HOUSE BILL No. 6035

April 13, 2010, Introduced by Reps. Ball, Corriveau, Johnson and Roy Schmidt and referred to the Committee on Health Policy.

A bill to amend 1956 PA 218, entitled

"The insurance code of 1956,"

by amending section 3539 (MCL 500.3539), as amended by 2005 PA 306, and by adding chapter 37A.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

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

HOUSE BILL No. 6035

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 BENEFIT PLANS

SEC. 3751. AS USED IN THIS CHAPTER:

(A) "CARRIER" MEANS A PERSON THAT PROVIDES HEALTH BENEFITS, COVERAGE, OR INSURANCE TO AN INDIVIDUAL UNDER A HEALTH BENEFIT PLAN IN THIS STATE. FOR THE PURPOSES OF THIS CHAPTER, CARRIER INCLUDES A HEALTH INSURANCE COMPANY AUTHORIZED TO DO BUSINESS IN THIS STATE, A 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.

(B) "COMMERCIAL CARRIER" MEANS A CARRIER OTHER THAN A HEALTH CARE CORPORATION OR HEALTH MAINTENANCE ORGANIZATION.

(C) "ELIGIBLE CLAIM" MEANS ANY CLAIM COVERED UNDER ANY HEALTH BENEFIT PLAN.

(D) "HEALTH BENEFIT PLAN" OR "PLAN" MEANS AN INDIVIDUAL OR NONGROUP EXPENSE-INCURRED HOSPITAL, MEDICAL, OR SURGICAL POLICY, 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; MEDICARE SUPPLEMENTAL COVERAGE; 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; OR MEDICAID OR MEDICARE COVERAGE.

(E) "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.

(F) "MEDICAID" MEANS A PROGRAM FOR MEDICAL ASSISTANCE ESTABLISHED UNDER TITLE XIX OF THE SOCIAL SECURITY ACT, 42 USC 1396 TO 1396W-2.

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

(H) "MI-CAPP BOARD" OR "BOARD" MEANS THE MICHIGAN CATASTROPHIC PROTECTION PLAN BOARD CREATED IN SECTION 3771.

(I) "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 THAT IS SUBJECT TO POLICY FORM OR PREMIUM APPROVAL BY THE COMMISSIONER.

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. 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 COMPLETE MEDICAL UNDERWRITING AND RESOLVE ALL REASONABLE QUESTIONS ARISING FROM THE WRITTEN INFORMATION SUBMITTED ON OR WITH AN APPLICATION BEFORE ISSUING THE PLAN'S CONTRACT. THIS SECTION DOES NOT LIMIT A CARRIER'S REMEDIES UPON A SHOWING OF INTENTIONAL MISREPRESENTATION OF MATERIAL FACT.

SEC. 3759. RATE DIFFERENTIALS FOR HEALTH CONDITIONS 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 HEALTH CONDITIONS OF INDIVIDUALS ALREADY COVERED UNDER THE HEALTH BENEFIT PLAN. A CARRIER MAY USE RATE DIFFERENTIALS BASED ON HEALTH CONDITIONS FOR ANY INDIVIDUAL WHO IS SUBSEQUENTLY ADDED TO THE HEALTH BENEFIT PLAN ONLY AT THE TIME THE INDIVIDUAL IS ADDED TO THE PLAN.

SEC. 3761. (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 FRAUD, INTENTIONAL MISREPRESENTATION OF MATERIAL FACT, NONPAYMENT OF PREMIUMS, 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.

(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 THE COMMISSIONER AND 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 PLAN CURRENTLY BEING OFFERED IN THE INDIVIDUAL MARKET BY THAT CARRIER WITHOUT EXCLUDING OR LIMITING COVERAGE FOR A PREEXISTING CONDITION OR PROVIDING A WAITING PERIOD.

