SUBSTITUTE FOR

HOUSE BILL NO. 5282

A bill to amend 1956 PA 218, entitled

"The insurance code of 1956,"

by amending sections 2213b, 3406f, 3503, 3519, 3521, 3525, and 3539 (MCL 500.2213b, 500.3406f, 500.3503, 500.3519, 500.3521, 500.3525, and 500.3539), section 2213b as amended by 1998 PA 457, section 3406f as added by 1996 PA 517, section 3503 as amended by 2006 PA 366, sections 3519 and 3539 as amended by 2005 PA 306, and sections 3521 and 3525 as added by 2000 PA 252, and by adding chapter 37A.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Sec. 2213b. ~~(1) Except as provided in this section, an insurer that delivers, issues for delivery, or renews in this state an expense-incurred hospital, medical, or surgical individual policy under chapter 34 shall renew or continue in force the policy at the option of the individual.~~

(1) ~~(2)~~ Except as provided in this section **AND SECTION 3711**, an insurer that delivers, issues for delivery, or renews in this state an expense-incurred hospital, medical, or surgical group policy or certificate under chapter 36 shall renew or continue in force the policy or certificate at the option of the sponsor of the plan.

(2) ~~(3)~~ Guaranteed renewal is not required in cases of fraud, intentional misrepresentation of material fact, lack of payment, if the insurer no longer offers that particular type of coverage in the market, or if the individual or group moves outside the service area.

(3) ~~(4)~~ Subsections (1) ~~,~~ **AND** (2) ~~, and (3)~~ do not apply to a short-term or 1-time limited duration policy or certificate of no longer than 6 months.

(4) ~~(5)~~ For the purposes of this section and section 3406f, a short-term or 1-time limited duration policy or certificate of no longer than 6 months is an individual health policy that meets all of the following:

(a) Is issued to provide coverage for a period of 185 days or less, except that the health policy may permit a limited extension of benefits after the date the policy ended solely for expenses attributable to a condition for which a covered person incurred expenses during the term of the policy.

(b) Is nonrenewable, provided that the health insurer may provide coverage for 1 or more subsequent periods that satisfy subdivision (a), if the total of the periods of coverage do not exceed a total of 185 days out of any 365-day period, plus any

additional days permitted by the policy for a condition for which a covered person incurred expenses during the term of the policy.

(c) Does not cover any preexisting conditions.

(d) Is available with an immediate effective date, without underwriting, upon receipt by the insurer of a completed application indicating eligibility under the health insurer's eligibility requirements, except that coverage that includes optional benefits may be offered on a basis that does not meet this requirement.

(5) ~~(6)~~ An insurer that delivers, issues for delivery, or renews in this state a short-term or 1-time limited duration policy or certificate of no longer than 6 months shall provide ~~the following to the commissioner:~~

~~(a) By no later than February 1, 1999, a written report that discloses both of the following:~~

~~(*i*) The gross written premium for short-term or 1-time limited duration policies or certificates of no longer than 6 months issued in this state during the 1996 calendar year.~~

~~(*ii*) The gross written premium for all individual expense-incurred hospital, medical, or surgical policies or certificates issued or delivered in this state during the 1996 calendar year other than policies or certificates described in subparagraph (*i*).~~

~~(b) By~~ **BY** no later than March 31, 1999 and annually thereafter, a written annual report that discloses both of the following:

(A) ~~(*i*)~~ The gross written premium for short-term or 1-time limited duration policies or certificates issued in this state

during the preceding calendar year.

(B) ~~*(ii)*~~ The gross written premium for all individual expense-incurred hospital, medical, or surgical policies or certificates issued or delivered in this state during the preceding calendar year other than policies or certificates described in ~~subparagraph *(i)*~~ **SUBDIVISION (A)**.

(6) ~~(7)~~ The commissioner shall maintain copies of reports prepared pursuant to subsection ~~(6)~~ **(5)** on file with the annual statement of each reporting insurer. The commissioner shall annually compile the reports received under subsection ~~(6)~~ **(5)**. The commissioner shall provide this annual compilation to the senate and house of representatives standing committees on insurance issues no later than the June 1 immediately following the February 1 or March 31 date for which the reports under subsection ~~(6)~~ **(5)** are provided.

(7) ~~(8)~~ In each calendar year, a health insurer shall not continue to issue short-term or 1-time limited duration policies or certificates if to do so the collective gross written premiums on those policies or certificates would total more than 10% of the collective gross written premiums for all individual expense-incurred hospital, medical, or surgical policies or certificates issued or delivered in this state either directly by that insurer or through a corporation that owns or is owned by that insurer.

Sec. 3406f. (1) An insurer may exclude or limit coverage for a condition ~~as follows:~~

~~(a) For an individual covered under an individual policy or certificate or any other policy or certificate not covered under~~

~~subdivision (b) or (c), only if the exclusion or limitation relates to a condition for which medical advice, diagnosis, care, or treatment was recommended or received within 6 months before enrollment and the exclusion or limitation does not extend for more than 12 months after the effective date of the policy or certificate.~~

~~(b) For an individual covered under a group policy or certificate covering 2 to 50 individuals, only if the exclusion or limitation relates to a condition for which medical advice, diagnosis, care, or treatment was recommended or received within 6 months before enrollment and the exclusion or limitation does not extend for more than 12 months after the effective date of the policy or certificate.~~

~~(c) For~~ **FOR** an individual covered under a group policy or certificate covering more than 50 individuals, only if the exclusion or limitation relates to a condition for which medical advice, diagnosis, care, or treatment was recommended or received within 6 months before enrollment and the exclusion or limitation does not extend for more than 6 months after the effective date of the policy or certificate.

(2) As used in this section, "group" means a group health plan as defined in ~~section 2791(a)(1) and (2) of part C of title XXVII of the public health service act, chapter 373, 110 Stat. 1972, 42 U.S.C. 300gg-91~~ **42 USC 300GG-91**, and includes government plans that are not federal government plans.

(3) This section applies only to an insurer that delivers, issues for delivery, or renews in this state an expense-incurred

hospital, medical, or surgical policy or certificate. This section does not apply to any policy or certificate that provides coverage for specific diseases or accidents only, or to any hospital indemnity, medicare supplement, long-term care, disability income, or 1-time limited duration policy or certificate of no longer than 6 months.

