# HOUSE BILL No. 4934

May 13, 2009, Introduced by Reps. Corriveau, Ball, Coulouris, Johnson, Simpson, Haugh, Melton, Young, Lipton, Marleau, Mayes, Gregory, Roy Schmidt, Hansen, LeBlanc, Scripps, Meadows, Moore and Green and referred to the Committee on Health Policy.

A bill to amend 1956 PA 218, entitled

"The insurance code of 1956,"

by amending sections 2213b, 3406f, 3501, 3503, 3519, 3521, 3525, 3539, and 3851 (MCL 500.2213b, 500.3406f, 500.3501, 500.3503, 500.3519, 500.3521, 500.3525, 500.3539, and 500.3851), section 2213b as amended by 1998 PA 457, section 3406f as added by 1996 PA 517, sections 3501, 3521, and 3525 as added by 2000 PA 252, section 3503 as amended by 2006 PA 366, sections 3519 and 3539 as amended by 2005 PA 306, and section 3851 as added by 1992 PA 84, and by adding chapter 37A; and to repeal acts and parts of acts.

**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

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under chapter 34 shall renew or continue in force the policy at the option of the individual. **THIS SUBSECTION DOES NOT APPLY TO A HEALTH BENEFIT PLAN AS DEFINED IN SECTION 3751.**

(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.

(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.

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

(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.

(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 **TO THE COMMISSIONER** 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)**.

(7) The commissioner shall maintain copies of reports prepared pursuant to subsection (6) on file with the annual statement of each reporting insurer. The commissioner shall annually compile the reports received under subsection (6). 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) are provided.

(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. 3501. As used in this chapter:

(a) "Affiliated provider" means a health professional, licensed hospital, licensed pharmacy, or any other institution, organization, or person having a contract with a health maintenance organization to render 1 or more health maintenance services to an enrollee.

(b) "Basic health services" means:

(*i*) Physician services including consultant and referral services by a physician, but not including psychiatric services.

(*ii*) Ambulatory services.

(*iii*) Inpatient hospital services, other than those for the treatment of mental illness.

(*iv*) Emergency health services.

(*v*) Outpatient mental health services, not fewer than 20 visits per year.

(*vi*) Intermediate and outpatient care for substance abuse as follows:

(A) For group contracts, if the fees for a group contract would be increased by 3% or more because of the provision of services under this subparagraph, the group subscriber may decline the services. For individual contracts, if the total fees for all individual contracts would be increased by 3% or more because of the provision of the services required under this subparagraph in all of those contracts, the named subscriber of each contract may decline the services.

(B) Charges, terms, and conditions for the services required

to be provided under this subparagraph shall not be less favorable than the maximum prescribed for any other comparable service.

(C) The services required to be provided under this subparagraph shall not be reduced by terms or conditions that apply to other services in a group or individual contract. This sub-subparagraph shall not be construed to prohibit contracts that provide for deductibles and copayment provisions for services for intermediate and outpatient care for substance abuse.

(D) The services required to be provided under this subparagraph shall, at a minimum, provide for up to $2,968.00 in services for intermediate and outpatient care for substance abuse per individual per year. This minimum shall be adjusted annually by March 31 each year in accordance with the annual average percentage increase or decrease in the United States consumer price index for the 12-month period ending the preceding December 31.

(E) As used in this subparagraph, "intermediate care", "outpatient care", and "substance abuse" have those meanings ascribed to them in section 3425.

(*vii*) Diagnostic laboratory and diagnostic and therapeutic radiological services.

(*viii*) Home health services.

(*ix*) Preventive health services.

(c) "Credentialing verification" means the process of obtaining and verifying information about a health professional and evaluating that health professional when that health professional applies to become a participating provider with a health maintenance organization.

(d) "Enrollee" means an individual who is entitled to receive health maintenance services under a health maintenance contract.

(e) "Health maintenance contract" means a contract between a health maintenance organization and a subscriber or group of subscribers, to provide, when medically indicated, designated health maintenance services, as described in and pursuant to the terms of the contract. ~~, including, at a minimum, basic health maintenance services.~~ Health maintenance contract includes a prudent purchaser contract.

(f) "Health maintenance organization" means an entity that does the following:

(*i*) Delivers health maintenance services that are medically indicated to enrollees under the terms of its health maintenance contract, directly or through contracts with affiliated providers, in exchange for a fixed prepaid sum or per capita prepayment, without regard to the frequency, extent, or kind of health services.

(*ii*) Is responsible for the availability, accessibility, and quality of the health maintenance services provided.

(g) "Health maintenance services" means services provided to enrollees of a health maintenance organization under their health maintenance contract.

(h) "Health professional" means an individual licensed, certified, or authorized in accordance with state law to practice a health profession in his or her respective state.