(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. 3762. (1) 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 INCLUDE SUPPORTING DATA USED IN THE DEVELOPMENT OF THE RATE. THE ACTUARIAL CERTIFICATION SHALL INCLUDE A CERTIFICATION THAT, TO THE BEST OF THE ACTUARY'S KNOWLEDGE AND BELIEF, THE BENEFITS PROVIDED ARE REASONABLE IN RELATION TO THE PREMIUMS CHARGED AND THE PREMIUMS ARE ESTABLISHED IN COMPLIANCE WITH THIS CHAPTER. THE COMMISSIONER SHALL UNIFORMLY APPLY FOR ALL CARRIERS THE STANDARD AS TO WHETHER THE BENEFITS PROVIDED ARE REASONABLE IN RELATION TO THE PREMIUM CHARGED AND ARE ADEQUATE, EQUITABLE, AND NOT EXCESSIVE. IF THE COMMISSIONER CONSIDERS THAT THE PROPOSED RATE IS NOT ADEQUATE OR EQUITABLE, IS EXCESSIVE, OR IS OTHERWISE NOT IN COMPLIANCE WITH THIS CHAPTER, THE COMMISSIONER, NOT MORE THAN 60 DAYS AFTER THE PROPOSED RATE IS FILED, SHALL NOTIFY THE CARRIER 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 CARRIER, AND THE REVISED RATE SHALL NOT TAKE EFFECT UNTIL APPROVED BY THE COMMISSIONER AFTER THE HEARING. WITHIN 30 DAYS AFTER THE HEARING, THE COMMISSIONER SHALL NOTIFY THE CARRIER IN WRITING OF THE DISPOSITION OF THE PROPOSED

REVISED RATE, TOGETHER WITH THE COMMISSIONER'S FINDINGS OF FACT AND CONCLUSIONS.

(2) NOT LESS THAN 30 DAYS BEFORE THE EFFECTIVE DATE OF A PROPOSED CHANGE IN A RATE CHARGED, THE CARRIER SHALL ISSUE TO EACH INDIVIDUAL 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 RATE IN WRITING BEFORE THE EXPIRATION OF 60 DAYS AFTER THE DATE OF FILING, THE CARRIER IMMEDIATELY SHALL NOTIFY EACH INDIVIDUAL WHO WILL BE AFFECTED BY THE PROPOSED CHANGE.

SEC. 3763. (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 CONDITION OR CLAIMS EXPERIENCE OF THE INDIVIDUAL.

(B) ENCOURAGING OR DIRECTING AN INDIVIDUAL TO SEEK COVERAGE FROM ANOTHER CARRIER BECAUSE OF THE HEALTH CONDITION 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 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 HEALTH 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 HEALTH CONDITION OR CLAIMS EXPERIENCE OF THE INDIVIDUAL PLACED BY THE PRODUCER WITH THE CARRIER.

SEC. 3771. (1) THE MI-CAPP BOARD IS CREATED WITHIN THE OFFICE OF FINANCIAL AND INSURANCE REGULATION.

(2) THE BOARD SHALL CONSIST OF THE COMMISSIONER AND THE FOLLOWING 6 MEMBERS, APPOINTED BY THE COMMISSIONER:

(A) ONE MEMBER REPRESENTING HEALTH CARE CORPORATIONS.

(B) ONE MEMBER REPRESENTING HEALTH MAINTENANCE ORGANIZATIONS, BUT NOT HEALTH MAINTENANCE ORGANIZATIONS OWNED BY A HEALTH CARE CORPORATION.

(C) ONE MEMBER REPRESENTING COMMERCIAL CARRIERS.

(D) ONE MEMBER REPRESENTING THE GENERAL PUBLIC WHO IS NOT EMPLOYED BY A CARRIER.

(E) ONE MEMBER WHO IS A HEALTH ECONOMIST WHO IS NOT EMPLOYED BY A CARRIER.

(F) ONE MEMBER WHO IS IN GOOD STANDING WITH THE AMERICAN ACADEMY OF ACTUARIES WHO IS NOT EMPLOYED BY A CARRIER.

(3) THE MEMBERS FIRST APPOINTED TO THE BOARD SHALL BE APPOINTED WITHIN 14 DAYS AFTER THE EFFECTIVE DATE OF THIS CHAPTER.