~~(4) The commissioner and the director of community health shall examine the issue of crediting prior continuous health care coverage to reduce the period of time imposed by preexisting condition limitations or exclusions under subsection (1)(a), (b), and (c) and shall report to the governor and the senate and the house of representatives standing committees on insurance and health policy issues by May 15, 1997. The report shall include the commissioner's and director's findings and shall propose alternative mechanisms or a combination of mechanisms to credit prior continuous health care coverage towards the period of time imposed by a preexisting condition limitation or exclusion. The report shall address at a minimum all of the following:~~

~~(a) Cost of crediting prior continuous health care coverages.~~

~~(b) Period of lapse or break in coverage, if any, permitted in a prior health care coverage.~~

~~(c) Types and scope of prior health care coverages that are permitted to be credited.~~

~~(d) Any exceptions or exclusions to crediting prior health care coverage.~~

~~(e) Uniform method of certifying periods of prior creditable coverage.~~

Sec. 3503. (1) All of the provisions of this act that apply to a domestic insurer authorized to issue an expense-incurred hospital, medical, or surgical policy or certificate, including, but not limited to, sections 223 and 7925 and chapters 34**,** ~~and~~ 36, **AND 37A** apply to a health maintenance organization under this chapter unless specifically excluded, or otherwise specifically provided for in this chapter.

(2) Sections 408, 410, 411, 901, and 5208, chapter 77, and, except as otherwise provided in subsection (1), chapter 79 do not apply to a health maintenance organization.

Sec. 3519. (1) A health maintenance organization contract and the contract's rates, including any deductibles, copayments, and coinsurances, between the organization and its subscribers shall be fair, sound, and reasonable in relation to the services provided, and the procedures for offering and terminating contracts shall not be unfairly discriminatory.

(2) A health maintenance organization contract and the contract's rates shall not discriminate on the basis of race, color, creed, national origin, residence within the approved service area of the health maintenance organization, lawful occupation, sex, handicap, or marital status, except that marital status may be used to classify individuals or risks for the purpose of insuring family units. The commissioner may approve a rate differential based on sex, age, residence, disability, marital status, or lawful occupation, if the differential is supported by sound actuarial principles, a reasonable classification system, and is related to the actual and credible loss statistics or reasonably

anticipated experience for new coverages. A healthy lifestyle program as defined in section 3517(2) is not subject to the commissioner's approval under this subsection and is not required to be supported by sound actuarial principles, a reasonable classification system, or be related to actual and credible loss statistics or reasonably anticipated experience for new coverages.

(3) All health maintenance organization contracts shall include, at a minimum, basic health services.

(4) SUBSECTIONS (1) AND (2) DO NOT APPLY TO THE EXTENT THAT THEY CONFLICT WITH CHAPTER 37A.

Sec. 3521. (1) The methodology used to determine prepayment rates by category rates charged by the health maintenance organization and any changes to either the methodology or the rates shall be filed with and approved by the commissioner before becoming effective.

(2) A health maintenance organization shall submit supporting data used in the development of a prepayment rate or rating methodology and all other data sufficient to establish the financial soundness of the prepayment plan or rating methodology.

(3) The commissioner may annually require a schedule of rates for all subscriber contracts and riders. All submissions shall note changes of rates previously filed or approved.

(4) THIS SECTION DOES NOT APPLY TO THE EXTENT THAT IT CONFLICTS WITH CHAPTER 37A.

Sec. 3525. (1) Except as otherwise provided in subsection (2), if a health maintenance organization desires to change a contract it offers to enrollees or desires to change a rate charged, a copy

of the proposed revised contract or 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 60 days after the filing. If the commissioner considers that the proposed revised contract or rate is illegal or unreasonable in relation to the services provided, the commissioner, not more than 60 days after the proposed revised contract or rate is filed, shall notify the organization in writing, specifying the reasons for disapproval or for approval with modifications. For an approval with modifications, the notice shall specify what modifications in the filing are required for approval, the reasons for the modifications, and that the filing becomes effective after the modifications are made and approved by the commissioner. The commissioner shall schedule a hearing not more than 30 days after receipt of a written request from the health maintenance organization, and the revised contract or rate shall not take effect until approved by the commissioner after the hearing. Within 30 days after the hearing, the commissioner shall notify the organization in writing of the disposition of the proposed revised contract or rate, together with the commissioner's findings of fact and conclusions.

(2) If the revised contract or rate is the result of collective bargaining and affects only the members of the groups engaged in the collective bargaining, subsection (1) does not apply but the revised contract or rate shall be immediately filed with the commissioner.

(3) Not less than 30 days before the effective date of a

proposed change in a health maintenance contract or the rate charged, the health maintenance organization shall issue to each subscriber or group of subscribers who will be affected by the proposed change a clear written statement stating the extent and nature of the proposed change. If the commissioner has approved a proposed change in a contract or rate in writing before the expiration of 60 days after the date of filing, the organization immediately shall notify each subscriber or group of subscribers who will be affected by the proposed change.

(4) THIS SECTION DOES NOT APPLY TO THE EXTENT THAT IT CONFLICTS WITH CHAPTER 37A.

Sec. 3539. ~~(1) For an individual covered under a nongroup contract or under a contract not covered under subsection (2), a health maintenance organization may exclude or limit coverage for a condition only if the exclusion or limitation relates to a condition for which medical advice, diagnosis, care, or treatment was recommended or received within 6 months before enrollment and the exclusion or limitation does not extend for more than 6 months after the effective date of the health maintenance contract.~~

(1) ~~(2)~~ A health maintenance organization shall not exclude or limit coverage for a preexisting condition for an individual covered under a group contract.

~~(3) Except as provided in subsection (5), a health maintenance organization that has issued a nongroup contract shall renew or continue in force the contract at the option of the individual.~~

(2) ~~(4)~~ Except as provided in subsection ~~(5)~~ **(3) AND SECTION 3711**, a health maintenance organization that has issued a group

contract shall renew or continue in force the contract at the option of the sponsor of the plan.

(3) ~~(5)~~ Guaranteed renewal is not required in cases of fraud, intentional misrepresentation of material fact, lack of payment, if the health maintenance organization no longer offers that particular type of coverage in the market, or if the individual or group moves outside the service area.

(4) ~~(6)~~ A health maintenance organization is not required to continue a healthy lifestyle program or to continue any incentive associated with a healthy lifestyle program, including, but not limited to, goods, vouchers, or equipment.

(5) ~~(7)~~ As used in this section, "group" means a group of 2 or more subscribers.

CHAPTER 37A

INDIVIDUAL HEALTH COVERAGE PLANS

SEC. 3751. AS USED IN THIS CHAPTER:

(A) "BASE PREMIUM" MEANS THE LOWEST PREMIUM CHARGED FOR A RATING PERIOD UNDER A RATING SYSTEM BY A CARRIER TO INDIVIDUALS FOR EACH HEALTH BENEFIT PLAN IN A GEOGRAPHIC AREA.

