups of 6 or more
12 members shall not require enrollment of more than 75% of the
13 group's members who are receiving health care coverage from the
14 group. A minimum participation rule for groups of fewer than 6
15 members may require enrollment of up to 100% of the group's
16 members who are receiving health care coverage from the group.

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

25 (6) A health care corporation shall have the right to status
26 as a party in interest, whether by intervention or otherwise, in
27 any judicial, quasi-judicial, or administrative agency proceeding

1 in this state for the purpose of enforcing any rights it may have
2 for reimbursement of payments made or advanced for health care
3 services on behalf of 1 or more of its subscribers or members.

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

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

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

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

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

25 (d) Follow generally accepted accounting principles and
26 practices.

27 (e) Have a community advisory board.

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

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

5 (9) As used in this section:

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

7 (i) Predicted risk of diseases.

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

9 (iii) Establishing prenatal and clinical diagnosis or
10 prognosis.

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

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

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

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

21 (c) "Genetic test" means the analysis of human DNA, RNA,
22 chromosomes, and those proteins and metabolites used to detect
23 heritable or somatic disease-related genotypes or karyotypes for
24 clinical purposes. A genetic test must be generally accepted in
25 the scientific and medical communities as being specifically
26 determinative for the presence, absence, or mutation of a gene or
27 chromosome in order to qualify under this definition. Genetic

1 test does not include a routine physical examination or a routine
2 analysis, including, but not limited to, a chemical analysis, of
3 body fluids, unless conducted specifically to determine the
4 presence, absence, or mutation of a gene or chromosome.

5 **Sec. 422c. A health care corporation may condition the**
6 **granting of long-term care coverage based on answers given on an**
7 **application under section 422a and pursuant to underwriting**
8 **standards established by the corporation.**

9 Sec. 502. (1) A health care corporation may enter into
10 participating contracts for reimbursement with professional
11 health care providers practicing legally in this state **or with**
12 **health practitioners practicing legally in any other jurisdiction**
13 for health care services that the professional health care
14 providers **or practitioners** may legally perform. A participating
15 contract may cover all members or may be a separate and
16 individual contract on a per claim basis, as set forth in the
17 provider class plan, if, in entering into a separate and
18 individual contract on a per claim basis, the participating
19 provider certifies to the health care corporation:

20 (a) That the provider will accept payment from the
21 corporation as payment in full for services rendered for the
22 specified claim for the member indicated.

23 (b) That the provider will accept payment from the
24 corporation as payment in full for all cases involving the
25 procedure specified, for the duration of the calendar year. As
26 used in this subdivision, provider does not include a person
27 licensed as a dentist under part 166 of the public health code,

1 1978 PA 368, MCL 333.16601 to 333.16648.

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

7 (2) A contract entered into pursuant to subsection (1) shall
8 provide that the private provider-patient relationship shall be
9 maintained to the extent provided for by law. A health care
10 corporation shall continue to offer a reimbursement arrangement
11 to any class of providers with which it has contracted prior to
12 August 27, 1985 and that continues to meet the standards set by
13 the corporation for that class of providers.

14 (3) A health care corporation shall not restrict the methods
15 of diagnosis or treatment of professional health care providers
16 who treat members. Except as otherwise provided in section 502a,
17 each member of the health care corporation shall at all times
18 have a choice of professional health care providers. This
19 subsection does not apply to limitations in benefits contained in
20 certificates, to the reimbursement provisions of a provider
21 contract or reimbursement arrangement, or to standards set by the
22 corporation for all contracting providers. A health care
23 corporation may refuse to reimburse a health care provider for
24 health care services that are overutilized, including those
25 services rendered, ordered, or prescribed to an extent that is
26 greater than reasonably necessary.

27 (4) A health care corporation may provide to a member, upon

1 request, a list of providers with whom the corporation contracts,
2 for the purpose of assisting a member in obtaining a type of
3 health care service. However, except as otherwise provided in
4 section 502a, an employee, agent, or officer of the corporation,
5 or an individual on the board of directors of the corporation,
6 shall not make recommendations on behalf of the corporation with
7 respect to the choice of a specific health care provider. Except
8 as otherwise provided in section 502a, an employee, agent, or
9 officer of the corporation, or a person on the board of directors
10 of the corporation who influences or attempts to influence a
11 person in the choice or selection of a specific professional
12 health care provider on behalf of the corporation, is guilty of a
13 misdemeanor.

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

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

21 (7) Contracts entered into under this section **with**
22 **professional health care providers licensed in this state** are
23 subject to the provisions of sections 504 to 518.

