SENATE BILL No. 453

May 1, 2003, Introduced by Senator GEORGE 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 204, 206, 211, 301, 303, 304, 306, 307, 602, 607, 608, and 609 (MCL 550.1204, 550.1206, 550.1211, 550.1301, 550.1303, 550.1304, 550.1306, 550.1307, 550.1602, 550.1607, 550.1608, and 550.1609), section 211 as amended by 1993 PA 127, section 301 as amended by 1988 PA 45, section 608 as amended by 1991 PA 73, and section 609 as amended by 1991 PA 61, and by adding sections 204a, 205a, 206a, 301a, 306a, 403c, 502b, and 502c; and to repeal acts and parts of acts.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

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:

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(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), 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 take into account the risk-based capital requirements as developed by the national association of insurance commissioners in order to determine 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.

Sec. 205a. A health care corporation shall report financial information in conformity with sound actuarial practices and statutory accounting principles, including approved permitted practices, 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.

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. 206a. Notwithstanding any other provision of this act, a health care corporation shall not establish, invest in, purchase, own, hold, or otherwise acquire, either directly or indirectly, any network of, or legal entity that has established a network of, health care facilities or providers. If, prior to the effective date of this section, a health care facility has established, has invested in, has purchased, owns, holds, or has otherwise acquired, either directly or indirectly, any network of, or legal entity that has established a network of, health care facilities or providers, the health care corporation shall divest itself of any interest in the network or legal entity by not later than 2 years after the effective date of this section.

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. 301. (1) ~~The~~ **Except as otherwise provided in section 301a, the** property and lawful business of a health care corporation existing and authorized to do business under this act shall be held and managed by a board of directors to consist of not more than 35 members. The board shall exercise the powers and authority necessary to carry out the lawful purposes of the corporation, as limited by this act and the articles of incorporation and the bylaws of the corporation.

(2) ~~Four~~ **Except as otherwise provided in section 301a, 4**

voting members of the board shall be representatives of the public appointed by the governor by and with the advice and consent of the senate. Two of those members shall be retired individuals 62 years of age or older. The term of office of each representative of the public shall be 2 years, and until a successor is appointed and qualified. If a vacancy occurs before the conclusion of a 2-year term, the appointment of a representative to complete the term shall be made in the same manner as the original appointment.

(3) ~~The board of directors shall consist of not more than 25% provider directors. In addition to physician and hospital provider directors, not less than 1 provider director shall be a registered professional nurse who shall be representative of licensees under part 172 of the public health code, Act No. 368 of the Public Acts of 1978, as amended, being sections 333.17201 to 333.17242 of the Michigan Compiled Laws, and not less than 1 provider director shall be representative of the provider whose services, in the 1984 calendar year in the case of an existing health care corporation, or, in the calendar year immediately following incorporation in the case of a newly-formed health care corporation, generated the largest number of benefit claims received by the corporation from its subscribers. Other provider directors shall be as broadly representative of provider classes as possible.~~ **The terms of all provider board of director members shall end on the effective date of section 301a.**

(4) The bylaws of a health care corporation may authorize not more than 1 officer or employee of the corporation to serve as a

voting or nonvoting director.

(5) ~~The~~ **Except as otherwise provided in section 301a, the** remaining members of the board of directors shall include representatives of large subscriber groups, medium subscriber groups, small subscriber groups, and nongroup subscribers, in proportions ~~which~~ **that** fairly represent the total subscriber population of the health care corporation. However, at least 3 directors shall represent nongroup subscribers, at least 1 of whom shall be a retired individual 62 years of age or older, and at least 3 directors shall represent small subscriber groups. Large and medium subscriber groups shall be represented, to the greatest extent possible, by an equal number of labor and management representatives and shall be categorized as labor subscriber representatives or management subscriber representatives.