(B) "CARRIER" MEANS A PERSON THAT PROVIDES HEALTH BENEFITS, COVERAGE, OR INSURANCE TO AN INDIVIDUAL IN THIS STATE. FOR THE PURPOSES OF THIS CHAPTER, CARRIER INCLUDES A HEALTH INSURANCE COMPANY AUTHORIZED TO DO BUSINESS IN THIS STATE, A NONPROFIT HEALTH CARE CORPORATION, A HEALTH MAINTENANCE ORGANIZATION, OR ANY OTHER PERSON PROVIDING A PLAN OF HEALTH BENEFITS, COVERAGE, OR INSURANCE SUBJECT TO STATE INSURANCE REGULATION. CARRIER DOES NOT INCLUDE A HEALTH MAINTENANCE ORGANIZATION THAT PROVIDES ONLY MEDICAID

COVERAGE.

(C) "GEOGRAPHIC AREA" MEANS AN AREA IN THIS STATE THAT INCLUDES NOT LESS THAN 1 ENTIRE COUNTY, ESTABLISHED BY A CARRIER PURSUANT TO SECTION 3765 AND USED FOR ADJUSTING PREMIUM FOR AN INDIVIDUAL HEALTH BENEFIT PLAN SUBJECT TO THIS CHAPTER. IN ADDITION, IF THE GEOGRAPHIC AREA INCLUDES 1 ENTIRE COUNTY AND ADDITIONAL COUNTIES OR PORTIONS OF COUNTIES, THE COUNTIES OR PORTIONS OF COUNTIES MUST BE CONTIGUOUS WITH AT LEAST 1 OTHER COUNTY OR PORTION OF ANOTHER COUNTY IN THAT GEOGRAPHIC AREA.

(D) "HEALTH BENEFIT PLAN" OR "PLAN" MEANS AN INDIVIDUAL EXPENSE-INCURRED HOSPITAL, MEDICAL, SURGICAL, OR DENTAL POLICY, NONPROFIT HEALTH CARE CORPORATION CERTIFICATE, OR HEALTH MAINTENANCE ORGANIZATION CONTRACT. HEALTH BENEFIT PLAN DOES NOT INCLUDE ACCIDENT-ONLY, CREDIT, OR DISABILITY INCOME INSURANCE; LONG-TERM CARE INSURANCE; COVERAGE ISSUED AS A SUPPLEMENT TO LIABILITY INSURANCE; COVERAGE ONLY FOR A SPECIFIED DISEASE OR ILLNESS; WORKER'S COMPENSATION OR SIMILAR INSURANCE; AUTOMOBILE MEDICAL-PAYMENT INSURANCE; OR MEDICAID COVERAGE.

(E) "INDEX RATE" MEANS THE ARITHMETIC AVERAGE DURING A RATING PERIOD OF THE BASE PREMIUM AND THE HIGHEST PREMIUM CHARGED TO AN INDIVIDUAL FOR EACH HEALTH BENEFIT PLAN OFFERED BY EACH CARRIER TO INDIVIDUALS IN A GEOGRAPHIC AREA.

(F) "INDIVIDUAL" MEANS A PERSON WHO IS NOT ELIGIBLE TO PARTICIPATE IN A HEALTH BENEFIT PLAN THROUGH A GROUP OR WHO, AS A RESULT OF HAVING TO PAY MORE THAN 50% OF THE PREMIUM TO PARTICIPATE IN A HEALTH BENEFIT PLAN THROUGH A GROUP, DECLINES TO PARTICIPATE IN THE GROUP PLAN AND DECLINES ANY PAYMENT OR REIMBURSEMENT FROM

THE EMPLOYER FOR THE PURCHASE OF AN INDIVIDUAL HEALTH BENEFIT PLAN.

(G) "INITIAL CONDITION" MEANS THE INITIAL HEALTH CONDITION AT THE TIME OF APPLICATION OF THE APPLICANT AND EACH INDIVIDUAL WHO WILL BE COVERED UNDER THE APPLICANT'S HEALTH BENEFIT PLAN. INITIAL CONDITION ALSO MEANS THE INITIAL HEALTH CONDITION AT THE TIME OF ENROLLMENT OF ANY INDIVIDUAL SUBSEQUENTLY ADDED TO THE HEALTH BENEFIT PLAN.

(H) "MEDICAID" MEANS A PROGRAM FOR MEDICAL ASSISTANCE ESTABLISHED UNDER TITLE XIX OF THE SOCIAL SECURITY ACT, 42 USC 1396 TO 1396V.

(I) "MEDICARE" MEANS THE FEDERAL MEDICARE PROGRAM ESTABLISHED UNDER TITLE XVIII OF THE SOCIAL SECURITY ACT, 42 USC 1395 TO 1395HHH.

(J) "NONPROFIT HEALTH CARE CORPORATION" MEANS A NONPROFIT HEALTH CARE CORPORATION OPERATING PURSUANT TO THE NONPROFIT HEALTH CARE CORPORATION REFORM ACT, 1980 PA 350, MCL 550.1101 TO 550.1704.

(K) "PREMIUM" MEANS ALL MONEY PAID BY AN INDIVIDUAL AS A CONDITION OF RECEIVING COVERAGE FROM A CARRIER.

(*l*) "RATING PERIOD" MEANS THE CALENDAR PERIOD FOR WHICH PREMIUMS ESTABLISHED BY A CARRIER ARE ASSUMED TO BE IN EFFECT, AS DETERMINED BY THE CARRIER.

(M) "SHORT-TERM OR 1-TIME LIMITED DURATION BENEFIT PLAN OF NO LONGER THAN 6 MONTHS" MEANS AN INDIVIDUAL HEALTH BENEFIT PLAN THAT MEETS ALL OF THE FOLLOWING:

(*i*) IS ISSUED TO PROVIDE COVERAGE FOR A PERIOD OF 185 DAYS OR LESS, EXCEPT THAT THE HEALTH BENEFIT PLAN MAY PERMIT A LIMITED EXTENSION OF BENEFITS AFTER THE DATE THE PLAN ENDED SOLELY FOR

EXPENSES ATTRIBUTABLE TO A CONDITION FOR WHICH A COVERED PERSON INCURRED EXPENSES DURING THE TERM OF THE PLAN.

(*ii*) IS NONRENEWABLE, PROVIDED THAT THE CARRIER MAY PROVIDE COVERAGE FOR 1 OR MORE SUBSEQUENT PERIODS THAT SATISFY SUBPARAGRAPH (*i*), IF THE TOTAL OF THE PERIODS OF COVERAGE DO NOT EXCEED A TOTAL OF 185 DAYS OUT OF ANY 365-DAY PERIOD, PLUS ANY ADDITIONAL DAYS PERMITTED BY THE PLAN FOR A CONDITION FOR WHICH A COVERED PERSON INCURRED EXPENSES DURING THE TERM OF THE PLAN.

