HOUSE BILL No. 6037

April 13, 2010, Introduced by Reps. Corriveau, Ball, 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 sections 3501, 3503, 3519, and 3537 (MCL 500.3501, 500.3503, 500.3519, and 500.3537), sections 3501 and 3537 as added by 2000 PA 252, section 3503 as amended by 2006 PA 366, and section 3519 as amended by 2005 PA 306, and by adding section 3406s and chapter 37B.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

SEC. 3406S. (1) IF THE MI-HEALTH BOARD DETERMINES THAT SECTION 3406A, 3406B, 3406C, 3406D, 3406E, 3406M, 3406N, 3406P, 3406Q, 3406R, 3425, 3609A, 3613, 3614, 3615, 3616, OR 3616A SHOULD BE WAIVED AS PROVIDED IN SECTION 3783, THEN THE SECTIONS SO IDENTIFIED BY THE MI-HEALTH BOARD ARE NOT REQUIRED TO BE PROVIDED OR OFFERED

HOUSE BILL No. 6037

IN A STANDARD GUARANTEED ISSUE HEALTH PLAN OR AN ENHANCED GUARANTEED ISSUE HEALTH PLAN.

(2) AS USED IN THIS SECTION:

(A) "MI-HEALTH BOARD" MEANS THE MI-HEALTH BOARD CREATED IN SECTION 3782.

(B) "STANDARD GUARANTEED ISSUE HEALTH PLAN" AND "ENHANCED GUARANTEED ISSUE HEALTH PLAN" MEAN THOSE PLANS AS REGULATED UNDER CHAPTER 37B.

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~~ **$3,774.00** 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,~~ **EXCEPT AS OTHERWISE PROVIDED, A HEALTH MAINTENANCE CONTRACT SHALL INCLUDE,** at a minimum, basic health ~~maintenance~~ services. **HOWEVER, A HEALTH MAINTENANCE CONTRACT ISSUED UNDER CHAPTER 37B DOES NOT HAVE TO INCLUDE BASIC HEALTH SERVICES AND NOT MORE THAN 1 HEALTH MAINTENANCE CONTRACT ISSUED UNDER CHAPTER 37A HAS TO INCLUDE BASIC HEALTH 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, **37A, AND 37B** 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~~ **EXCEPT AS OTHERWISE PROVIDED, ALL** health maintenance organization contracts shall include, at a minimum, basic health services. **HOWEVER, A HEALTH MAINTENANCE CONTRACT ISSUED UNDER CHAPTER 37B DOES NOT HAVE TO INCLUDE BASIC HEALTH SERVICES AND NOT MORE THAN 1 HEALTH MAINTENANCE CONTRACT ISSUED UNDER CHAPTER 37A HAS TO INCLUDE BASIC HEALTH SERVICES.**

Sec. 3537. (1) After the initial 24 months of operation, a health maintenance organization shall have an open enrollment period of not less than 30 days at least once during each consecutive 12-month period. During each enrollment period, the health maintenance organization shall accept up to its capacity as determined by the organization and submitted to the commissioner not less than 60 days before the commencement of the enrollment period, individuals in the order in which they apply for enrollment in a manner that does not unfairly discriminate on the basis of

age, sex, race, health, or economic status. The commissioner may waive compliance by the organization with this open enrollment requirement for any 12-month period for which the organization demonstrates to the commissioner's satisfaction that either of the following will occur:

(a) It has enrolled, or will be compelled to enroll, a disproportionate number of individuals who are likely to utilize its services more often than an actuarially determined average as determined under rules promulgated by the commissioner, and enrollment during an open enrollment period of an additional number of those individuals will jeopardize its economic viability.

(b) If it maintained an open enrollment period, it would not be able to comply with the rules promulgated under this chapter.

(2) A health maintenance organization providing health maintenance services to specified groups of individuals may accept members of the groups before accepting other individuals in the order in which they apply.

(3) A health maintenance organization which, under this section, enrolls individuals who are not members of a group may rate this nongroup membership on the basis of actual and credible loss experience.

(4) THE COMMISSIONER SHALL WAIVE COMPLIANCE BY A HEALTH MAINTENANCE ORGANIZATION WITH THIS SECTION FOR ANY 12-MONTH PERIOD FOR WHICH THE ORGANIZATION DEMONSTRATES TO THE COMMISSIONER'S SATISFACTION THAT THE NUMBER OF INDIVIDUALS ENROLLED UNDER SECTION 3785 IS NOT LESS THAN THE NUMBER OF INDIVIDUALS IT WOULD HAVE ENROLLED UNDER THIS SECTION.

CHAPTER 37B

GUARANTEED ISSUE HEALTH PLANS

SEC. 3780. AS USED IN THIS CHAPTER:

(A) "BOARD" MEANS THE MI-HEALTH BOARD CREATED IN SECTION 3782.