(4) MEMBERS OF THE BOARD SHALL SERVE FOR TERMS OF 4 YEARS OR UNTIL A SUCCESSOR IS APPOINTED, WHICHEVER IS LATER, EXCEPT THAT OF THE MEMBERS FIRST APPOINTED, 2 SHALL SERVE FOR 2 YEARS, 2 SHALL

SERVE FOR 3 YEARS, AND 2 SHALL SERVE FOR 4 YEARS.

(5) IF A VACANCY OCCURS ON THE BOARD, THE COMMISSIONER SHALL MAKE AN APPOINTMENT FOR THE UNEXPIRED TERM IN THE SAME MANNER AS THE ORIGINAL APPOINTMENT.

(6) THE GOVERNOR MAY REMOVE A MEMBER OF THE BOARD FOR INCOMPETENCY, DERELICTION OF DUTY, MALFEASANCE, MISFEASANCE, OR NONFEASANCE IN OFFICE, OR ANY OTHER GOOD CAUSE.

(7) THE FIRST MEETING OF THE BOARD SHALL BE CALLED BY THE COMMISSIONER. AT THE FIRST MEETING, THE BOARD SHALL ELECT FROM AMONG ITS MEMBERS A CHAIRPERSON AND OTHER OFFICERS AS IT CONSIDERS NECESSARY OR APPROPRIATE. AFTER THE FIRST MEETING, THE BOARD SHALL MEET AT LEAST QUARTERLY, OR MORE FREQUENTLY AT THE CALL OF THE CHAIRPERSON OR IF REQUESTED BY 4 OR MORE MEMBERS.

(8) FOUR MEMBERS OF THE BOARD CONSTITUTE A QUORUM FOR THE TRANSACTION OF BUSINESS AT A MEETING OF THE BOARD. FOUR MEMBERS PRESENT AND SERVING ARE REQUIRED FOR OFFICIAL ACTION OF THE BOARD.

(9) THE BUSINESS THAT THE BOARD MAY PERFORM SHALL BE CONDUCTED AT A PUBLIC MEETING OF THE BOARD HELD IN COMPLIANCE WITH THE OPEN MEETINGS ACT, 1976 PA 267, MCL 15.261 TO 15.275.

(10) A WRITING PREPARED, OWNED, USED, IN THE POSSESSION OF, OR RETAINED BY THE BOARD IN THE PERFORMANCE OF AN OFFICIAL FUNCTION IS SUBJECT TO THE FREEDOM OF INFORMATION ACT, 1976 PA 442, MCL 15.231 TO 15.246.

(11) MEMBERS OF THE BOARD SHALL SERVE WITHOUT COMPENSATION. HOWEVER, MEMBERS OF THE BOARD MAY BE REIMBURSED FOR THEIR ACTUAL AND NECESSARY EXPENSES INCURRED IN THE PERFORMANCE OF THEIR OFFICIAL DUTIES AS MEMBERS OF THE BOARD.

SEC. 3773. (1) THE MICHIGAN CLAIMS FUND IS CREATED WITHIN THE STATE TREASURY. MONEY IN THE FUND SHALL BE USED ONLY AS PROVIDED IN SECTION 3775.

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

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

(4) THE COMMISSIONER SHALL BE THE ADMINISTRATOR OF THE MICHIGAN CLAIMS FUND FOR AUDITING PURPOSES.

SEC. 3775. (1) THE BOARD SHALL EXPEND MONEY FROM THE MICHIGAN CLAIMS FUND TO REIMBURSE CARRIERS FOR ELIGIBLE CLAIMS. A CARRIER IS ELIGIBLE TO RECEIVE REIMBURSEMENT FROM THE MICHIGAN CLAIMS FUND FOR 90% OF CLAIMS PAID BETWEEN $80,000.00 AND $800,000.00 IN A CALENDAR YEAR THAT HAVE BEEN PAID BY THE CARRIER ON BEHALF OF A COVERED ENROLLEE.