(*iii*) DOES NOT COVER ANY PREEXISTING CONDITIONS.

(*iv*) IS AVAILABLE WITH AN IMMEDIATE EFFECTIVE DATE, WITHOUT UNDERWRITING, UPON RECEIPT BY THE CARRIER OF A COMPLETED APPLICATION INDICATING ELIGIBILITY UNDER THE CARRIER'S ELIGIBILITY REQUIREMENTS, EXCEPT THAT COVERAGE THAT INCLUDES OPTIONAL BENEFITS MAY BE OFFERED ON A BASIS THAT DOES NOT MEET THIS REQUIREMENT.

SEC. 3753. THIS CHAPTER APPLIES TO ANY INDIVIDUAL HEALTH BENEFIT PLAN, INCLUDING A MEDICARE SUPPLEMENT PLAN, THAT IS SUBJECT TO POLICY FORM OR PREMIUM APPROVAL BY THE COMMISSIONER.

SEC. 3755. (1) AT THE TIME OF INITIAL APPLICATION, EACH INDIVIDUAL SEEKING TO BE COVERED UNDER A HEALTH BENEFIT PLAN SHALL COMPLETE A HEALTH QUESTIONNAIRE ESTABLISHED BY THE CARRIER. A CARRIER, EXCEPT A NONPROFIT HEALTH CARE CORPORATION, MAY REFUSE COVERAGE TO AN INDIVIDUAL UNDER A HEALTH BENEFIT PLAN IF BASED ON THE RESPONSES TO THE HEALTH QUESTIONNAIRE THE INDIVIDUAL DOES NOT SATISFY THE CRITERIA ESTABLISHED FOR COVERAGE BY THE CARRIER. IF A CARRIER REFUSES COVERAGE FOR AN INDIVIDUAL UNDER THIS SUBSECTION, THE CARRIER SHALL PROVIDE THE INDIVIDUAL WITH A WRITTEN NOTICE OF REJECTION. AN INDIVIDUAL REFUSED COVERAGE UNDER THIS SUBSECTION IS

ELIGIBLE FOR A GUARANTEED ACCESS HEALTH BENEFIT PLAN FROM A NONPROFIT HEALTH CARE CORPORATION UNDER SUBSECTION (3).

(2) A NONPROFIT HEALTH CARE CORPORATION SHALL NOT REFUSE COVERAGE TO AN INDIVIDUAL DUE TO ANY PAST OR CURRENT MEDICAL CONDITION, HISTORY, OR TREATMENT. A NONPROFIT HEALTH CARE CORPORATION MAY, BASED ON THE RESPONSES TO THE HEALTH QUESTIONNAIRE, MAKE AVAILABLE TO AN INDIVIDUAL COVERAGE ONLY UNDER A GUARANTEED ACCESS HEALTH BENEFIT PLAN UNDER SUBSECTION (3).

(3) A NONPROFIT HEALTH CARE CORPORATION SHALL ESTABLISH AT LEAST 4 COMMISSIONABLE GUARANTEED ACCESS HEALTH BENEFIT PLANS FOR INDIVIDUALS WHO DO NOT QUALIFY FOR COVERAGE UNDER SUBSECTIONS (1) AND (2).

(4) A NONPROFIT HEALTH CARE CORPORATION SHALL CONSULT WITH THE COMMISSIONER IN DEVELOPING THE HEALTH QUESTIONNAIRE AND THE GUARANTEED ACCESS HEALTH BENEFIT PLANS REQUIRED UNDER THIS SECTION.

SEC. 3757. (1) A CARRIER MAY EXCLUDE OR LIMIT COVERAGE UNDER A HEALTH BENEFIT PLAN FOR A CONDITION ONLY IF THE EXCLUSION OR LIMITATION RELATES TO A CONDITION FOR WHICH MEDICAL ADVICE, DIAGNOSIS, CARE, OR TREATMENT WAS RECOMMENDED OR RECEIVED WITHIN 6 MONTHS BEFORE ENROLLMENT AND THE EXCLUSION OR LIMITATION DOES NOT EXTEND FOR MORE THAN 12 MONTHS AFTER THE EFFECTIVE DATE OF THE POLICY.

(2) NOTWITHSTANDING SUBSECTION (1), A CARRIER SHALL NOT EXCLUDE OR LIMIT COVERAGE FOR A PREEXISTING CONDITION OR PROVIDE A WAITING PERIOD IF ALL OF THE FOLLOWING APPLY:

(A) THE INDIVIDUAL'S MOST RECENT HEALTH CARE COVERAGE PRIOR TO APPLYING FOR COVERAGE WITH THE CARRIER WAS UNDER A GROUP HEALTH

PLAN.

(B) THE PERSON WAS CONTINUOUSLY COVERED PRIOR TO THE APPLICATION FOR COVERAGE WITH THE CARRIER UNDER 1 OR MORE HEALTH PLANS FOR AN AGGREGATE OF AT LEAST 18 MONTHS WITH NO BREAK IN COVERAGE THAT EXCEEDED 62 DAYS.

(C) THE PERSON IS NO LONGER ELIGIBLE FOR GROUP COVERAGE AND IS NOT ELIGIBLE FOR MEDICARE OR MEDICAID.

(D) THE PERSON DID NOT LOSE ELIGIBILITY FOR COVERAGE FOR FAILURE TO PAY ANY REQUIRED CONTRIBUTION OR FOR AN ACT TO DEFRAUD ANY CARRIER.

(E) IF THE PERSON WAS ELIGIBLE FOR CONTINUATION OF HEALTH COVERAGE FROM THAT GROUP HEALTH PLAN PURSUANT TO THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985, PUBLIC LAW 99-272, HE OR SHE HAS ELECTED AND EXHAUSTED THE COVERAGE.

(3) AS USED IN THIS SECTION, "GROUP HEALTH PLAN" MEANS A GROUP HEALTH BENEFIT PLAN THAT COVERS 2 OR MORE INSUREDS, SUBSCRIBERS, MEMBERS, ENROLLEES, OR EMPLOYEES.

SEC. 3759. (1) EXCEPT AS OTHERWISE PROVIDED IN THIS SECTION, A CARRIER THAT HAS ISSUED A HEALTH BENEFIT PLAN SHALL RENEW OR CONTINUE IN FORCE THE PLAN AT THE OPTION OF THE INDIVIDUAL.