24 (8) A health care corporation shall not deny participation to
25 a freestanding surgical outpatient facility on the basis of
26 ownership if the facility meets the reasonable standards set by
27 the health care corporation for similar facilities, is licensed

1 under part 208 of the public health code, 1978 PA 368,
2 MCL 333.20801 to 333.20821, and complies with part 222 of the
3 public health code, 1978 PA 368, MCL 333.22201 to 333.22260.

4 (9) Notwithstanding any other provision of this act, if a
5 certificate provides for benefits for services that are within
6 the scope of practice of optometry, a health care corporation is
7 not required to provide benefits or reimburse for a practice of
8 optometric service unless that service was included in the
9 definition of practice of optometry under section 17401 of the
10 public health code, 1978 PA 368, MCL 333.17401, as of May 20,
11 1992.

12 (10) Notwithstanding any other provision of this act, a
13 health care corporation is not required to reimburse for services
14 otherwise covered under a certificate if the services were
15 performed by a member of a health care profession, which health
16 care profession was not licensed or registered by this state on
17 or before January 1, 1998 but that becomes a health care
18 profession licensed or registered by this state after January 1,
19 1998. This subsection does not change the status of a health
20 care profession that was licensed or registered by this state on
21 or before January 1, 1998.

22 Sec. 602. (1) Not later than March 1 each year, subject to
23 a 30-day extension ~~which~~ **that** may be granted by the
24 commissioner, a health care corporation shall file in the office
25 of the commissioner a sworn statement verified by at least 2 of
26 the principal officers of the corporation showing its condition
27 as of the preceding December 31. The statement shall be in a

1 form ~~—~~ and contain those matters ~~—, which—~~ **that** the
 2 commissioner prescribes for a health care corporation, including
 3 those matters contained in section ~~—205—~~ **204a**. The statement
 4 shall include the number of members and the number of
 5 subscribers' certificates issued by the corporation and
 6 outstanding.

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

10 Sec. 608. (1) The rates charged to nongroup **medicare**
 11 **supplemental** subscribers for each certificate shall be filed in
 12 accordance with section 610 and shall be subject to the prior
 13 approval of the commissioner. Annually, the commissioner shall
 14 approve, disapprove, or modify and approve the proposed or
 15 existing rates for each certificate subject to the standard that
 16 the rates must be determined to be equitable, adequate, and not
 17 excessive, as defined in section 609. **The rates charged to**
 18 **nongroup medicare supplemental subscribers shall not include rate**
 19 **differentials based on age or residence.** The burden of proof that
 20 rates to be charged meet these standards shall be upon the health
 21 care corporation proposing to use the rates.

22 ~~(2) The methodology and definitions of each rating system,~~
 23 ~~formula, component, and factor used to calculate rates for group~~
 24 ~~subscribers for each certificate, including the methodology and~~
 25 ~~definitions used to calculate administrative costs for~~
 26 ~~administrative services only and cost plus arrangements, shall be~~
 27 ~~filed in accordance with section 610 and shall be subject to the~~

~~1 prior approval of the commissioner. The definition of a group,
2 including any clustering principles applied to nongroup
3 subscribers or small group subscribers for the purpose of group
4 formation, shall be subject to the prior approval of the
5 commissioner. However, if a Michigan caring program is created
6 under section 436, that program shall be defined as a group
7 program for the purpose of establishing rates. The commissioner
8 shall approve, disapprove, or modify and approve the methodology
9 and definitions of each rating system, formula, component, and
10 factor for each certificate subject to the standard that the
11 resulting rates for group subscribers must be determined to be
12 equitable, adequate, and not excessive, as defined in section
13 609. In addition, the commissioner may from time to time review
14 the records of the corporation to determine proper application of
15 a rating system, formula, component, or factor with respect to
16 any group. The corporation shall refile for approval under this
17 subsection, every 3 years, the methodology and definitions of
18 each rating system, formula, component, and factor used to
19 calculate rates for group subscribers, including the methodology
20 and definitions used to calculate administrative costs for
21 administrative services only and cost plus arrangements. The
22 burden of proof that the resulting rates to be charged meet these
23 standards shall be upon the health care corporation proposing to
24 use the rating system, formula, component, or factor.~~

~~25~~ (2) ~~-(3)-~~ A proposed rate **filed under subsection (1)** shall
~~26~~ not take effect until a filing has been made with the
~~27~~ commissioner and approved under section 607 or this section, as

1 applicable, except as provided in ~~subsections (4) and (5)~~
2 **subsection (3).**

3 (3) ~~(4)~~ Upon request by a health care corporation, the
4 commissioner may allow rate adjustments to become effective prior
5 to approval, for federal or state mandated benefit changes.
6 However, a filing for these adjustments shall be submitted before
7 the effective date of the mandated benefit changes. If the
8 commissioner disapproves or modifies and approves the rates, an
9 adjustment shall be made retroactive to the effective date of the
10 mandated benefit changes or additions.