(6) The method of selection of the directors, other than the directors who are representatives of the public, ~~and additional provisions and requirements for further refinement or specification regarding the number of directors comprising each component~~ shall be specified in the bylaws. The ~~terms of office of directors~~ **method for filling vacancies in the offices of directors**, other than the directors who are representatives of the public, ~~and the method for filling vacancies in those offices~~ shall be provided in the bylaws. ~~However, if a term of office of more than 1 year is prescribed by the bylaws, at least 1/3 of the members of the board shall be selected each year.~~ **The term of office of any director except the term of office of the**

director under section 301a(3)(f) shall not exceed 3 years, and at least 1/3 of the members of the board, excluding the director under section 301a(3)(f), shall be selected each year. The bylaws shall provide that all members of the board shall be reimbursed only for all reasonable and necessary expenses incurred in carrying out their duties under this act and shall not receive any compensation for services to the health care corporation as director.

(7) The method of selection of each category of subscribers entitled to representation on the board under ~~subsection (5)~~ **this act** shall maximize subscriber participation to the extent reasonably practicable. This subsection ~~shall permit~~ **permits**, but **does** not require, the statewide election of a director. ~~or member of the corporate body.~~ The method of selection ~~shall~~ neither ~~permit~~ **permits** nor ~~require~~ **requires** nomination, endorsement, approval, or confirmation of a candidate or director by the ~~corporate body, the~~ board of directors, ~~or~~ the management of the health care corporation, or any member or members of any of these. This subsection ~~shall~~ **does** not apply to the selection of an officer or employee as a director pursuant to subsection (4). This subsection ~~shall~~ **does** not limit the rights of any director ~~, member of the corporate body,~~ or employee or officer of the health care corporation to participate in the selection process in his or her capacity as a subscriber, to the same extent as any other subscriber may participate.

~~(8) For the purposes of this section:~~

~~(a) "Health care provider" or "provider" includes:~~

~~(*i*) A person defined as a health care provider or provider in section 105(4); a person employed by a health care facility, as defined in section 105(3); or a director, officer, or trustee of a health care provider, as defined in section 105(4), unless the person serves in that capacity as a representative selected by the same subscriber group or collective bargaining representative which the person represents on the board of a health care corporation.~~

~~(*ii*) Except as provided in subdivision (b), a spouse, child, or parent of a health care provider who resides in the same household.~~

~~(*iii*) A person who receives more than 25% of his or her annual income through the provision of goods or services to health care providers, or who is an employee, officer, trustee, or director of a firm or organization which receives more than 25% of its annual income through the provision of goods or services to health care providers.~~

~~(b) For purposes of determining whether a director is a provider director, "health care provider" or "provider" does not include a spouse, child, or parent of a health care provider who resides in the same household if all of the following criteria are met:~~

~~(*i*) Not more than 1/3 of the total annual household income is earned by that health care provider.~~

~~(*ii*) The term of office of the director commences in the 1988 calendar year.~~

~~(*iii*) Not more than 2 directors qualify for the exemption~~

~~under this subdivision.~~

(8) ~~(9)~~ A director shall not be an employee, agent, officer, or director of an insurance company writing disability insurance inside or outside this state.

Sec. 301a. (1) All board of director members whose terms expire in April of 2004 shall not be reappointed or replaced.

(2) By June 30, 2004, the board of directors shall submit a plan to the commissioner detailing how it will reduce the size of the board by December 31, 2004 to 13 members including the chief executive officer. The plan shall be consistent with the requirements of this act and shall provide that an individual shall not serve more than 2 consecutive terms on the board. If a plan is not submitted by June 30, 2004, then the commissioner, after consultation with the board of directors, shall formulate and place into effect a plan consistent with this act. The plan submitted by the board of directors shall be considered to meet the requirements of this act if it is not disapproved by written order of the commissioner on or before October 1, 2004. As part of a disapproval order, the commissioner shall notify the board of directors in what respect all or any part of the plan submitted by the board of directors fails to meet the requirements of this act. Not later than 30 days after the date of the disapproval order, the board of directors shall submit a revised plan that meets the requirements of this act. If the board of directors fails to submit a revised plan or if the submitted revised plan does not meet the requirements of this act, as determined by the commissioner, then the commissioner

shall immediately formulate and place into effect a plan consistent with this act.

(3) Effective January 1, 2005, the board of directors shall consist of 13 members as follows:

(a) Three public members appointed by the governor with the advice and consent of the senate, at least 1 of whom shall be 62 years of age or older, and who shall represent the public interest in the charitable and benevolent mission of the nonprofit health insurer.

(b) One member representing nongroup subscribers.

(c) Two members representing self-insured groups.