(i) "Primary verification" means verification by the health maintenance organization of a health professional's credentials

based upon evidence obtained from the issuing source of the credential.

(j) "Prudent purchaser contract" means a contract offered by a health maintenance organization to groups or to individuals under which enrollees who select to obtain health care services directly from the organization or through its affiliated providers receive a financial advantage or other advantage by selecting those providers.

(k) "Secondary verification" means verification by the health maintenance organization of a health professional's credentials based upon evidence obtained by means other than direct contact with the issuing source of the credential.

(*l*) "Service area" means a defined geographical area in which health maintenance services are generally available and readily accessible to enrollees and where health maintenance organizations may market their contracts.

(m) "Subscriber" means an individual who enters into a health maintenance contract, or on whose behalf a health maintenance contract is entered into, with a health maintenance organization that has received a certificate of authority under this chapter and to whom a health maintenance contract is issued.

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~~ **A HEALTH MAINTENANCE ORGANIZATION SHALL OFFER AT LEAST 1** health maintenance organization ~~contracts shall include,~~ **CONTRACT THAT INCLUDES,** 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 A HEALTH BENEFIT PLAN 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) "ENROLLEE" MEANS AN INDIVIDUAL OR HIS OR HER DEPENDENT WHO IS A RESIDENT OF THIS STATE AND IS ENROLLED IN A HEALTH BENEFIT PLAN.**

**(D) "FEDERAL POVERTY LEVEL" MEANS THE POVERTY GUIDELINES PUBLISHED ANNUALLY IN THE FEDERAL REGISTER BY THE UNITED STATES**

**DEPARTMENT OF HEALTH AND HUMAN SERVICES UNDER ITS AUTHORITY TO REVISE THE POVERTY LINE UNDER SECTION 673(2) OF SUBTITLE B OF TITLE VI OF THE OMNIBUS BUDGET RECONCILIATION ACT OF 1981, PUBLIC LAW 97-35, 42 USC 9902.**

**(E) "GEOGRAPHIC AREA" MEANS AN AREA IN THIS STATE THAT INCLUDES NOT LESS THAN 4 ENTIRE COUNTIES, ESTABLISHED BY A CARRIER UNDER THIS CHAPTER AND USED FOR ADJUSTING PREMIUM FOR A HEALTH BENEFIT PLAN SUBJECT TO THIS CHAPTER. EACH COUNTY IN THE GEOGRAPHIC AREA SHALL BE CONTIGUOUS WITH AT LEAST 1 OTHER COUNTY IN THAT GEOGRAPHIC AREA.**

**(F) "HEALTH BENEFIT PLAN" OR "PLAN" MEANS AN INDIVIDUAL EXPENSE-INCURRED HOSPITAL, MEDICAL, OR SURGICAL POLICY, NONPROFIT HEALTH CARE CORPORATION CERTIFICATE, OR HEALTH MAINTENANCE ORGANIZATION CONTRACT AND INCLUDES A HEALTH BENEFIT PLAN SOLD DIRECTLY TO AN INDIVIDUAL UNDER A GROUP TRUST OR CERTIFICATE. 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; DENTAL-ONLY OR VISION-ONLY INSURANCE; WORKER'S COMPENSATION OR SIMILAR INSURANCE; AUTOMOBILE MEDICAL-PAYMENT INSURANCE; MEDICAID COVERAGE; OR MEDICARE, MEDICARE ADVANTAGE, OR MEDICARE PART D.**

**(G) "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.**

**(H) "MEDICAID" MEANS A PROGRAM FOR MEDICAL ASSISTANCE**

**ESTABLISHED UNDER TITLE XIX OF THE SOCIAL SECURITY ACT, 42 USC 1396 TO 1396W-2.**

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

**(J) "MICAPP FUND" MEANS THE MICHIGAN CATASTROPHIC PROTECTION PLAN FUND CREATED IN SECTION 3781.**

**(K) "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.**

**(*l*) "PREMIUM" MEANS ALL MONEY PAID BY AN INDIVIDUAL AS A CONDITION OF RECEIVING COVERAGE UNDER A HEALTH BENEFIT PLAN FROM A CARRIER.**

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

**(N) "RESIDENT" MEANS AN INDIVIDUAL WHO LIVES IN THIS STATE VOLUNTARILY WITH THE INTENTION OF MAKING HIS OR HER HOME IN THIS STATE AND NOT FOR A TEMPORARY PURPOSE AND WHO IS NOT RECEIVING ASSISTANCE FROM ANOTHER STATE. RESIDENT DOES NOT INCLUDE AN INDIVIDUAL WHO HAS MOVED INTO THIS STATE FOR THE SOLE PURPOSE OF SECURING COVERAGE UNDER A HEALTH BENEFIT PLAN UNDER THIS CHAPTER.**