11 ~~(5) Implementation prior to approval may be allowed if the~~
12 ~~health care corporation is participating with 1 or more health~~
13 ~~care corporations to underwrite a group whose employees are~~
14 ~~located in several states. Upon request from the commissioner,~~
15 ~~the corporation shall file with the commissioner, and the~~
16 ~~commissioner shall examine, the financial arrangement, formulae,~~
17 ~~and factors. If any are determined to be unacceptable, the~~
18 ~~commissioner shall take appropriate action.~~

19 Sec. 608a. (1) The rates for nongroup and group conversion
20 subscribers shall be filed with and approved by the
21 commissioner. The rates under this section shall not be filed
22 more frequently than annually. The rates shall be reasonable in
23 relation to the benefits provided. The rates shall be considered
24 reasonable if the filing includes an actuarial certification that
25 the anticipated loss ratio will not be less than 70%. The rates
26 shall be considered approved and effective 30 days after filing
27 with the commissioner.

1 (2) Not later than 180 days after every 2 years after a rate
2 approved under subsection (1) has been in effect, the health care
3 corporation shall determine if the minimum loss ratio has been
4 met for nongroup and group conversion subscribers. This
5 determination shall be based on the actual experience of the
6 nongroup and group conversion lines of business over the 2-year
7 period under review. The results of this determination shall be
8 filed with the commissioner.

9 (3) If the actual loss ratio is less than the minimum loss
10 ratio under subsection (1) for nongroup or group conversion
11 subscribers, the health care corporation shall give a pro rata
12 rate credit or credits to current subscribers. The rate credits
13 shall be determined separately for nongroup subscribers and group
14 conversion subscribers. In the aggregate, the rate credits shall
15 be in an amount equal to the difference between the actual loss
16 ratio and the minimum loss ratio. The rate credits shall begin
17 no later than 180 days after there has been a determination that
18 the minimum loss ratio was not met. The rate credits shall be
19 filed with the commissioner.

20 (4) The rates charged to nongroup and group conversion
21 subscribers may include rate differentials based on age and
22 residence if the differentials are supported by sound actuarial
23 principles and a reasonable classification system and are related
24 to actual and credible loss statistics or, for new coverages,
25 reasonably anticipated experience.

26 Sec. 608b. (1) The rates for group subscribers, other than
27 those covered under the small employer health market reform act,

1 shall be filed with and approved by the commissioner. The rates
2 under this section shall not be filed more frequently than
3 annually. The rates shall be reasonable in relation to the
4 benefits provided. The rates shall be considered reasonable if
5 the filing includes an actuarial certification that the
6 anticipated loss ratio will not be less than 70%. The rates
7 shall be considered approved and effective 30 days after filing
8 with the commissioner.

9 (2) Not later than 180 days after every 2 years after a rate
10 approved under subsection (1) has been in effect, the health care
11 corporation shall determine if the minimum loss ratio has been
12 met for each of the group lines of business. This determination
13 shall be based on the actual experience of each group line of
14 business over the 2-year period under review. The results of
15 this determination shall be filed with the commissioner.

16 (3) If the actual loss ratio is less than the anticipated
17 minimum loss ratio under subsection (1) for group subscribers,
18 the health care corporation shall give a pro rata rate credit or
19 credits to current group subscribers. The rate credits shall be
20 determined separately for each group line of business. In the
21 aggregate, the rate credits shall be in an amount equal to the
22 difference between the actual loss ratio and the minimum loss
23 ratio. The rate credits shall begin no later than 180 days after
24 there has been a determination that the anticipated minimum loss
25 ratio was not met. The rate credits shall be filed with the
26 commissioner.

27 Sec. 608c. (1) If the commissioner disapproves the rates

1 filed under section 608a or 608b, the commissioner shall issue a
2 written order of disapproval. The order shall state specifically
3 the reasons the rates fail to achieve the minimum loss ratio and
4 what modifications are required to meet the minimum loss ratio.

5 (2) If the commissioner disapproves the rates filed under
6 section 608a or 608b, the health care corporation may request a
7 contested case hearing contesting the disapproval under the
8 administrative procedures act. The hearing shall be conducted by
9 an independent hearing officer appointed by the commissioner.
10 The person appointed as the independent hearing officer shall
11 meet the qualifications and conditions listed under section
12 613(1). The hearing shall be conducted under the time frames and
13 guidelines established under section 613(2).

14 Sec. 608d. (1) For purposes of sections 608a to 608c, the
15 premium income used to calculate the anticipated and actual loss
16 ratio shall include any cost transfer received by the line of
17 business pursuant to section 609(5), but shall not include any
18 cost transfer paid by the line of business pursuant to section
19 609(5). In addition, the premium income used to calculate the
20 anticipated and actual loss ratio for group business shall not
21 include the reserve for the prior experience of the group.