(2) A GUARANTEED RENEWAL UNDER SUBSECTION (1) IS NOT REQUIRED IN CASES OF NONPAYMENT OF PREMIUMS, FRAUD, INTENTIONAL MISREPRESENTATION OF MATERIAL FACT, IF THE CARRIER NO LONGER OFFERS THAT PLAN, IF THE CARRIER NO LONGER OFFERS COVERAGE IN THE INDIVIDUAL MARKET, OR IF THE INDIVIDUAL MOVES OUTSIDE THE CARRIER'S SERVICE AREA. GUARANTEED RENEWAL OF A MEDICARE SUPPLEMENT PLAN IS SUBJECT TO SECTION 3819 AND IS NOT SUBJECT TO THIS SUBSECTION.

(3) A CARRIER SHALL NOT DISCONTINUE OFFERING A PARTICULAR PLAN IN THE INDIVIDUAL MARKET UNLESS THE CARRIER DOES ALL OF THE FOLLOWING:

(A) PROVIDES NOTICE TO EACH COVERED INDIVIDUAL PROVIDED COVERAGE UNDER THE PLAN OF THE DISCONTINUATION AT LEAST 90 DAYS PRIOR TO THE DATE OF THE DISCONTINUATION.

(B) OFFERS TO EACH INDIVIDUAL IN THE INDIVIDUAL MARKET PROVIDED THIS PLAN THE OPTION TO PURCHASE ANY OTHER PLAN CURRENTLY BEING OFFERED IN THE INDIVIDUAL MARKET.

(C) ACTS UNIFORMLY WITHOUT REGARD TO ANY HEALTH STATUS FACTOR OF ENROLLED INDIVIDUALS OR INDIVIDUALS WHO MAY BECOME ELIGIBLE FOR COVERAGE IN MAKING THE DETERMINATION TO DISCONTINUE COVERAGE AND IN OFFERING OTHER PLANS.

(4) A CARRIER SHALL NOT DISCONTINUE OFFERING ALL COVERAGE IN THE INDIVIDUAL MARKET UNLESS THE CARRIER DOES ALL OF THE FOLLOWING:

(A) PROVIDES NOTICE TO THE COMMISSIONER AND TO EACH INDIVIDUAL OF THE DISCONTINUATION AT LEAST 180 DAYS PRIOR TO THE DATE OF THE EXPIRATION OF COVERAGE.

(B) DISCONTINUES ALL HEALTH BENEFIT PLANS ISSUED IN THE INDIVIDUAL MARKET AND DOES NOT RENEW COVERAGE UNDER SUCH PLANS.

(5) IF A CARRIER DISCONTINUES COVERAGE UNDER SUBSECTION (4), THE CARRIER SHALL NOT PROVIDE FOR THE ISSUANCE OF ANY HEALTH BENEFIT PLANS IN THE INDIVIDUAL MARKET DURING THE 5-YEAR PERIOD BEGINNING ON THE DATE OF THE DISCONTINUATION OF THE LAST PLAN NOT SO RENEWED.

(6) SUBSECTIONS (1) THROUGH (5) DO NOT APPLY TO A SHORT-TERM OR 1-TIME LIMITED DURATION BENEFIT PLAN OF NO LONGER THAN 6 MONTHS.

SEC. 3763. (1) AS USED IN THIS SECTION, "ANTICIPATED LOSS RATIO" MEANS THE RATIO AT THE TIME OF THE RATE FILING, OR AT A TIME OF SUBSEQUENT RATE REVISIONS, OF THE EXPECTED FUTURE BENEFITS DURING THE RATING PERIOD, EXCLUDING DIVIDENDS, TO THE FUTURE PREMIUMS, LESS DIVIDENDS, BASED ON A CREDIBLE PREMIUM VOLUME OVER A REASONABLE PERIOD OF TIME WITH PROPER WEIGHT GIVEN TO TRENDS AND OTHER RELEVANT FACTORS. STATISTICAL DATA RELATING TO EXPECTED FUTURE BENEFITS SHALL BE PROVIDED TO THE COMMISSIONER UPON REQUEST FROM HEALTH BENEFIT PLANS SOLD OR TO BE SOLD IN THIS STATE WHEN AVAILABLE.

(2) THE RATES CHARGED TO INDIVIDUALS FOR HEALTH BENEFIT PLANS SHALL BE FILED WITH THE COMMISSIONER AND SHALL NOT TAKE EFFECT UNTIL 60 DAYS AFTER THE FILING, UNLESS THE COMMISSIONER APPROVES THE RATES IN WRITING BEFORE THE EXPIRATION OF 60 DAYS AFTER THE FILING. THE RATE FILING SHALL INCLUDE AN ACTUARIAL CERTIFICATION THAT THE BENEFITS PROVIDED ARE REASONABLE IN RELATION TO THE PREMIUM CHARGED AND ARE ADEQUATE, EQUITABLE, AND NOT EXCESSIVE. THE RATE FILING SHALL SHOW THE ANTICIPATED LOSS RATIO OR PLAN PREMIUM. EXCEPT FOR GUARANTEED-ACCESS HEALTH BENEFIT PLANS, THE BENEFITS PROVIDED ARE PRESUMED REASONABLE IN RELATION TO THE PREMIUMS CHARGED AND THE PREMIUMS ARE PRESUMED ADEQUATE, EQUITABLE, AND NOT EXCESSIVE IF THE ANTICIPATED LOSS RATIO EQUALS OR EXCEEDS 70%. FOR A GUARANTEED-ACCESS HEALTH BENEFIT PLAN, THE BENEFITS ARE PRESUMED REASONABLE IN RELATION TO THE PREMIUM CHARGED AND THE PREMIUM IS PRESUMED ADEQUATE, EQUITABLE, AND NOT EXCESSIVE IF THE PREMIUM DOES NOT EXCEED 150% OF THE WEIGHTED AVERAGE PREMIUM ASSOCIATED WITH AN INITIAL CONDITION RATING FACTOR OF 2 CHARGED BY THE 5 CARRIERS WITH

AT LEAST 50% OF THE INDIVIDUAL MARKET. THE WEIGHTED AVERAGE PREMIUM IS FOR AN EQUIVALENT HEALTH BENEFIT PLAN ADJUSTED APPROPRIATELY FOR THE DIFFERENCES IN ACTUARIAL VALUE OF BENEFITS, AGE, AND GEOGRAPHY.