**(O) "SHORT-TERM OR 1-TIME LIMITED DURATION BENEFIT PLAN OF NO LONGER THAN 6 MONTHS" MEANS A 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 A HEALTH BENEFIT PLAN, INCLUDING A MEDICARE SUPPLEMENT PLAN, THAT IS SUBJECT TO POLICY FORM OR PREMIUM APPROVAL BY THE COMMISSIONER.**

**SEC. 3754. A CARRIER SHALL GUARANTEE ISSUE TO AN INDIVIDUAL ALL HEALTH BENEFIT PLANS OFFERED BY THE CARRIER AND SHALL NOT REFUSE TO ISSUE COVERAGE TO AN INDIVIDUAL FOR ANY REASON, INCLUDING ANY PAST, PRESENT, OR FUTURE HEALTH CONDITION, EXCEPT AS FOLLOWS:**

**(A) AS OTHERWISE PERMITTED UNDER SECTION 3755.**

**(B) BECAUSE OF FRAUD OR INTENTIONAL MISREPRESENTATION OF THE APPLICANT.**

**(C) BECAUSE OF LACK OF PAYMENT.**

**(D) BECAUSE THE APPLICANT RESIDES OUTSIDE OF THE GEOGRAPHIC**

**COVERAGE AREA.**

**(E) AS OTHERWISE PERMITTED UNDER SECTION 401 OF THE NONPROFIT HEALTH CARE CORPORATION REFORM ACT, 1980 PA 350, MCL 550.1401.**

**SEC. 3755. (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 6 MONTHS AFTER THE EFFECTIVE DATE OF THE POLICY, CERTIFICATE, OR CONTRACT.**

**(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 INDIVIDUAL 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 INDIVIDUAL IS NO LONGER ELIGIBLE FOR GROUP COVERAGE AND IS NOT ELIGIBLE FOR MEDICARE OR MEDICAID.**

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

**(E) IF THE INDIVIDUAL 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. 3757. (1) AS USED IN THIS SECTION:**

**(A) "ACTUAL LOSS RATIO" MEANS THE RATIO FOR A 12-MONTH RATING PERIOD OF THE INCURRED CLAIMS TO PREMIUMS.**

**(B) "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 INCURRED CLAIMS DURING THE RATING PERIOD DEFINED IN THE RATE FILING TO THE FUTURE PREMIUMS, BASED ON A CREDIBLE PREMIUM VOLUME OVER A REASONABLE PERIOD OF TIME WITH PROPER WEIGHT GIVEN TO RATING TRENDS AND OTHER RELEVANT FACTORS. STATISTICAL DATA RELATING TO EXPECTED FUTURE INCURRED CLAIMS SHALL BE PROVIDED TO THE COMMISSIONER FROM CARRIERS FOR HEALTH BENEFIT PLANS SOLD OR TO BE SOLD IN THIS STATE WHEN AVAILABLE.**

**(2) THE RATES CHARGED TO INDIVIDUALS FOR HEALTH BENEFIT PLANS THAT ARE NOT NONPROFIT HEALTH CARE CORPORATION 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. THE BENEFITS PROVIDED SHALL BE PRESUMED REASONABLE IN RELATION TO THE PREMIUMS CHARGED AND THE**

**PREMIUMS ARE PRESUMED ADEQUATE, EQUITABLE, AND NOT EXCESSIVE AS FOLLOWS:**

**(A) FOR A HEALTH BENEFIT PLAN THAT IS NOT A HEALTH MAINTENANCE ORGANIZATION CONTRACT OR A MEDICARE SUPPLEMENT PLAN, IF THE ANTICIPATED LOSS RATIO EQUALS OR EXCEEDS 70%.**

**(B) FOR A HEALTH MAINTENANCE ORGANIZATION CONTRACT, IF THE ANTICIPATED LOSS RATIO EQUALS OR EXCEEDS 80%.**

**(C) FOR A MEDICARE SUPPLEMENT PLAN, IF THE ANTICIPATED LOSS RATIO EQUALS OR EXCEEDS 90%.**

**(3) 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, FOR HEALTH BENEFIT PLANS INTRODUCED ON OR AFTER JANUARY 1, 2010, 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 PROVIDED TO THE COMMISSIONER AT THE TIME OF THE RATE FILING:**

**(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 JANUARY 1, 2010.**

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

**(F) LAPSE RATE EXPERIENCE.**

**(4) NO LATER THAN 4 MONTHS AFTER THE END OF A 12-MONTH RATING PERIOD FOR RATES FILED UNDER SUBSECTION (2), 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.**