22 (2) As used in this section and sections 608a to 608c:

23 (a) "Loss ratio" means incurred claims as a percentage of
24 earned subscription income, where incurred claims are the amount
25 paid for health care services during the applicable period plus
26 the reserve for claims incurred but not paid as of the end of the
27 applicable period minus the reserve for claims incurred but not

1 paid as of the beginning of the applicable period.

2 (b) "Rate" includes any rating methodology or formula used by
3 the health care corporation to develop rates for group, nongroup,
4 or group conversion business.

5 Sec. 609. (1) A rate is not excessive if the rate is not
6 unreasonably high relative to the following elements,
7 individually or collectively; provision for anticipated benefit
8 costs; provision for administrative expense; provision for cost
9 transfers, if any; provision for a contribution to or from ~~the~~
10 ~~corporate contingency reserve that is consistent with the~~
11 ~~attainment or maintenance of the target contingency reserve level~~
12 ~~prescribed in section 205~~ **surplus that is consistent with the**
13 **attainment or maintenance of adequate and unimpaired surplus as**
14 **provided in section 204a;** and provision for adjustments due to
15 prior experience of groups, as defined in the group rating
16 system. A determination as to whether a rate is excessive
17 relative to ~~the~~ **these** elements, ~~listed above,~~ individually or
18 collectively, shall be based on the following: reasonable
19 evaluations of recent claim experience; projected trends in claim
20 costs; the allocation of administrative expense budgets; and the
21 present and anticipated ~~contingency reserve positions~~
22 **unimpaired surplus** of the health care corporation. To the extent
23 that any of these elements are considered excessive, the
24 provision in the rates for these elements shall be modified
25 accordingly.

26 (2) The administrative expense budget must be reasonable, as
27 determined by the commissioner after examination of material and

1 substantial administrative and acquisition expense items.

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

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

15 (5) Except for identified cost transfers, each line of
16 business, over time, shall be self-sustaining. However, there
17 may be cost transfers for the benefit of senior citizens and
18 group conversion subscribers. Cost transfers for the benefit of
19 senior citizens, in the aggregate, annually shall not exceed 1%
20 of the earned subscription income of the health care corporation
21 as reported in the most recent annual statement of the
22 corporation. Group conversion subscribers are those who have
23 maintained coverage with the health care corporation on an
24 individual basis after leaving a subscriber group. ~~The Michigan~~
25 ~~caring program created in section 436 is not subject to any~~
26 ~~assessment or surcharge for cost transfer under this subsection.~~

27 Sec. 610. (1) Except as provided under section ~~608(4) or~~

1 ~~(5)~~ **608(3)**, a filing of information and materials relative to a
2 proposed **nongroup medicare supplemental** rate shall be made not
3 less than ~~120~~ **90** days before the proposed effective date of the
4 proposed rate. A filing shall not be considered to have been
5 received until there has been substantial and material compliance
6 with the requirements prescribed in subsections (6) and (8).

7 (2) Within 30 days after a filing is made of information and
8 materials relative to a proposed **nongroup medicare supplemental**
9 rate, the commissioner shall do either of the following:

10 (a) Give written notice to the corporation, and to each
11 person described under section 612(1), that the filing is in
12 material and substantial compliance with subsections (6) and (8)
13 and that the filing is complete. The commissioner shall then
14 proceed to approve, approve with modifications, or disapprove the
15 rate filing 60 days after receipt of the filing, based upon
16 whether the filing meets the requirements of this act. However,
17 if a hearing has been requested under section 613, the
18 commissioner shall not approve, approve with modifications, or
19 disapprove a filing until the hearing has been completed and an
20 order issued.

21 (b) Give written notice to the corporation that the
22 corporation has not yet complied with subsections (6) and (8).
23 The notice shall state specifically ~~in what respects~~ **the**
24 **reasons** the filing fails to meet the requirements of subsections
25 (6) and (8).

26 (3) Within 10 days after the filing of notice pursuant to
27 subsection (2)(b), the corporation shall submit to the

1 commissioner ~~such~~ additional information and materials ~~as~~
2 requested by the commissioner. Within 10 days after receipt of
3 the additional information and materials, the commissioner shall
4 determine whether the filing is in material and substantial
5 compliance with subsections (6) and (8). If the commissioner
6 determines that the filing does not yet materially and
7 substantially meet the requirements of subsections (6) and (8),
8 the commissioner shall give notice to the corporation pursuant to
9 subsection (2)(b) or use visitation of the corporation's
10 facilities and examination of the corporation's records to obtain
11 the necessary information described in the notice issued pursuant
12 to subsection (2)(b). The commissioner shall use either
13 procedure previously mentioned, or a combination of both
14 procedures, in order to obtain the necessary information as
15 expeditiously as possible. The per diem, traveling,
16 reproduction, and other necessary expenses in connection with
17 visitation and examination shall be paid by the corporation, and
18 shall be credited to the general fund of the state.