(2) EACH CARRIER SHALL SUBMIT A REQUEST FOR REIMBURSEMENT ON A FORM PRESCRIBED BY THE BOARD FROM THE MICHIGAN CLAIMS FUND BY NO LATER THAN APRIL 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. ONCE CLAIMS PAID ON BEHALF OF A COVERED ENROLLEE REACH $800,000.00 IN A GIVEN CALENDAR YEAR, NO FURTHER CLAIMS ON BEHALF OF THAT COVERED ENROLLEE IN THAT CALENDAR YEAR ARE ELIGIBLE FOR

REIMBURSEMENT. CARRIERS MAY BE REQUIRED TO SUBMIT CLAIMS DATA IN CONNECTION WITH THE REIMBURSEMENT REQUEST AS THE BOARD CONSIDERS NECESSARY TO DISTRIBUTE MONEY AND OVERSEE THE OPERATION OF THE MICHIGAN CLAIMS FUND. THE BOARD MAY REQUIRE THAT THE DATA BE SUBMITTED ON A PER ENROLLEE, AGGREGATE BASIS OR CATEGORICAL 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 BOARD 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, SHALL NOT REVERT TO THE GENERAL FUND, AND SHALL BE MADE AVAILABLE FOR DISTRIBUTION IN THE NEXT CALENDAR YEAR.

SEC. 3777. (1) AS A CONDITION OF TRANSACTING BUSINESS IN THIS STATE, EACH CARRIER ENGAGED IN WRITING A HEALTH BENEFIT PLAN SHALL PAY AN ANNUAL ASSESSMENT INTO THE MICHIGAN CLAIMS FUND AS PROVIDED IN THIS SECTION.

(2) THE TOTAL ASSESSMENT 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 MICHIGAN CLAIMS FUND FOR THE SAME CALENDAR YEAR. BY NOT LATER

THAN APRIL 1 OF EACH YEAR, THE BOARD SHALL DETERMINE THE TOTAL ASSESSMENT AND SHALL NOTIFY CARRIERS OF THEIR ASSESSMENT. A CARRIER'S ASSESSMENT SHALL BE DETERMINED BY THE BOARD AND SHALL BE APPORTIONED ON AN EQUITABLE BASIS AMONG ALL CARRIERS OF HEALTH BENEFIT PLANS IN PROPORTION TO EACH CARRIER'S SHARE OF COVERED LIVES IN THE INDIVIDUAL MARKET. BY NOT LATER THAN 90 DAYS AFTER THE ASSESSMENT NOTICE IS ISSUED, EACH CARRIER SHALL PAY THE AMOUNT OF ITS ASSESSMENT TO THE MICHIGAN CLAIMS FUND.

SEC. 3778. THE PREMIUM RATES ESTABLISHED BY A CARRIER FOR A HEALTH BENEFIT PLAN SHALL RECOGNIZE THE AVAILABILITY OF REIMBURSEMENT FROM THE MICHIGAN CLAIMS FUND.

SEC. 3779. THE BOARD SHALL KEEP AN ACCURATE ACCOUNT OF ALL MICHIGAN CLAIMS FUND RECEIPTS AND EXPENDITURES AND SHALL REPORT BY OCTOBER 1, 2011 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 ASSESSMENTS COLLECTED AND CLAIMS PAID UNDER SECTIONS 3775 AND 3777.

Enacting section 1. This amendatory act does not take effect unless all of the following bills of the 95th Legislature are enacted into law:

(a) Senate Bill No. 1244 or House Bill No.____ (request no. 00083'09).

(b) Senate Bill No.____ or House Bill No. 6036(request no. H00083'09 *).

(c) Senate Bill No.____ or House Bill No. 6037(request no. 06174'10).

(d) Senate Bill No. 1245 or House Bill No.____ (request no. S06174'10 *).

(e) Senate Bill No. 1243 or House Bill No.____ (request no. 06472'10).

(f) Senate Bill No.____ or House Bill No. 6034(request no. H06472'10 *).

(g) Senate Bill No. 1242 or House Bill No.____ (request no. S06473'10 *).