**(5) IF THE ACTUAL LOSS RATIO FOR ALL HEALTH BENEFIT PLANS IN A LINE OF BUSINESS DOES NOT EQUAL OR EXCEED THE APPLICABLE ANTICIPATED LOSS RATIO UNDER SUBSECTION (2), 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 THE APPLICABLE ANTICIPATED LOSS RATIO FOR THE LINE OF BUSINESS. A CARRIER SHALL NOT BE ORDERED TO ISSUE A REFUND UNDER THIS SUBSECTION IN AN AMOUNT THAT IS LESS THAN $25.00 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. THE RATE CREDITS OR REFUNDS SHALL INCLUDE INTEREST FROM THE**

**BEGINNING OF THE RATING PERIOD TO THE DATE OF THE CREDIT OR REFUND CALCULATED AT THE AVERAGE RATE OF INTEREST FOR 13-WEEK UNITED STATES TREASURY RATES, AS DETERMINED BY THE COMMISSIONER. 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.**

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

**SEC. 3759. (1) FOR ADJUSTING PREMIUMS FOR HEALTH BENEFIT PLANS SUBJECT TO THIS CHAPTER, ALL OF THE FOLLOWING APPLY:**

**(A) A CARRIER MAY ESTABLISH UP TO 5 GEOGRAPHIC AREAS IN THIS STATE.**

**(B) A CARRIER THAT IS A NONPROFIT HEALTH CARE CORPORATION SHALL ESTABLISH GEOGRAPHIC AREAS THAT COVER ALL COUNTIES IN THIS STATE.**

**(C) A CARRIER SHALL NOT ESTABLISH GEOGRAPHIC AREAS FOR ANY MEDICARE SUPPLEMENT PLAN.**

**(2) THE RATES CHARGED TO INDIVIDUALS FOR HEALTH BENEFIT PLANS MAY INCLUDE RATE DIFFERENTIALS BASED ONLY ON AGE AND ONLY 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 65%. RATE DIFFERENTIALS BASED ON AGE SHALL NOT BE USED WITH ANY MEDICARE SUPPLEMENT PLAN. THIS SUBSECTION DOES NOT PROHIBIT ADJUSTMENTS PURSUANT TO SUBSECTION (3).

(3) IN ADDITION TO THE PREMIUM ADJUSTMENTS UNDER SUBSECTION (2), HEALTH BENEFIT PLAN OPTIONS, NUMBER OF FAMILY MEMBERS COVERED, AND MEDICARE ELIGIBILITY MAY BE USED IN ESTABLISHING THE PREMIUM FOR A HEALTH BENEFIT PLAN. A PREMIUM DISCOUNT, AFTER THE INITIAL EFFECTIVE DATE OF COVERAGE, BASED ON A LIFESTYLE-BASED GOOD HEALTH DISCOUNT FOR ADHERENCE TO A HEALTHY LIFESTYLE, SHALL BE OFFERED. HOWEVER, THE TOTAL MAXIMUM DISCOUNT FOR A LIFESTYLE-BASED GOOD HEALTH DISCOUNT, INCLUDING, BUT NOT LIMITED TO, DISCOUNTS FOR NO TOBACCO USE AND HEALTHY BODY MASS INDEX, SHALL NOT EXCEED 50% OF THE PREMIUM FOR THE HEALTH BENEFIT PLAN.

SEC. 3761. 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 BASED ON AGE THAT 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 3759(3).

SEC. 3763. HEALTH BENEFIT PLANS THAT HAVE BEEN OR WILL BE CLOSED TO NEW APPLICANTS ARE SUBJECT TO RATING LIMITS AND RESTRICTIONS IN SECTIONS 3759 AND 3761.

SEC. 3765. NOTWITHSTANDING ANY OTHER PROVISION OF THIS ACT, A CARRIER SHALL NOT RESCIND, CANCEL, OR LIMIT A HEALTH BENEFIT PLAN

**DUE TO THE CARRIER'S FAILURE TO RESOLVE ALL REASONABLE QUESTIONS ARISING FROM THE WRITTEN INFORMATION SUBMITTED ON OR WITH AN APPLICATION BEFORE ISSUING THE HEALTH BENEFIT PLAN. THIS SECTION DOES NOT LIMIT A CARRIER'S REMEDIES UPON A SHOWING OF INTENTIONAL MISREPRESENTATION OF MATERIAL FACT.**

**SEC. 3767. (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 AT A PREMIUM RATE THAT DOES NOT TAKE INTO ACCOUNT THE CLAIMS EXPERIENCE OR ANY CHANGE IN THE HEALTH STATUS OF ANY COVERED 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 SECTION.**

**(3) A CARRIER SHALL NOT DISCONTINUE OFFERING A PARTICULAR HEALTH BENEFIT PLAN 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 COVERED INDIVIDUAL PROVIDED COVERAGE UNDER THE PLAN THE OPTION TO PURCHASE ANY OTHER HEALTH BENEFIT PLAN CURRENTLY BEING OFFERED BY THAT CARRIER.**