19 (4) If a filing is approved, approved with modifications, or
20 disapproved under subsection (2)(a), the commissioner shall issue
21 a written order of the approval, approval with modifications, or
22 disapproval. If the filing was approved with modifications or
23 disapproved, the order shall state specifically ~~in what~~
24 ~~respects~~ **the reasons** the filing fails to meet the requirements
25 of this act and, if applicable, what modifications are required
26 for approval under this act. If the filing was approved with
27 modifications, the order shall state that the filing shall take

1 effect after the modifications are made and approved by the
2 commissioner. If the filing was disapproved, the order shall
3 state that the filing shall not take effect.

4 (5) The inability to approve 1 or more rating classes of
5 business within a line of business because of a requirement to
6 submit further data or because a request for a hearing under
7 section 613 has been granted shall not delay the approval of
8 rates by the commissioner ~~which~~ **that** could otherwise be
9 approved or the implementation of rates already approved, unless
10 the approval or implementation would affect the consideration of
11 the unapproved classes of business.

12 (6) Information furnished under subsection (1) in support of
13 a nongroup **medicare supplemental** rate filing shall include the
14 following:

15 (a) Recent claim experience on the benefits or comparable
16 benefits for which the rate filing applies.

17 (b) Actual prior trend experience.

18 (c) Actual prior administrative expenses.

19 (d) Projected trend factors.

20 (e) Projected administrative expenses.

21 (f) Contributions for risk and contingency reserve factors.

22 (g) Actual health care corporation contingency reserve
23 position.

24 (h) Projected health care corporation contingency reserve
25 position.

26 (i) Other information ~~which~~ the corporation considers
27 pertinent to evaluating the risks to be rated, or relevant to the

1 determination to be made under this section.

2 (j) Other information ~~which~~ the commissioner considers
3 pertinent to evaluating the risks to be rated, or relevant to the
4 determination to be made under this section.

5 (7) A copy of the filing, and all supporting information,
6 except for the information ~~which~~ **that** may not be disclosed
7 under section 604, shall be open to public inspection as of the
8 date filed with the commissioner.

9 (8) The commissioner shall make available forms and
10 instructions for filing for proposed rates under ~~sections~~
11 **section** 608(1). ~~and 608(2).~~ The forms with instructions shall
12 be available not less than 180 days before the proposed effective
13 date of the filing.

14 Sec. 611. It is the intent of the legislature to promote
15 uniformity of rates among subscribers to the greatest extent
16 practicable. **This section does not prohibit the use of rate**
17 **differentials as permitted by sections 608a and 608b.**

18 Sec. 612. (1) Upon receipt of a **nongroup medicare**
19 **supplemental** rate filing under section 610, the commissioner
20 immediately shall notify each person who has requested in writing
21 notice of those filings within the previous 2 years, specifying
22 the nature and extent of the proposed rate revision and
23 identifying the location, time, and place where the copy of the
24 rate filing described in section 610(7) shall be open to public
25 inspection and copying. The notice shall also state that if the
26 person has standing, the person shall have, upon making a written
27 request for a hearing within ~~60~~ 30 days after receiving notice

1 of the rate filing, an opportunity for an evidentiary hearing
2 under section 613 to determine whether the proposed rates meet
3 the requirements of this act. The request shall identify the
4 issues ~~which~~ **that** the requesting party asserts are involved,
5 what portion of the rate filing is requested to be heard, and how
6 the party has standing. The corporation shall place
7 advertisements giving notice, containing the information
8 specified above, in at least 1 newspaper ~~which serves~~ **serving**
9 each geographic area in which significant numbers of subscribers
10 reside.

11 (2) The commissioner may charge a fee for providing, pursuant
12 to subsection (1), a copy of the rate filing described in section
13 610(7). The commissioner may charge a fee for providing a copy
14 of the entire filing to a person whose request for a hearing has
15 been granted by the commissioner pursuant to section 613. The
16 fee shall be limited to actual mailing costs and to the actual
17 incremental cost of duplication, including labor and the cost of
18 deletion and separation of information as provided in section 14
19 of ~~Act No. 442 of the Public Acts of 1976, being section 15.244~~
20 ~~of the Michigan Compiled Laws~~ **the freedom of information act,**
21 **1976 PA 442, MCL 15.244.** Copies of the filing may be provided
22 free of charge or at a reduced charge if the commissioner
23 determines that a waiver or reduction of the fee is in the public
24 interest because the furnishing of a copy of the filing will
25 primarily benefit the general public. In calculating the costs
26 under this subsection, the commissioner shall not attribute more
27 than the hourly wage of the lowest paid, full-time clerical

1 employee of the ~~insurance bureau~~ **office of financial and**
2 **insurance services** to the cost of labor incurred in duplication
3 and mailing and to the cost of separation and deletion. The
4 commissioner shall use the most economical means available to
5 provide copies of a rate filing.

