HOUSE BILL No. 6036

April 13, 2010, Introduced by Reps. Roy Schmidt, Ball, Johnson and Corriveau 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, and 3711 (MCL 500.2213b, 500.3406f, and 500.3711), section 2213b as amended by 1998 PA 457, section 3406f as added by 1996 PA 517, and section 3711 as added by 2003 PA 88, and by adding sections 2264b and 3710.

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. **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

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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. 2264B. (1) ANY POLICY, CERTIFICATE, OR CONTRACT DELIVERED, ISSUED FOR DELIVERY, OR RENEWED IN THIS STATE THAT PROVIDES FOR HOSPITAL OR MEDICAL CARE COVERAGE OR REIMBURSEMENT FOR HOSPITAL OR MEDICAL CARE FOR DEPENDENT CHILDREN SHALL PERMIT CONTINUATION OF THAT COVERAGE FOR A CHILD UNTIL THAT CHILD ATTAINS AGE 26 EVEN IF THE CHILD IS NO LONGER CONSIDERED A DEPENDENT IF THE CHILD MEETS ALL OF THE FOLLOWING:

(A) IS UNMARRIED.

(B) HAS NO DEPENDENTS OF HIS OR HER OWN.

(C) IS A RESIDENT OF THIS STATE OR RESIDES SOMEWHERE ELSE TEMPORARILY.

(D) IS NOT ELIGIBLE FOR A GROUP HEALTH BENEFITS OR COVERAGE PLAN FROM HIS OR HER EMPLOYER.

(E) IS NOT PROVIDED COVERAGE UNDER ANY OTHER GROUP OR INDIVIDUAL HEALTH BENEFITS OR COVERAGE PLAN.

(F) HAS NOT ACCEPTED A FINANCIAL INCENTIVE FROM HIS OR HER EMPLOYER OR OTHER SOURCE TO DECLINE ANY OTHER GROUP OR INDIVIDUAL HEALTH BENEFITS OR COVERAGE PLAN.

(G) WAS CONTINUOUSLY COVERED PRIOR TO THE APPLICATION FOR CONTINUATION COVERAGE UNDER 1 OR MORE INDIVIDUAL OR GROUP HEALTH BENEFITS OR COVERAGE PLANS WITH NO BREAK IN COVERAGE THAT EXCEEDED 62 DAYS.

(2) A COVERED PERSON'S POLICY, CERTIFICATE, OR CONTRACT MAY REQUIRE PAYMENT OF A PREMIUM BY THE COVERED PERSON OR CHILD, SUBJECT TO THE COMMISSIONER'S APPROVAL, FOR ANY PERIOD OF CONTINUATION COVERAGE ELECTED UNDER SUBSECTION (1). THE PREMIUM SHALL NOT EXCEED 102% OF THE APPLICABLE PORTION OF THE PREMIUM PREVIOUSLY PAID FOR THAT DEPENDENT'S COVERAGE UNDER THE POLICY, CERTIFICATE, OR CONTRACT BEFORE THE TERMINATION OF COVERAGE AT THE SPECIFIC AGE PROVIDED FOR IN THE POLICY, CERTIFICATE, OR CONTRACT. THE APPLICABLE PORTION OF THE PREMIUM PREVIOUSLY PAID FOR THAT DEPENDENT'S COVERAGE SHALL BE DETERMINED PURSUANT TO RULES ADOPTED BY THE COMMISSIONER UNDER THE ADMINISTRATIVE PROCEDURES ACT OF 1969, 1969 PA 306, MCL 24.201 TO 24.328, BASED UPON THE DIFFERENCE BETWEEN THE POLICY'S, CERTIFICATE'S, OR CONTRACT'S RATING TIERS FOR

ADULT AND DEPENDENT COVERAGE OR FAMILY COVERAGE, AS APPROPRIATE, AND SINGLE COVERAGE, OR BASED UPON ANY OTHER FORMULA OR DEPENDENT RATING TIER THAT THE COMMISSIONER CONSIDERS APPROPRIATE AND THAT PROVIDES A SUBSTANTIALLY SIMILAR RESULT.

(3) THIS SECTION DOES NOT PROHIBIT AN EMPLOYER FROM REQUIRING AN EMPLOYEE TO PAY ALL OR PART OF THE COST OF COVERAGE PROVIDED FOR THAT EMPLOYEE'S CHILD UNDER THIS SECTION.

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. 3710. NOTWITHSTANDING ANY OTHER PROVISION OF THIS ACT, A HEALTH BENEFIT PLAN SHALL NOT BE RESCINDED, CANCELED, OR LIMITED DUE TO THE PLAN'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 HEALTH BENEFIT PLAN'S REMEDIES UPON A SHOWING OF INTENTIONAL MISREPRESENTATION OF MATERIAL FACT.

Sec. 3711. (1) Except as provided in this section, a small employer carrier that offers health coverage in the small employer group market in connection with a health benefit plan shall renew or continue in force that plan at the option of the small employer or sole proprietor **AT A PREMIUM RATE THAT DOES NOT TAKE INTO ACCOUNT THE CLAIMS EXPERIENCE OR ANY CHANGE IN THE HEALTH STATUS OF ANY COVERED PERSON THAT OCCURRED AFTER THE INITIAL ISSUANCE OF THE HEALTH BENEFIT PLAN**.

(2) Guaranteed renewal under subsection (1) is not required in cases of: fraud or intentional misrepresentation of the small employer or, for coverage of an insured individual, fraud or misrepresentation by the insured individual or the individual's representative; lack of payment; noncompliance with minimum participation requirements; if the small employer carrier no longer offers that particular type of coverage in the market; or if the sole proprietor or small employer moves outside the geographic area.

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

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

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

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

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

(f) Senate Bill No.____ or House Bill No.____ (request no. 06473'10).

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