(3) A NONPROFIT HEALTH CARE CORPORATION SHALL ASSUME FULL LIABILITY FOR ALL ADMINISTRATIVE EXPENSES FOR GUARANTEED-ACCESS HEALTH BENEFIT PLANS AND FOR CLAIM EXPENSES FOR GUARANTEED-ACCESS HEALTH BENEFIT PLANS UP TO 35% ABOVE THE MINIMUM LOSS RATIO FOR HEALTH BENEFIT PLANS THAT ARE NOT GUARANTEED-ACCESS HEALTH BENEFIT PLANS. THE NONPROFIT HEALTH CARE CORPORATION SHALL FILE ANNUAL REPORTS WITH THE COMMISSIONER REGARDING THE PREMIUMS, ADMINISTRATIVE EXPENSES, CLAIMS EXPERIENCE, AND LOSSES FOR ALL GUARANTEED-ACCESS HEALTH BENEFIT PLANS. THE COMMISSIONER SHALL PRESCRIBE THE FORM OF THE REPORT. THE REPORT SHALL BE FILED SEPARATELY AND SHALL NOT BE INCLUDED IN ANY OTHER REPORT FILED BY THE NONPROFIT HEALTH CARE CORPORATION.

(4) BEGINNING 2 YEARS AFTER THE EFFECTIVE DATE OF THIS CHAPTER, ALL CARRIERS, INCLUDING A NONPROFIT HEALTH CARE CORPORATION, SHALL ASSUME FULL LIABILITY FOR ALL EXCESS LOSSES AND COMMISSIONS IN THE GUARANTEED-ACCESS HEALTH BENEFIT PLANS. EXCESS LOSSES ARE THE SUM OF ALL CLAIMS LOSSES AND COMMISSIONS OVER 35% ABOVE THE MINIMUM LOSS RATIO FOR HEALTH BENEFIT PLANS THAT ARE NOT GUARANTEED-ACCESS HEALTH BENEFIT PLANS. EACH CARRIER SHALL BE REQUIRED TO PAY ITS PROPORTIONATE SHARE OF SUCH LOSSES BASED ON EACH CARRIER'S SHARE OF COVERED LIVES IN THE INDIVIDUAL MARKET. FOR PURPOSES OF THIS SECTION, THE INDIVIDUAL MARKET INCLUDES ALL INDIVIDUAL HEALTH BENEFIT PLANS EXCEPT MEDICARE SUPPLEMENT AND GUARANTEED-ACCESS HEALTH BENEFIT PLANS.

(5) THE COMMISSIONER SHALL DETERMINE EACH CARRIER'S PROPORTIONATE SHARE OF THE EXCESS LOSSES FOR THE GUARANTEED-ACCESS HEALTH BENEFIT PLANS. THE COMMISSIONER SHALL ISSUE ASSESSMENT NOTICES TO CARRIERS FOR THEIR PROPORTIONATE SHARE OF SUCH LOSSES. NO LATER THAN 90 DAYS AFTER THE ASSESSMENT NOTICES ARE ISSUED, THE CARRIERS SHALL PAY THE AMOUNT OF THEIR RESPECTIVE ASSESSMENTS TO THE COMMISSIONER. THE COMMISSIONER SHALL DEPOSIT ASSESSMENT PAYMENTS INTO THE GUARANTEED-ACCESS FUND WHICH IS CREATED WITHIN THE STATE TREASURY. THE STATE TREASURER MAY RECEIVE MONEY OR OTHER ASSETS FROM ANY SOURCE FOR DEPOSIT INTO THE FUND. THE STATE TREASURER SHALL DIRECT THE INVESTMENT OF THE FUND. THE STATE TREASURER SHALL CREDIT TO THE FUND INTEREST AND EARNINGS FROM FUND INVESTMENTS. MONEY IN THE FUND AT THE CLOSE OF THE FISCAL YEAR SHALL REMAIN IN THE FUND AND SHALL NOT LAPSE TO THE GENERAL FUND. THE COMMISSIONER SHALL BE THE ADMINISTRATOR OF THE FUND FOR AUDITING PURPOSES. MONEY IN THE FUND SHALL BE USED ONLY AS PROVIDED IN THIS CHAPTER AND TO PAY THE NONPROFIT HEALTH CARE CORPORATION TO OFFSET ALL EXCESS LOSSES IN THE GUARANTEED-ACCESS HEALTH BENEFIT PLANS. THE COMMISSIONER SHALL NOT ISSUE AN ASSESSMENT TO ANY CARRIER UNTIL THE EXCESS LOSS EQUALS OR EXCEEDS $10,000,000.00. THE COMMISSIONER SHALL BE ENTITLED TO REIMBURSEMENT OF THE ACTUAL COSTS OF ADMINISTERING THIS SECTION. DOCUMENTATION OF THE ACTUAL COSTS OF ADMINISTRATION SHALL BE MADE AVAILABLE TO ANY CARRIER UPON REQUEST.

(6) THE ACTUARIAL CERTIFICATION REQUIRED UNDER SUBSECTION (2) SHALL INCLUDE A DESCRIPTION OF THE GROSS PREMIUMS, THE ANTICIPATED LOSS RATIOS, AND A CERTIFICATION THAT, TO THE BEST OF THE ACTUARY'S KNOWLEDGE AND BELIEF, THE BENEFITS PROVIDED ARE REASONABLE IN

RELATION TO THE PREMIUMS CHARGED, THE PREMIUMS ARE ESTABLISHED IN COMPLIANCE WITH THIS CHAPTER, AND ANY PREMIUM DIFFERENCES AMONG THE HEALTH BENEFIT PLANS REFLECT THE ACTUARIAL VALUE OF THE HEALTH BENEFIT PLAN DIFFERENCES AND NOT THE UNDERLYING EXPERIENCE OF THE HEALTH BENEFIT PLANS. THE INFORMATION USED TO SUPPORT THE CERTIFICATION SHALL INCLUDE ALL OF THE FOLLOWING AND SHALL BE AVAILABLE UPON REQUEST TO THE COMMISSIONER:

(A) THE SPECIFIC FORMULA AND ASSUMPTIONS USED IN CALCULATING GROSS PREMIUMS.

(B) THE EXPECTED CLAIM COSTS.

(C) IDENTIFICATION OF MORBIDITY AND MORTALITY TABLES OR EXPERIENCE STUDIES USED AND SUFFICIENT EXPLANATION FOR EVALUATION OF THEIR VALIDITY, INCLUDING COPIES OF SUCH TABLES IF THEY ARE NOT CURRENTLY PUBLISHED.

(D) THE EXPERIENCE OF THE CARRIER ON SIMILAR COVERAGES OR ON THE SAME HEALTH BENEFIT PLAN IF THE HEALTH BENEFIT PLAN IS IN EFFECT ON THE EFFECTIVE DATE OF THIS CHAPTER.

(E) THE APPLICABILITY OF THE FILING TO IN-FORCE BUSINESS ON SUBSTANTIALLY SIMILAR HEALTH BENEFIT PLANS.