(d) Three members representing small subscriber groups.

(e) Three members representing medium/large subscriber groups.

(f) The chief executive officer of the nonprofit health insurer.

Sec. 303. (1) Regular or special meetings of the board or a **board** committee ~~of the board~~ shall be held within this state. With respect to regular or special meetings of the board or a **board** committee, ~~of the board,~~ the bylaws shall include provisions regarding all of the following:

(a) The minimum number of regular meetings to be held each year.

(b) The publication and advance distribution of an agenda, including provisions respecting the time and place of the meeting and the business to be conducted. **Notice of meetings and the meeting agenda shall be posted on the health core corporation's**

website as soon as practical after publication or dissemination under this subdivision.

(c) Voting procedures. The use of proxies and round robins shall not be allowed.

(2) Notice of a regular meeting shall be given at least 15 days before the meeting and notice of a special meeting shall be given at least 24 hours before the meeting. ~~Attendance of a director at a meeting constitutes a waiver of notice of the meeting, except in cases in which a director attends a meeting for the express purpose of objecting to the transaction of any business because the meeting is not lawfully called or convened.~~ **All meetings shall be open to the public except as otherwise provided in section 304(2).**

(3) Unless otherwise restricted by the articles of incorporation or bylaws, a member of the board or of a committee designated by the board may participate in a meeting by means of conference telephone or similar communications equipment by means of which all individuals participating in the meeting can hear each other. Participation in a meeting pursuant to this subsection constitutes presence in person at the meeting.

(4) A majority of the **board** members ~~of the board~~ then in office, or of the members of a **board** committee, ~~thereof,~~ constitutes a quorum for the transaction of business, unless the articles or bylaws provide for a larger number. The vote of the majority of members present at a meeting at which a quorum is present constitutes the action of the board or of the committee, unless the vote of a larger number is required by this act, the

articles, or the bylaws. The following actions shall require the vote of not less than a majority of the members of the board then in office:

(a) Adoption of bylaws, amendments to bylaws, or repealers of bylaws.

(b) Adoption of articles of incorporation, amendments to articles, or repealers of articles.

(c) The proposal or establishment of rates or rating systems; the adoption of provider class plans or provider contracts; or the adoption of compensation for officers of the corporation.

(5) The bylaws shall provide that a record roll call vote shall be taken at the request of any 5 board members. The vote of each member shall be recorded in the minutes.

Sec. 304. (1) A health care corporation shall keep accurate books and records of account and **complete and detailed** minutes of the proceedings of the board of directors ~~of the health care corporation,~~ **and board** committees. ~~of the board, and the corporate body.~~ The books, records, and minutes may be in written form or in any other form capable of being converted into written form within a reasonable time **and shall be made available electronically to the commissioner**. One copy of the minutes or draft minutes from each meeting of the board of directors shall be transmitted to the commissioner within 15 days after the meeting was held. Upon the request of a member of the board of directors, consistent with the board member's fiduciary duty under section 310, a subscriber shall receive, within 15 days

after receipt of the request, a copy of the minutes or draft minutes of 1 or more meetings of the board ~~, its~~ **or board** committee ~~, or the corporate body,~~ and may be charged not more than the reasonable cost of copying and postage.

(2) Minutes shall be kept and need not be disclosed, except to the commissioner as provided in section 603, for those portions of meetings ~~which~~ **that** are held for the following purposes:

(a) To consider the hiring, promotion, dismissal, suspension, or discipline of an employee.

(b) To consider the purchase, lease, or sale of real property.

(c) For strategy and negotiation sessions connected with the negotiations of a collective bargaining agreement when either party requests a closed meeting.

(d) For trial or settlement strategy sessions in connection with specific contemplated or pending litigation. If these sessions are with respect to litigation to which the commissioner or the attorney general is a party, minutes regarding these sessions ~~shall~~ **are** not ~~be~~ subject to examination and free access under section 603.

(e) To consider medical records of an individual.

(f) To consider the acquisition or disposal of certificates of stock, bonds, certificates of indebtedness, and other intangibles in which the corporation may invest funds under section 206, if the information regarding proposed acquisition or disposal may affect the price paid or received.

(g) To consider provider appeals when the provider has requested a closed hearing.