**(C) ACTS UNIFORMLY WITHOUT REGARD TO ANY HEALTH STATUS FACTOR OF COVERED 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 HEALTH BENEFIT PLANS IN THIS STATE UNLESS THE CARRIER DOES ALL OF THE FOLLOWING:**

**(A) PROVIDES NOTICE TO THE COMMISSIONER AND TO EACH COVERED 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 THIS STATE 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. 3769. (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 HEALTH STATUS OR CLAIMS EXPERIENCE OF THE INDIVIDUAL.**

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

**(2) EXCEPT AS OTHERWISE 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 HEALTH STATUS 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 HEALTH STATUS 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 HEALTH STATUS OR CLAIMS EXPERIENCE OF THE INDIVIDUAL PLACED BY THE PRODUCER WITH THE CARRIER.**

**SEC. 3771. (1) A HEALTH CARE AFFORDABILITY FUND IS CREATED AS A CHARITABLE ENDOWMENT FUND 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.**

**(2) BY MAY 1, 2010 AND ANNUALLY THEREAFTER, THE COMMISSIONER SHALL ASSESS EACH NONPROFIT CARRIER WITH AN ASSESSMENT FEE EQUIVALENT TO THE AMOUNT OF LOCAL TAX AND TAX LEVIED UNDER THE MICHIGAN BUSINESS TAX ACT, 2007 PA 36, MCL 208.1101 TO 208.1601, THAT THE NONPROFIT CARRIER WOULD HAVE BEEN REQUIRED TO PAY IN THE**

**IMMEDIATELY PRECEDING CALENDAR YEAR IF THE CARRIER WAS SUBJECT TO THOSE TAXES.**

**(3) A NONPROFIT CARRIER ASSESSED UNDER SUBSECTION (2) SHALL PAY THE ASSESSMENT FEE TO THE COMMISSIONER BY NO LATER THAN 60 DAYS AFTER THE ASSESSMENT FEE NOTICE IS ISSUED. THE COMMISSIONER SHALL DEPOSIT ASSESSMENT FEES INTO THE HEALTH CARE AFFORDABILITY FUND.**

**(4) MONEY IN THE HEALTH CARE AFFORDABILITY FUND SHALL BE EXPENDED TO SUBSIDIZE THE COST OF HEALTH BENEFIT PLANS IN THE FOLLOWING ORDER OF PRIORITY:**

**(A) TO EXTEND THE ELIGIBILITY OF THE MICHILD PROGRAM TO INCLUDE CHILDREN IN HOUSEHOLDS WITH A HOUSEHOLD INCOME OF NOT MORE THAN 300% OF THE FEDERAL POVERTY LEVEL.**

**(B) TO SUBSIDIZE THE COST OF HEALTH BENEFIT PLANS, OTHER THAN MEDICARE SUPPLEMENT PLANS, FOR INDIVIDUALS WITH A HOUSEHOLD INCOME OF NOT MORE THAN 300% OF THE FEDERAL POVERTY LEVEL.**

**(C) TO SUBSIDIZE THE COST OF HEALTH BENEFIT PLANS THAT ARE MEDICARE SUPPLEMENT PLANS FOR INDIVIDUALS WITH A HOUSEHOLD INCOME OF NOT MORE THAN 300% OF THE FEDERAL POVERTY LEVEL.**

**(5) A SUBSIDY GRANTED UNDER THIS SECTION SHALL NOT BE USED EXCEPT TO LOWER PREMIUMS OR PROPOSED PREMIUM INCREASES FOR HEALTH BENEFIT PLANS AS DESCRIBED IN SUBSECTION (4).**

**(6) THE COMMISSIONER SHALL REPORT BY NOVEMBER 1, 2010 AND ANNUALLY THEREAFTER TO THE GOVERNOR, AND ALL MEMBERS OF THE SENATE AND HOUSE OF REPRESENTATIVES STANDING COMMITTEES ON APPROPRIATIONS, INSURANCE, AND HEALTH ISSUES ON THE AMOUNTS OF THE ASSESSMENT FEES COLLECTED UNDER THIS SECTION AND THE AMOUNT OF SUBSIDIES GRANTED UNDER THIS SECTION.**