(F) LAPSE RATE EXPERIENCE.

(7) NO LATER THAN 4 MONTHS AFTER THE END OF A 12-MONTH RATING PERIOD, A CARRIER SHALL SUBMIT INFORMATION TO THE COMMISSIONER THAT SHOWS THE ACTUAL LOSS RATIO FOR THE RATING PERIOD FOR ALL HEALTH BENEFIT PLANS, INCLUDING PLANS THAT HAVE BEEN OR WILL BE CLOSED TO NEW APPLICANTS.

(8) IF THE ACTUAL LOSS RATIO FOR ALL HEALTH BENEFIT PLANS IN A LINE OF BUSINESS DOES NOT EQUAL OR EXCEED 70%, THE COMMISSIONER

SHALL ORDER THE CARRIER TO ISSUE RATE CREDITS OR REFUNDS TO INDIVIDUALS CURRENTLY IN A HEALTH BENEFIT PLAN IN THAT LINE OF BUSINESS IN AN AMOUNT THAT WILL RESULT IN A MINIMUM LOSS RATIO FOR THE RATING PERIOD EQUAL TO 70% FOR THE LINE OF BUSINESS. A CARRIER SHALL NOT BE ORDERED TO ISSUE A REFUND IN AN AMOUNT THAT IS LESS THAN $100.00 PER INDIVIDUAL APPLICANT. THE RATE CREDITS OR REFUNDS SHALL BE ISSUED NO LATER THAN 90 DAYS AFTER THE COMMISSIONER'S ORDER TO ISSUE RATE CREDITS OR REFUNDS. THE CLAIMS EXPERIENCE OF ANY LINE OF BUSINESS NOT DETERMINED TO BE CREDIBLE SHALL BE COMBINED WITH OTHER SIMILAR INDIVIDUAL LINES OF BUSINESS FOR PURPOSES OF DETERMINING LOSS RATIOS. AS USED IN THIS SUBSECTION, ALL OF THE FOLLOWING CONSTITUTE LINES OF BUSINESS:

(A) ALL HEALTH BENEFIT PLANS THAT ARE MEDICARE SUPPLEMENT PLANS.

(B) ALL HEALTH BENEFIT PLANS THAT ARE GROUP CONVERSION PLANS A CARRIER IS REQUIRED TO ISSUE UNDER SECTION 3612 OR SECTION 410A OF THE NONPROFIT HEALTH CARE CORPORATION REFORM ACT, 1980 PA 350, MCL 550.1410A.

(C) ALL HEALTH BENEFIT PLANS THAT ARE NEITHER MEDICARE SUPPLEMENT NOR GROUP CONVERSION PLANS.

(9) FOR A HEALTH BENEFIT PLAN ISSUED BY A NONPROFIT HEALTH CARE CORPORATION, THE ATTORNEY GENERAL MAY BRING AN ACTION OR APPLY TO THE CIRCUIT COURT FOR A COURT ORDER TO ENFORCE AN ORDER REQUIRING RATE CREDITS UNDER THIS SECTION.

SEC. 3765. (1) FOR ADJUSTING PREMIUMS FOR HEALTH BENEFIT PLANS SUBJECT TO THIS CHAPTER, A CARRIER MAY ESTABLISH UP TO 10 GEOGRAPHIC AREAS IN THIS STATE.

(2) EXCEPT AS OTHERWISE PROVIDED IN SUBSECTION (5), THE RATES CHARGED TO INDIVIDUALS FOR HEALTH BENEFIT PLANS MAY INCLUDE RATE DIFFERENTIALS BASED ON AGE AND INITIAL CONDITION IF THE DIFFERENTIALS ARE SUPPORTED BY SOUND ACTUARIAL PRINCIPLES AND A REASONABLE CLASSIFICATION SYSTEM AND ARE RELATED TO ACTUAL AND CREDIBLE LOSS STATISTICS OR REASONABLY ANTICIPATED EXPERIENCE IN THE CASE OF NEW HEALTH BENEFIT PLANS. PREMIUMS RESULTING FROM THESE RATE FACTORS SHALL NOT VARY FROM THE INDEX RATE FOR THAT HEALTH BENEFIT PLAN BY MORE THAN 80%. RATE DIFFERENTIALS BASED ON AGE SHALL NOT BE USED WITH ANY MEDICARE SUPPLEMENT PLAN.

(3) CARRIERS MAY USE AN APPLICATION FORM FOR A HEALTH BENEFIT PLAN THAT IS DESIGNED TO ELICIT THE HEALTH HISTORY OF AN APPLICANT AND EACH INDIVIDUAL WHO WILL BE COVERED UNDER THE APPLICANT'S HEALTH BENEFIT PLAN.

(4) CARRIERS MAY ESTABLISH UP TO 10 RATING TIERS TO REFLECT RATE DIFFERENTIALS FOR INITIAL CONDITION BASED ON THE ANSWERS GIVEN ON AN APPLICATION UNDER SUBSECTION (3) IF THE DIFFERENTIALS ARE SUPPORTED BY SOUND ACTUARIAL PRINCIPLES AND A REASONABLE CLASSIFICATION SYSTEM AND ARE RELATED TO ACTUAL AND CREDIBLE LOSS STATISTICS OR REASONABLY ANTICIPATED EXPERIENCE IN THE CASE OF NEW HEALTH BENEFIT PLANS. THE VARIATION IN RATES RESULTING FROM INITIAL CONDITION SHALL NOT EXCEED A 2-TO-1 RATIO.

(5) RATE DIFFERENTIALS FOR INITIAL CONDITION MAY BE USED ONLY WHEN COVERAGE IS INITIALLY ISSUED AND CANNOT BE CHANGED BY A CARRIER AT ANY TIME AFTER ISSUE AS A RESULT OF SUBSEQUENT CHANGES IN INITIAL CONDITION OF INDIVIDUALS ALREADY COVERED UNDER THE HEALTH BENEFIT PLAN. A CARRIER MAY USE RATE DIFFERENTIALS BASED ON

INITIAL CONDITION FOR ANY INDIVIDUAL WHO IS SUBSEQUENTLY ADDED TO THE HEALTH BENEFIT PLAN ONLY AT THE TIME THE INDIVIDUAL IS ADDED TO THE PLAN. INITIAL CONDITION RATING SHALL NOT BE USED WITH ANY MEDICARE SUPPLEMENT PLAN.

(6) IN ADDITION TO THE PREMIUM ADJUSTMENTS UNDER SUBSECTION (2), HEALTH BENEFIT PLAN OPTIONS, NUMBER OF FAMILY MEMBERS COVERED, MEDICARE ELIGIBILITY, AND TOBACCO USE MAY BE USED IN ESTABLISHING THE PREMIUM FOR A HEALTH BENEFIT PLAN. THE MAXIMUM SURCHARGE FOR TOBACCO USE SHALL NOT EXCEED 35% OF THE PREMIUM FOR A HEALTH BENEFIT PLAN.