(h) To discuss marketing strategy with regard to a particular customer or limited group of customers, or to discuss a new or changed benefit, the premature disclosure of which would have an adverse impact on the health care corporation.

(i) To consider the removal of a director from the board when the director requests a closed hearing.

(3) The date and time of preparation and existence of the minutes described in subsection (2), the contents of which shall not be disclosable except to the commissioner as provided in section 603, shall be noted in the minutes required to be kept under subsection (1). Once action is taken by the board to implement a consideration or discussion described in subsection (2)(b), (f), (g), or (h), once a collective bargaining agreement is reached as described in subsection (2)(c), once litigation is no longer pending as described in subsection (2)(d), or once a closed hearing is concluded as described in subsection (2)(i), and upon the request of the director to whom the hearing pertained, the minutes relating to the consideration, discussion, or strategy session shall be published and disseminated with the next succeeding set of minutes published and disseminated under subsection (1), and may be disclosed by the commissioner to other persons under section 603(3).

(4) The circuit court, upon proof of a proper purpose, may compel the production of books and records for examination by a subscriber or the attorney general.

Sec. 306. (1) A contract or other transaction between a health care corporation and 1 or more of its directors or officers, or between a health care corporation and any other corporation, firm, or association of any type or kind in which 1 or more of its directors or officers are directors or officers, or are otherwise interested, is not void or voidable solely because of such common directorship, officership, or interest, or solely because the directors are present at the meeting of the board or committee ~~ thereof which~~ **that** authorizes or approves the contract or transaction, if all of the following conditions are satisfied:

(a) The contract or other transaction is fair and reasonable to the corporation when it is authorized, approved, or ratified.

(b) The material facts as to the officer's or director's relationship or interest and as to the contract or transaction are disclosed or known to the board or committee, and the board or committee authorizes, approves, or ratifies the contract or transaction by a vote sufficient for the purpose. The conditions of this subdivision shall be considered satisfied only if the officer or director has announced the potential conflict prior to the vote, the minutes of the meeting reflect that announcement, and the officer or director abstained from the vote.

(2) When the validity of a contract described in subsection (1) is questioned, the burden of establishing its validity on the grounds prescribed is upon the director, officer, corporation, firm, or association asserting its validity.

(3) Common or interested directors shall not be counted in

determining the presence of a quorum at a board or committee meeting at the time a contract or transaction described in subsection (1) is authorized, approved, or ratified.

~~(4) The board, by affirmative vote of a majority of directors in office and irrespective of any personal interest of any of them, may establish reasonable compensation of directors for services to the health care corporation as directors or officers of the health care corporation.~~

(4) ~~(5)~~ The bylaws of a health care corporation may include provisions regarding conflict of interest which are more stringent than this section.

Sec. 306a. The board shall establish a compensation plan for executive and senior level management of the health care corporation, including any bonus plan tied to performance of the health care corporation. The plan is not effective until it is filed with and approved by the commissioner. The board shall notify the commissioner of any bonus issued to an executive or senior level member of management of the health care corporation within 10 days of issuance of the bonus. The board shall identify in the compensation plan, subject to the commissioner's approval, those executive and senior level management positions covered under the compensation plan.

Sec. 307. **(1)** The board of directors may establish those advisory councils and, unless otherwise provided in the articles of incorporation or bylaws, those committees it considers necessary to perform its duties. ~~Members of the corporate body may serve on committees of the board of directors.~~ With respect

to ~~committees of the~~ board **committees**, the bylaws shall include provisions regarding all of the following:

(a) Provisions ~~which~~ **that** assure that the membership of each committee provides for representation of all of the components of directors, as defined in the bylaws, to the greatest extent practicable.

(b) Provisions regarding emergency meetings of the executive committee of the health care corporation, and action by that committee on behalf of the board in cases of emergency, as defined **in and authorized** by the bylaws.

(2) The board of directors shall establish a provider advisory council within 90 days after the effective date of this subsection. The provider advisory council shall consist of not more than 12 members who shall fairly represent the classes of health care providers with whom the health care corporation contracts for services.

(3) The provider advisory council established under subsection (2) shall provide advice to the board of directors on matters concerning the impact of board policies on health care providers, including, but not limited to, participating contracts, coverage for medical services, billing and payment procedures and practices, and subscriber access to an appropriate number and mix of health care providers in this state.