**SEC. 3773. EACH CARRIER SHALL OFFER NOT LESS THAN 1 HEALTH BENEFIT PLAN THAT INCORPORATES THE PRINCIPLES OF VALUE-BASED INSURANCE DESIGN, PROMOTES HEALTHY BEHAVIORS, AND STRIVES FOR IMPROVEMENTS IN BOTH HEALTH OUTCOMES AND HEALTH CARE COST CONTAINMENTS. THIS HEALTH BENEFIT PLAN SHALL USE INCENTIVES TO PROVIDE HEALTH PROMOTION, INCLUDING, BUT NOT LIMITED TO, SMOKING CESSATION PROGRAMS AND PROMOTING NUTRITION AND PHYSICAL EXERCISE; CHRONIC CARE MANAGEMENT; AND DISEASE PREVENTION. INCENTIVES MAY INCLUDE REWARDS, PREMIUM DISCOUNTS, OR REBATES OR MAY OTHERWISE WAIVE OR MODIFY COPAYMENTS, DEDUCTIBLES, OR OTHER COST-SHARING MEASURES. INCENTIVES SHALL BE AVAILABLE TO ALL SIMILARLY SITUATED INDIVIDUALS, SHALL BE DESIGNED TO PROMOTE HEALTH AND PREVENT DISEASE, AND SHALL NOT BE USED TO IMPOSE HIGHER COSTS ON AN INDIVIDUAL BASED ON A HEALTH FACTOR.**

**SEC. 3775. (1) THE COMMISSIONER SHALL DEVELOP BY RULE PROMULGATED PURSUANT TO THE ADMINISTRATIVE PROCEDURES ACT OF 1969, 1969 PA 306, MCL 24.201 TO 24.328, A BASIC HEALTH BENEFIT PLAN AND A BASIC ENHANCED HEALTH BENEFIT PLAN. THE BASIC HEALTH BENEFIT PLAN SHALL APPROXIMATE THE LOWEST LEVEL OF COVERAGE OFFERED IN THE STATE IN THE INDIVIDUAL HEALTH MARKET. THE BASIC ENHANCED HEALTH BENEFIT PLAN SHALL APPROXIMATE THE AVERAGE LEVEL OF COVERAGE OFFERED IN THE STATE IN THE INDIVIDUAL HEALTH MARKET. BOTH PLANS SHALL BE DESIGNED TO SATISFY ALL OF THE FOLLOWING:**

**(A) TO MINIMIZE NONEMERGENCY EMERGENCY ROOM USE.**

**(B) TO ENCOURAGE HEALTH AND WELLNESS.**

**(C) TO INCLUDE COVERAGE FOR MEDICALLY NECESSARY AND APPROPRIATE INPATIENT AND OUTPATIENT HOSPITAL SERVICES,**

**PROFESSIONAL MEDICAL AND SURGICAL SERVICES, AND DIAGNOSTIC SERVICES.**

**(2) AS A CONDITION OF TRANSACTING BUSINESS IN THIS STATE, EACH CARRIER ENGAGED IN WRITING HEALTH COVERAGE OR INSURANCE IN THIS STATE SHALL OFFER THE BASIC HEALTH BENEFIT PLAN AND THE BASIC ENHANCED HEALTH BENEFIT PLAN DEVELOPED UNDER SUBSECTION (1) TO INDIVIDUALS IN THIS STATE.**

**SEC. 3781. (1) THE MICHIGAN CATASTROPHIC PROTECTION PLAN FUND IS CREATED WITHIN THE STATE TREASURY. MONEY IN THE MICAPP FUND SHALL BE USED ONLY AS PROVIDED IN SECTION 3783.**

**(2) THE STATE TREASURER MAY RECEIVE MONEY OR OTHER ASSETS FROM ANY SOURCE FOR DEPOSIT INTO THE MICAPP FUND. THE STATE TREASURER SHALL DIRECT THE INVESTMENT OF THE MICAPP FUND. THE STATE TREASURER SHALL CREDIT TO THE MICAPP FUND INTEREST AND EARNINGS FROM FUND INVESTMENTS.**

**(3) MONEY IN THE MICAPP FUND AT THE CLOSE OF THE FISCAL YEAR SHALL REMAIN IN THE MICAPP FUND AND SHALL NOT LAPSE TO THE GENERAL FUND.**

**(4) THE COMMISSIONER SHALL BE THE ADMINISTRATOR OF THE MICAPP FUND FOR AUDITING PURPOSES.**

**SEC. 3783. (1) MONEY SHALL BE EXPENDED FROM THE MICAPP FUND TO REIMBURSE CARRIERS FOR ELIGIBLE CLAIMS PAID UNDER A HEALTH BENEFIT PLAN. A CARRIER IS ELIGIBLE TO RECEIVE REIMBURSEMENT FROM THE MICAPP FUND FOR 100% OF CLAIMS PAID AFTER $25,000.00 IN CLAIMS IN A CALENDAR YEAR HAVE BEEN PAID BY THE CARRIER ON BEHALF OF AN INDIVIDUAL COVERED UNDER A HEALTH BENEFIT PLAN.**