SEC. 3767. THE PERCENTAGE INCREASE IN PREMIUMS CHARGED TO AN INDIVIDUAL IN A GEOGRAPHIC AREA FOR A NEW RATING PERIOD SHALL NOT EXCEED THE SUM OF THE ANNUAL PERCENTAGE ADJUSTMENT IN THE GEOGRAPHIC AREA'S INDEX RATE FOR THE HEALTH BENEFIT PLAN AND ANY ADJUSTMENT PURSUANT TO SECTION 3765(2). THE ADJUSTMENT PURSUANT TO SECTION 3765(2) SHALL NOT EXCEED 10% ANNUALLY AND SHALL BE ADJUSTED PRO RATA FOR RATING PERIODS OF LESS THAN 1 YEAR. THIS SECTION DOES NOT PROHIBIT AN ADJUSTMENT DUE TO CHANGE IN COVERAGE OR TO ADJUSTMENTS UNDER SECTION 3765(6).

SEC. 3769. HEALTH BENEFIT PLANS THAT HAVE BEEN OR WILL BE CLOSED TO NEW APPLICANTS ARE SUBJECT TO RATING LIMITS AND RESTRICTIONS IN SECTIONS 3765 AND 3767.

SEC. 3771. (1) A CARRIER SHALL NOT, DIRECTLY OR INDIRECTLY, ENGAGE IN ANY OF THE FOLLOWING:

(A) ENCOURAGING OR DIRECTING AN INDIVIDUAL TO REFRAIN FROM FILING AN APPLICATION FOR A HEALTH BENEFIT PLAN WITH THE CARRIER BECAUSE OF THE INITIAL CONDITION OR CLAIMS EXPERIENCE OF THE

INDIVIDUAL.

(B) ENCOURAGING OR DIRECTING AN INDIVIDUAL TO SEEK COVERAGE FROM ANOTHER CARRIER BECAUSE OF THE INITIAL CONDITION OR CLAIMS EXPERIENCE OF THE INDIVIDUAL.

(2) EXCEPT AS PROVIDED IN SUBSECTION (3), A CARRIER SHALL NOT, DIRECTLY OR INDIRECTLY, ENTER INTO ANY CONTRACT, AGREEMENT, OR ARRANGEMENT WITH A PRODUCER THAT PROVIDES FOR OR RESULTS IN THE COMPENSATION PAID TO A PRODUCER FOR THE SALE OF A HEALTH BENEFIT PLAN TO BE VARIED BECAUSE OF THE INITIAL CONDITION OR CLAIMS EXPERIENCE OF THE INDIVIDUAL.

(3) SUBSECTION (2) DOES NOT APPLY TO A COMPENSATION ARRANGEMENT THAT PROVIDES COMPENSATION TO A PRODUCER ON THE BASIS OF PERCENTAGE OF PREMIUM, PROVIDED THAT THE PERCENTAGE DOES NOT VARY BECAUSE OF THE INITIAL CONDITION OR CLAIMS EXPERIENCE OF THE INDIVIDUAL.

(4) A CARRIER SHALL NOT TERMINATE, FAIL TO RENEW, OR LIMIT ITS CONTRACT OR AGREEMENT OF REPRESENTATION WITH A PRODUCER FOR ANY REASON RELATED TO THE INITIAL CONDITION OR CLAIMS EXPERIENCE OF THE INDIVIDUAL PLACED BY THE PRODUCER WITH THE CARRIER.

SEC. 3773. (1) AN INDIVIDUAL ENROLLED IN A NONPROFIT HEALTH CARE CORPORATION NONGROUP OR GROUP CONVERSION HEALTH BENEFIT PLAN "A" THROUGH "G" ON THE EFFECTIVE DATE OF THIS CHAPTER MAY REMAIN ENROLLED IN THAT PLAN; HOWEVER, AN INDIVIDUAL DOES NOT HAVE THE OPTION TO CHANGE ENROLLMENT TO ANOTHER HEALTH BENEFIT PLAN "A" THROUGH "G". AN INDIVIDUAL WHO IS NOT ENROLLED IN HEALTH BENEFIT PLAN "A" THROUGH "G" ON THE EFFECTIVE DATE OF THIS CHAPTER IS NOT ELIGIBLE TO ENROLL IN 1 OF THOSE PLANS.

(2) THE RATES CHARGED TO INDIVIDUALS IN EACH HEALTH BENEFIT PLAN "A" THROUGH "G" SHALL BE DETERMINED UNDER A SYSTEM OF COMMUNITY RATING AND SHALL NOT BE ADJUSTED FOR ANY OF THE RATE FACTORS IN SECTION 3765. RATES SHALL BE FILED WITH THE COMMISSIONER AND SHALL NOT TAKE EFFECT UNTIL 60 DAYS AFTER THE FILING, UNLESS THE COMMISSIONER APPROVES THE RATES IN WRITING BEFORE THE EXPIRATION OF 60 DAYS AFTER THE FILING. THE RATE FILING SHALL INCLUDE AN ACTUARIAL CERTIFICATION THAT THE BENEFITS PROVIDED ARE REASONABLE IN RELATION TO THE PREMIUMS CHARGED. FOR NONGROUP HEALTH BENEFIT PLANS "A" THROUGH "G", THE BENEFITS PROVIDED ARE PRESUMED REASONABLE IN RELATION TO THE PREMIUMS CHARGED IF THE PERCENTAGE INCREASE IN THE PREMIUMS FILED WITH THE COMMISSIONER ARE NOT GREATER THAN THE PROJECTED PERCENTAGE CHANGE IN ANNUAL CLAIMS COST FOR ALL NONGROUP HEALTH BENEFIT PLANS PLUS 10%. FOR GROUP CONVERSION HEALTH BENEFIT PLANS "A" THROUGH "G", THE BENEFITS PROVIDED ARE PRESUMED REASONABLE IN RELATION TO THE PREMIUMS CHARGED IF THE PERCENTAGE INCREASE IN THE PREMIUMS FILED WITH THE COMMISSIONER ARE NOT GREATER THAN THE PROJECTED PERCENTAGE CHANGE AND ANNUAL CLAIMS COST FOR ALL GROUP CONVERSION HEALTH BENEFIT PLANS PLUS 10%.

Enacting section 1. This amendatory act does not take effect unless House Bill No. 5283 (request no. 03042'07) of the 94th Legislature is enacted into law.