6 Sec. 613. (1) If the request for a hearing under this
7 section is with regard to a rate filing not yet acted upon under
8 section 610(2)(a), no such action shall be taken by the
9 commissioner until after the hearing has been completed.
10 However, the commissioner shall proceed to act upon those
11 portions of a rate filing upon which no hearing has been
12 requested. Within 15 days after receipt of a request for a
13 hearing, the commissioner shall determine if the person has
14 standing. If the commissioner determines that the person has
15 standing, the person may have access to the entire filing subject
16 to the same confidentiality requirements as the commissioner
17 under section 604, and shall be subject to the penalty provision
18 of section 604(5). Upon determining that the person has
19 standing, the commissioner shall immediately appoint an
20 independent hearing officer before whom the hearing shall be
21 held. In appointing an independent hearing officer, the
22 commissioner shall select a person qualified to conduct hearings,
23 who has experience or education in the area of health care
24 corporation or insurance rate determination and finance, and who
25 is not otherwise associated financially with a health care
26 corporation or a health care provider. The person selected shall
27 not be currently or actively employed by this state. For

1 purposes of this subsection, an employee of an educational
2 institution shall not be considered to be employed by this
3 state. For purposes of this section, a person has "standing" if
4 any of the following circumstances exist:

5 (a) The person is, or there are reasonable grounds to believe
6 that the person could be, aggrieved by the proposed rate.

7 (b) The person is acting on behalf of 1 or more named persons
8 described in subdivision (a).

9 (c) The person is the commissioner, the attorney general, or
10 the health care corporation.

11 (2) ~~Not more than 30 days after receipt of a request for a~~
12 ~~hearing, and upon not less than 15 days' notice to all parties,~~
13 ~~the hearing shall be commenced.~~ **A hearing shall be held not**
14 **later than 45 days after receipt of a request for a hearing. A**
15 **pretrial conference may be held prior to the start of a hearing**
16 **but cannot delay the start of a hearing.** Each party to the
17 hearing shall be given a reasonable opportunity for discovery
18 before and throughout the course of the hearing. However, the
19 hearing officer may terminate discovery at any time, for good
20 cause shown, **and discovery cannot delay the start of a hearing.**
21 The hearing officer shall conduct the hearing pursuant to the
22 administrative procedures act. The hearing shall be conducted in
23 an expeditious manner. At the hearing, the burden of proving
24 compliance with this act shall be upon the health care
25 corporation.

26 (3) In rendering a proposal for a decision, the hearing
27 officer shall consider the factors prescribed in section 609.

1 (4) Within 30 days after receipt of the hearing officer's
2 proposal for decision, the commissioner shall by order render a
3 decision ~~which~~ **that** shall include a statement of findings.

4 (5) The commissioner shall withdraw an order of approval or
5 approval with modifications if the commissioner finds that the
6 filing no longer meets the requirements of this act.

7 Sec. 614. (1) Not less than ~~75~~ **45** days after a **nongroup**
8 **medicare supplemental rate** filing is received, as provided in
9 section 610, the health care corporation may petition the
10 commissioner, who shall make a determination with respect to
11 interim rates and shall order interim rates in the amount
12 prescribed in subsection (2). Interim rates shall not be
13 implemented if the commissioner finds that the health care
14 corporation has substantially contributed to the delay or that
15 the health care corporation has not provided information
16 requested by the commissioner relative to a determination under
17 this section. The interim rate determination shall not be a
18 contested case under chapter 4 of the administrative procedures
19 act, **MCL 24.271 to 24.287**.

20 (2) ~~The~~ **Within 15 days after receiving the petition for**
21 **interim rates, the** commissioner shall grant an interim rate, in
22 an amount as determined by the commissioner, if the commissioner
23 makes a finding that the corporation has ~~made a convincing~~
24 ~~showing that there is~~ **shown** probable cause to believe that the
25 failure to grant the interim rate will result in an underwriting
26 loss for that line of business for the period for which rates are
27 being requested. As used in this subsection, "underwriting loss"

1 means the difference between income from current rates plus
2 investment income, and projected claims plus projected
3 administrative expenses.

4 (3) If the final rate determination results in approval of a
5 lower rate, appropriate refunds or adjustments, as determined by
6 the commissioner, shall be made to reflect payments made in
7 excess of the approved rate.