**(2) EACH CARRIER SHALL SUBMIT A REQUEST FOR REIMBURSEMENT ON A**

**FORM PRESCRIBED BY THE COMMISSIONER FROM THE MICAPP FUND BY NO LATER THAN MARCH 1 FOLLOWING THE END OF THE CALENDAR YEAR FOR WHICH THE REIMBURSEMENT REQUEST IS BEING MADE. CLAIMS ARE ELIGIBLE FOR REIMBURSEMENT ONLY FOR THE CALENDAR YEAR IN WHICH THE CLAIMS ARE PAID. CARRIERS MAY BE REQUIRED TO SUBMIT CLAIMS DATA IN CONNECTION WITH THE REIMBURSEMENT REQUEST AS THE COMMISSIONER CONSIDERS NECESSARY TO DISTRIBUTE MONEY AND OVERSEE THE OPERATION OF THE MICAPP FUND. THE COMMISSIONER MAY REQUIRE THAT THE DATA BE SUBMITTED ON A PER ENROLLEE OR AGGREGATE BASIS.**

**(3) IF THE TOTAL AMOUNT REQUESTED FOR REIMBURSEMENT UNDER THIS SECTION BY ALL CARRIERS FOR A CALENDAR YEAR EXCEEDS FUNDS AVAILABLE FOR DISTRIBUTION FOR CLAIMS PAID BY ALL CARRIERS DURING THAT SAME CALENDAR YEAR, THE COMMISSIONER SHALL PROVIDE FOR THE PRO RATA DISTRIBUTION OF THE AVAILABLE FUNDS. EACH CARRIER SHALL BE ELIGIBLE TO RECEIVE ONLY THE PROPORTIONATE AMOUNT OF THE AVAILABLE FUNDS AS THE INDIVIDUAL CARRIER'S TOTAL ELIGIBLE CLAIMS PAID BEARS TO THE TOTAL ELIGIBLE CLAIMS PAID BY ALL CARRIERS.**

**(4) IF FUNDS AVAILABLE FOR DISTRIBUTION FOR CLAIMS PAID BY ALL CARRIERS DURING A CALENDAR YEAR EXCEED THE TOTAL AMOUNT REQUESTED FOR REIMBURSEMENT BY ALL CARRIERS DURING THAT SAME CALENDAR YEAR, ANY EXCESS FUNDS SHALL BE CARRIED FORWARD AND SHALL BE MADE AVAILABLE FOR DISTRIBUTION IN THE NEXT CALENDAR YEAR.**

**SEC. 3785. (1) AS A CONDITION OF TRANSACTING BUSINESS IN THIS STATE, EACH CARRIER ENGAGED IN WRITING HEALTH COVERAGE OR INSURANCE IN THIS STATE SHALL PAY AN ANNUAL PARTICIPATION CONTRIBUTION INTO THE MICAPP FUND AS PROVIDED IN THIS SECTION.**

**(2) THE TOTAL PARTICIPATION CONTRIBUTION IN A CALENDAR YEAR**

**SHALL BE THE SUM OF THE ESTIMATE OF TOTAL REIMBURSEMENT TO BE MADE FOR CLAIMS PAID IN THE SAME CALENDAR YEAR PLUS THE ESTIMATED COST OF ADMINISTERING THE MICAPP FUND FOR THE SAME CALENDAR YEAR. BY NOT LATER THAN MAY 1 OF EACH YEAR, THE COMMISSIONER SHALL DETERMINE THE TOTAL PARTICIPATION CONTRIBUTION AND SHALL NOTIFY EACH CARRIER OF THE AMOUNT OWED. A CARRIER'S PARTICIPATION CONTRIBUTION SHALL BE DETERMINED BY MULTIPLYING THE TOTAL PARTICIPATION CONTRIBUTION BY A FRACTION, THE NUMERATOR OF WHICH SHALL BE THE CARRIER'S DIRECT PREMIUMS EARNED IN THE PRECEDING CALENDAR YEAR FOR ALL HEALTH BENEFIT PLANS SUBJECT TO THIS CHAPTER, AND THE DENOMINATOR OF WHICH SHALL BE THE DIRECT PREMIUMS EARNED IN THE PRECEDING CALENDAR YEAR FOR ALL HEALTH BENEFIT PLANS SUBJECT TO THIS CHAPTER FOR ALL CARRIERS. BY NOT LATER THAN 90 DAYS AFTER THE PARTICIPATION CONTRIBUTION NOTICE IS ISSUED, EACH CARRIER SHALL PAY THE AMOUNT IT OWES TO THE COMMISSIONER. THE COMMISSIONER SHALL DEPOSIT PARTICIPATION CONTRIBUTION PAYMENTS INTO THE MICAPP FUND.**