(4) Except as otherwise provided in subsection (1)(b), a council or committee established under this section shall act in an advisory capacity to the board of directors. Except as otherwise provided in subsection (1)(b), the board of directors

shall meet and approve a council or committee recommendation before it is implemented. The minutes of all meetings of councils and committees established under this section shall be given to the members of the board of directors and shall be included in the minutes of the board of directors' meetings.

Sec. 403c. (1) A health care corporation delivering, issuing for delivery, or renewing in this state a medium subscriber group or large subscriber group certificate shall furnish to a payor, within 30 days after receiving a written request therefore and upon payment of a reasonable charge, all of the following information by coverage component for the certificate incurred during the immediately preceding 24-month period:

(a) Total number of individuals covered.

(b) Total number of claims.

(c) Total dollar amount of claims.

(d) Amount paid or allocated to providers on a per individual basis not included in subdivisions (a) to (c).

(e) All pertinent information used by the health care corporation to make its rates for that group. This subdivision does not require the release of any information otherwise exempt from disclosure under this chapter. The commissioner shall determine not less often than annually what is pertinent information under this subdivision.

(2) Information furnished under subsection (1) shall not disclose personal data that may reveal the identity of a covered individual. Information furnished under subsection (1) shall be

collected and provided to a payor based on the group the payor sponsors.

(3) As used in this section:

(a) "Coverage component" includes, but is not limited to, in-patient and out-patient facility coverage, professional provider coverage, and pharmacy coverage.

(b) "Payor" means the purchaser of group coverage whether the purchase is made directly from the health care corporation or is made through a third party administrator, an agency, or another entity.

Sec. 502b. A health care corporation shall submit to the commissioner for approval standard participating contract formats and any substantive changes to those participating contract formats. The contract format or change is considered approved 30 days after filing with the commissioner unless approved or disapproved within the 30 days. As used in this section, "substantive changes to those participating contract formats" means any change to a participating contract that alters the method of payment to a health care provider, alters the risk, if any, assumed by each party to the contract, or affects a provision required by law.

Sec. 502c. (1) A health care corporation shall provide evidence to the commissioner that it has executed participating contracts with a sufficient number of health care providers to enable the health care corporation to deliver health care services covered under a certificate.

(2) A health care corporation shall establish and maintain

adequate participating contracts to ensure reasonable proximity between participating providers and members for the delivery of covered health care services. In determining whether a health care corporation has complied with this subsection, the commissioner shall give due consideration to the relative availability of health care providers in a geographic area.

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. 607. (1) ~~A health care corporation shall submit a copy of any new or revised certificate to the commissioner along with applicable proposed rates and rate rationale. The certificates, and applicable proposed rates, shall be deemed approved and effective 30 days after filing with the commissioner, except as otherwise provided in this section.~~

Except as otherwise provided in subsection (2), if a health care corporation wants to offer a new certificate, change an existing certificate, or change a rate charge, a copy of the proposed revised certificate or proposed rate shall be filed with the commissioner and shall not take effect until 60 days after the filing unless the commissioner approves the change in writing before the expiration of the 60 days. The commissioner may subsequently disapprove any certificate ~~deemed approved~~ **or rate change**.

(2) The commissioner shall exempt from prior approval certificates resulting from a collective bargaining agreement.

(3) The commissioner may disapprove, or approve with modifications, a certificate and applicable rates under ~~1 or more~~ **either or both** of the following circumstances:

(a) If the rate charged for the benefits provided is not equitable, not adequate, or excessive, as defined in section 609.

(b) If the certificate contains 1 or more provisions ~~which~~ **that** are unjust, unfair, inequitable, misleading, deceptive, or ~~which~~ **that** encourage misrepresentation of the coverage.

~~(c) If a certificate reduces the scope, amount, or duration of benefits so as to have the effect of reducing the comprehensiveness of existing health care benefits available to groups or to individuals. The commissioner may approve a certificate which reduces the scope, amount, or duration of health care benefits if the commissioner determines that the certificate will be offered as an alternative in addition to an~~

~~existing certificate which provides comprehensive health care benefits and if the commissioner determines that approval of the alternative certificate will not adversely affect the opportunity for groups or individuals to obtain comprehensive health care benefits.~~

(4) The commissioner shall approve a certificate and applicable proposed rates if all of the following conditions are met:

(a) If the rate charged for the benefits provided is equitable, adequate, and not excessive, as defined in section 609.