8 (4) The order establishing an interim rate adjustment made
9 pursuant to this section ~~shall be~~ **is** limited to adjusting rates
10 for certificates then in effect, and shall not be used to alter
11 certificates or implement new certificates.

12 (5) This section shall apply only to rates subject to section
13 608(1) for which a hearing has been requested.

14 **Sec. 620. (1) Except as otherwise provided in this section,**
15 **a health care corporation compliance self-evaluative audit**
16 **document is privileged information and is not discoverable or**
17 **admissible as evidence in any civil, criminal, or administrative**
18 **proceeding.**

19 (2) Except as otherwise provided in this section, a person
20 involved in preparing a compliance self-evaluative audit or
21 compliance self-evaluative audit document is not subject to
22 examination concerning that audit or audit document in any civil,
23 criminal, or administrative proceeding. However, if the
24 compliance self-evaluative audit, compliance self-evaluative
25 audit document, or any portion of the audit or audit document is
26 not privileged, the individual involved in the preparation of the
27 audit or audit document may be examined concerning the portion of

1 the audit or audit document that is not privileged. A person
2 involved in preparing a compliance self-evaluative audit or
3 compliance self-evaluative audit document who becomes aware of
4 any alleged criminal violation of this act shall report that act
5 to the health care corporation. Within 30 days after receiving
6 the report, the health care corporation shall provide the
7 information to the commissioner.

8 (3) A compliance self-evaluative audit document furnished to
9 the commissioner voluntarily or as a result of a request of the
10 commissioner under a claim of authority to compel disclosure
11 under subsection (7) shall not be provided by the commissioner to
12 any other person and shall be accorded the same confidentiality
13 and other protections provided under this act without waiving the
14 privileges in subsections (1) and (2). Any use of a compliance
15 self-evaluative audit document furnished voluntarily or as a
16 result of a request of the commissioner under a claim of
17 authority to compel disclosure under subsection (7) is limited to
18 determining whether or not any disclosed defects in a health care
19 corporation's policies and procedures or inappropriate treatment
20 of customers has been remedied or that an appropriate plan for
21 remedy is in place.

22 (4) A compliance self-evaluative audit document submitted to
23 the commissioner remains subject to all applicable statutory or
24 common law privileges including, but not limited to, the work
25 product doctrine, attorney-client privilege, or the subsequent
26 remedial measures exclusion. A compliance self-evaluative audit
27 document submitted to the commissioner remains the property of

1 the health care corporation and is not subject to disclosure
2 under the freedom of information act, 1976 PA 442, MCL 15.231 to
3 15.246.

4 (5) Disclosure of a compliance self-evaluative audit document
5 to a governmental agency, whether voluntary or pursuant to
6 compulsion of law, does not constitute a waiver of the privileges
7 under subsections (1) and (2) with respect to any other person or
8 other governmental agency.

9 (6) The privileges under subsections (1) and (2) do not apply
10 to the extent that they are expressly waived by the health care
11 corporation that prepared or caused to be prepared the compliance
12 self-evaluative audit document.

13 (7) The privileges in subsections (1) and (2) do not apply as
14 follows:

15 (a) If a court, after an in camera review, requires
16 disclosure in a civil or administrative proceeding after
17 determining 1 or more of the following:

18 (i) The privilege is asserted for a fraudulent purpose.

19 (ii) The material is not subject to the privilege as provided
20 under subsection (13).

21 (b) If a court, after an in camera review, requires
22 disclosure in a criminal proceeding after determining 1 or more
23 of the following:

24 (i) The privilege is asserted for a fraudulent purpose.

25 (ii) The material is not subject to the privilege as provided
26 under subsection (13).

27 (iii) The material contains evidence relevant to the

1 commission of a criminal offense under this act.

2 (8) Within 14 days after the commissioner or the attorney
3 general makes a written request by certified mail for disclosure
4 of a compliance self-evaluative audit document, the health care
5 corporation that prepared the document or caused the document to
6 be prepared may file with the Ingham county circuit court a
7 petition requesting an in camera hearing on whether the
8 compliance self-evaluative audit document or portions of the
9 audit document are subject to disclosure. Failure by the health
10 care corporation to file a petition waives the privilege provided
11 by this section for that request. A health care corporation
12 asserting the compliance self-evaluative privilege in response to
13 a request for disclosure under this subsection shall include in
14 its request for an in camera hearing all of the information
15 listed in subsection (10). Within 30 days after the filing of
16 the petition, the court shall issue an order scheduling an in
17 camera hearing to determine whether the compliance
18 self-evaluative audit document or portions of the audit document
19 are privileged or are subject to disclosure.