**SEC. 3787. THE COMMISSIONER SHALL KEEP AN ACCURATE ACCOUNT OF ALL MICAPP FUND RECEIPTS AND EXPENDITURES AND SHALL REPORT BY NOVEMBER 1, 2010 AND ANNUALLY THEREAFTER TO THE GOVERNOR AND TO ALL MEMBERS OF THE HOUSE OF REPRESENTATIVES AND SENATE STANDING COMMITTEES ON APPROPRIATIONS, HEALTH, AND INSURANCE ISSUES ON THE AMOUNT OF PARTICIPATION CONTRIBUTIONS COLLECTED AND REIMBURSEMENT FOR CLAIMS PAID UNDER SECTIONS 3783 AND 3785.**

**SEC. 3799. (1) THE COMMISSIONER SHALL CONDUCT AN INDEPENDENT, COMPREHENSIVE ANALYSIS OF THE INDIVIDUAL HEALTH COVERAGE MARKET ON A STATEWIDE BASIS. IN CONDUCTING THIS ANALYSIS, THE COMMISSIONER SHALL SEEK ADVICE AND INPUT FROM APPROPRIATE INDEPENDENT SOURCES**

**AND MAY RETAIN QUALIFIED ACCOUNTING AND ACTUARIAL CONSULTANTS.**

**(2) BY NOT LATER THAN OCTOBER 1, 2012, THE COMMISSIONER SHALL ISSUE A REPORT ON THE SPECIFIC CLASSIFICATIONS AND KINDS OR TYPES OF INSURANCE, IF ANY, WHERE COMPETITION DOES NOT EXIST AND ANY SUGGESTED STATUTORY OR OTHER CHANGES NECESSARY TO INCREASE OR ENCOURAGE COMPETITION, LOWER PREMIUMS, AND PROVIDE GREATER ACCESS TO ALL STATE RESIDENTS. THE FINDINGS SHALL NOT BE BASED ON ANY SINGLE MEASURE OF COMPETITION, BUT APPROPRIATE WEIGHT SHALL BE GIVEN TO ALL MEASURES OF COMPETITION. THE FINDINGS SHALL BE BASED ON RELEVANT ECONOMIC TESTS, INCLUDING, BUT NOT LIMITED TO, ALL OF THE FOLLOWING:**

**(A) THE EXTENT TO WHICH ANY CARRIER CONTROLS ALL OR A PORTION OF THE HEALTH BENEFIT PLAN MARKET.**

**(B) WHETHER THE TOTAL NUMBER OF CARRIERS WRITING HEALTH BENEFIT PLAN COVERAGE IN THIS STATE IS SUFFICIENT TO PROVIDE MULTIPLE OPTIONS TO INDIVIDUALS.**

**(C) THE DISPARITY AMONG HEALTH BENEFIT PLAN RATES AND CLASSIFICATIONS TO THE EXTENT THAT THOSE CLASSIFICATIONS RESULT IN RATE DIFFERENTIALS.**

**(D) THE AVAILABILITY OF HEALTH BENEFIT PLAN COVERAGE TO INDIVIDUALS IN ALL GEOGRAPHIC AREAS.**

**(E) THE OVERALL RATE LEVEL THAT IS NOT EXCESSIVE, INADEQUATE, OR UNFAIRLY DISCRIMINATORY.**

**(F) ANY OTHER FACTORS THE COMMISSIONER CONSIDERS RELEVANT.**

**(3) THE REPORT REQUIRED UNDER SUBSECTION (2) SHALL BE FORWARDED TO THE GOVERNOR, THE SECRETARY OF THE SENATE, THE CLERK OF THE HOUSE OF REPRESENTATIVES, AND ALL THE MEMBERS OF THE SENATE**

**AND HOUSE STANDING COMMITTEES ON INSURANCE AND HEALTH ISSUES.**

Sec. 3851. (1) A **GROUP** medicare supplement policy form or certificate form shall not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificate holders in the form of aggregate benefits, not including anticipated refunds or credits, ~~the following:~~

~~(a) For group policies~~ at least 75% of the aggregate amount of premiums earned calculated on the basis of incurred claims experience and earned premiums for the entire period for which rates are computed and in accordance with accepted actuarial principles and practices.

~~(b) For individual policies at least 65% of the aggregate amount of premium earned calculated on the basis of incurred claims experience and earned premiums for the entire period for which rates are computed and in accordance with accepted actuarial principles and practices.~~

**(2) INDIVIDUAL MEDICARE SUPPLEMENT POLICIES ARE SUBJECT TO CHAPTER 37A.**

**(3)** ~~(2)~~ All filings of rates and rating schedules **UNDER SUBSECTION (1)** shall demonstrate that expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio

standards.

Enacting section 1. Section 3537 of the insurance code of 1956, 1956 PA 218, MCL 500.3537, is repealed.

Enacting section 2. This amendatory act takes effect October 1, 2009.

Enacting section 3. This amendatory act does not take effect unless Senate Bill No.____ or House Bill No. 4935(request no. 01734'09) of the 95th Legislature is enacted into law.