(b) If the certificate does not contain any provision ~~which~~ **that** is unjust, unfair, inequitable, misleading, deceptive, or ~~which~~ **that** encourages misrepresentation of the coverage.

(5) If the commissioner disapproves a certificate and any applicable proposed rates under this section, he or she shall issue a notice of disapproval ~~which specifies in what respects~~ **specifying how** a filing fails to meet the requirements of this act. The notice shall state that the filing shall not become effective.

(6) If the commissioner approves, or approves with modifications, a certificate and any applicable proposed rates under this section, he or she shall issue a notice of approval or approval with modifications. If the notice is of approval with modifications, the notice shall specify what modifications in the filing are required for approval under this act, and the reasons for the modifications. The notice shall also state that the

filing shall become effective after the modifications are made and approved by the commissioner.

(7) Upon request by a health care corporation, the commissioner may allow certificates and rates to be implemented prior to filing to allow implementation of a new certificate on the date requested.

Sec. 608. (1) The rates charged to nongroup subscribers for each certificate shall be filed in accordance with section ~~610 and shall be subject to the prior approval of the commissioner~~ **607**. Annually, the commissioner shall approve, disapprove, or modify and approve the proposed or existing rates for each certificate subject to the standard that the rates must be determined to be equitable, adequate, and not excessive, as defined in section 609. The burden of proof that rates to be charged meet these standards shall be upon the health care corporation proposing to use the rates.

(2) ~~The~~ **A health care corporation shall file the** methodology and definitions of each rating system, formula, component, and factor used to calculate rates for group subscribers for each certificate, including the methodology and definitions used to calculate administrative costs for administrative services only and cost-plus arrangements ~~, shall be filed~~ in accordance with section ~~610 and shall be subject to the prior approval of the commissioner~~ **607**. The definition of a group, including any clustering principles applied to nongroup subscribers or small group subscribers for the purpose of group formation, ~~shall be~~ **is** subject to the prior approval of the

commissioner. ~~However, if a Michigan caring program is created under section 436, that program shall be defined as a group program for the purpose of establishing rates.~~ The commissioner shall approve, disapprove, or modify and approve the methodology and definitions of each rating system, formula, component, and factor for each certificate subject to the standard that the resulting rates for group subscribers must be determined to be equitable, adequate, and not excessive, as defined in section 609. In addition, the commissioner may from time to time review the records of the corporation to determine proper application of a rating system, formula, component, or factor ~~with respect to~~ **for** any group. The corporation shall refile **every 3 years** for approval under this subsection ~~, every 3 years,~~ **of** the methodology and definitions of each rating system, formula, component, and factor used to calculate rates for group subscribers, including the methodology and definitions used to calculate administrative costs for administrative services only and cost-plus arrangements. The burden of proof that the resulting rates to be charged meet these standards shall be upon the health care corporation proposing to use the rating system, formula, component, or factor.

(3) A proposed rate shall not take effect until a filing has been made with the commissioner and approved under section 607 or this section, as applicable, except as provided in subsections (4) and (5).

(4) Upon request by a health care corporation, the commissioner may allow rate adjustments to become effective prior

to approval, for federal or state mandated benefit changes. However, **the health care corporation shall submit** a filing for these adjustments ~~shall be submitted~~ before the effective date of the mandated benefit changes. If the commissioner disapproves or modifies and approves the rates, an adjustment ~~shall be made~~ **is** retroactive to the effective date of the mandated benefit changes or additions.

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

Sec. 609. (1) A rate is not excessive if the rate is not unreasonably high relative to the following elements, individually or collectively; provision for anticipated benefit costs; provision for administrative expense; provision for cost transfers, if any; provision for a contribution to or from ~~the corporate contingency reserve that is consistent with the attainment or maintenance of the target contingency reserve level prescribed in section 205~~ **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. Sections 205, 305, 610, 612, 613, and 614 of the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1205, 550.1305, 550.1610, 550.1612, 550.1613, and 550.1614, are repealed.