20 (9) If the court requires disclosure under subsections (7)
21 and (8), the court may compel the disclosure of only those
22 portions of a compliance self-evaluative audit document relevant
23 to issues in dispute in the underlying proceeding. Information
24 required to be disclosed shall not be considered a public
25 document and shall not be considered to be a waiver of the
26 privilege for any other civil, criminal, or administrative
27 proceeding.

1 (10) A health care corporation asserting the privilege under
2 this section in response to a request for disclosure under
3 subsection (8) shall provide to the commissioner or the attorney
4 general, at the time of filing any objection to the disclosure,
5 all of the following information:

6 (a) The date of the compliance self-evaluative audit
7 document.

8 (b) The identity of the entity or individual conducting the
9 audit.

10 (c) The general nature of the activities covered by the
11 compliance self-evaluative audit.

12 (d) An identification of the portions of the compliance
13 self-evaluative audit document for which the privilege is being
14 asserted.

15 (11) A health care corporation asserting the privilege under
16 this section has the burden of demonstrating the applicability of
17 the privilege. Once a health care corporation has established
18 the applicability of the privilege, a party seeking disclosure
19 under subsection (7)(a)(i) has the burden of proving that the
20 privilege is asserted for a fraudulent purpose. The commissioner
21 or attorney general seeking disclosure under
22 subsection (7)(b)(iii) has the burden of proving the elements
23 listed in subsection (7)(b)(iii).

24 (12) The parties may at any time stipulate in proceedings
25 under this section to entry of an order directing that specific
26 information contained in a compliance self-evaluative audit
27 document is or is not subject to the privileges provided under

1 subsections (1) and (2). Any such stipulation may be limited to
2 the instant proceeding and, absent specific language to the
3 contrary, is not applicable to any other proceeding.

4 (13) The privileges provided under subsections (1) and (2) do
5 not extend to any of the following:

6 (a) Documents, communications, data, reports, or other
7 information expressly required to be collected, developed,
8 maintained, or reported to a regulatory agency under this act or
9 other federal or state law.

10 (b) Information obtained by observation or monitoring by any
11 regulatory agency.

12 (c) Information obtained from a source independent of the
13 compliance audit.

14 (d) Documents, communication, data, reports, memoranda,
15 drawings, photographs, exhibits, computer records, maps, charts,
16 graphs, and surveys kept or prepared in the ordinary course of
17 business.

18 (14) This section does not limit, waive, or abrogate the
19 scope or nature of any other statutory or common law privilege.

20 (15) As used in this section:

21 (a) "Compliance self-evaluative audit" means a voluntary,
22 internal evaluation, review, assessment, audit, or investigation
23 for the purpose of identifying or preventing noncompliance with
24 or promoting compliance with laws, regulations, orders, or
25 industry or professional standards, conducted by or on behalf of
26 a health care corporation licensed or regulated under this act or
27 which involves an activity regulated under this act.

1 (b) "Compliance self-evaluative audit document" means a
2 document prepared as a result of or in connection with a
3 compliance audit. A compliance self-evaluative audit document
4 may include a written response to the findings of a compliance
5 self-evaluative audit. A compliance self-evaluative audit
6 document may include, but is not limited to, field notes and
7 records of observations, findings, opinions, suggestions,
8 conclusions, drafts, memoranda, drawings, photographs, exhibits,
9 computer-generated or electronically recorded information,
10 telephone records, maps, charts, graphs, and surveys, if this
11 supporting information is collected or prepared in the course of
12 a compliance self-evaluative audit or attached as an exhibit to
13 the audit. A compliance self-evaluative audit document also
14 includes, but is not limited to, any of the following:

15 (i) A compliance self-evaluative audit report prepared by an
16 auditor, who may be an employee of the health care corporation or
17 an independent contractor, which may include the scope of the
18 audit, the information gained in the audit, and conclusions and
19 recommendations, with exhibits and appendices.

20 (ii) Memoranda and documents analyzing portions or all of the
21 compliance self-evaluative audit report and discussing potential
22 implementation issues.

23 (iii) An implementation plan that addresses correcting past
24 noncompliance, improving current compliance, and preventing
25 future noncompliance.

26 (iv) Analytic data generated in the course of conducting the
27 compliance self-evaluative audit.

1 Enacting section 1. To the extent that a provision of this
2 act concerning health coverage, including, but not limited to,
3 premiums, rates, filings, and coverages, conflicts with the small
4 employer health market reform act, the small employer health
5 market reform act supersedes this act.

6 Enacting section 2. This amendatory act does not take
7 effect unless Senate Bill No. 235
8 of the 92nd Legislature is enacted into
9 law.

10 Enacting section 3. Section 205 of the nonprofit health
11 care corporation reform act, 1980 PA 350, MCL 550.1205, is
12 repealed.