(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 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) "FEDERAL POVERTY LEVEL" MEANS THE POVERTY GUIDELINES PUBLISHED PERIODICALLY IN THE FEDERAL REGISTER BY THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES UNDER ITS AUTHORITY TO REVISE THE POVERTY LINE UNDER 42 USC 9902.

(D) "GEOGRAPHIC AREA" MEANS AN AREA IN THIS STATE THAT INCLUDES NOT LESS THAN 4 ENTIRE COUNTIES, ESTABLISHED BY THE BOARD AND USED FOR ADJUSTING PREMIUM FOR A STANDARD GUARANTEED ISSUE HEALTH PLAN OR ENHANCED GUARANTEED ISSUE HEALTH PLAN. EACH COUNTY IN THE GEOGRAPHIC AREA SHALL BE CONTIGUOUS WITH AT LEAST 1 OTHER COUNTY IN THAT GEOGRAPHIC AREA.

(E) "HEALTH BENEFIT PLAN" OR "PLAN" MEANS THAT TERM AS DEFINED IN SECTION 3751.

(F) "HEALTH CARE AFFORDABILITY FUND" OR "FUND" MEANS THE FUND CREATED IN SECTION 3787.

(G) "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.

(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) "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 PUBLIC 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.

(K) "SHORT-TERM OR 1-TIME LIMITED DURATION PLAN OF NO LONGER THAN 6 MONTHS" MEANS THAT TERM AS DEFINED IN SECTION 3751.

SEC. 3782. (1) THE MI-HEALTH BOARD IS CREATED WITHIN THE OFFICE OF FINANCIAL AND INSURANCE REGULATION.

(2) THE MI-HEALTH BOARD SHALL CONSIST OF THE FOLLOWING 13 MEMBERS:

(A) THE DIRECTOR OF THE DEPARTMENT OF COMMUNITY HEALTH OR HIS OR HER DESIGNEE.

(B) THE DIRECTOR OF THE DEPARTMENT OF HUMAN SERVICES OR HIS OR HER DESIGNEE, WHO SHALL SERVE AS AN EX OFFICIO NONVOTING MEMBER.

(C) THE COMMISSIONER OR HIS OR HER DESIGNEE.

(D) THE DEPUTY DIRECTOR FOR MEDICAL SERVICES ADMINISTRATION OR HIS OR HER DESIGNEE, WHO SHALL SERVE AS AN EX OFFICIO NONVOTING

MEMBER.

(E) THREE MEMBERS APPOINTED BY THE GOVERNOR WITH THE ADVICE AND CONSENT OF THE SENATE, 1 OF WHOM SHALL BE A MEMBER IN GOOD STANDING OF THE AMERICAN ACADEMY OF ACTUARIES WHO IS NOT EMPLOYED BY A CARRIER, HOSPITAL, OR HEALTH PROFESSIONAL, 1 OF WHOM SHALL BE A HEALTH ECONOMIST WHO IS NOT EMPLOYED BY A CARRIER, HOSPITAL, OR HEALTH PROFESSIONAL, AND 1 OF WHOM SHALL REPRESENT A HEALTH CARE CORPORATION.

(F) THREE MEMBERS APPOINTED BY THE SENATE MAJORITY LEADER, 1 OF WHOM SHALL REPRESENT HEALTH MAINTENANCE ORGANIZATIONS BUT SHALL NOT BE FROM A HEALTH MAINTENANCE ORGANIZATION OWNED BY A HEALTH CARE CORPORATION, 1 OF WHOM SHALL REPRESENT LOW-INCOME HEALTH CARE ADVOCACY ORGANIZATIONS BUT SHALL NOT BE EMPLOYED BY A CARRIER, HOSPITAL, OR HEALTH PROFESSIONAL, AND 1 OF WHOM SHALL REPRESENT HEALTH PROFESSIONALS.

(G) THREE MEMBERS APPOINTED BY THE SPEAKER OF THE HOUSE OF REPRESENTATIVES, 1 OF WHOM SHALL REPRESENT THE GENERAL PUBLIC BUT SHALL NOT BE EMPLOYED BY A CARRIER, HOSPITAL, OR HEALTH PROFESSIONAL, 1 OF WHOM SHALL REPRESENT CARRIERS WHO ARE NOT HEALTH MAINTENANCE ORGANIZATIONS OR HEALTH CARE CORPORATIONS, AND 1 OF WHOM SHALL REPRESENT HOSPITALS.

(3) THE MEMBERS FIRST APPOINTED TO THE BOARD SHALL BE APPOINTED WITHIN 30 DAYS AFTER THE EFFECTIVE DATE OF THIS CHAPTER. APPOINTED BOARD MEMBERS 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 1 YEAR, 2 SHALL SERVE FOR 2 YEARS, 2 SHALL SERVE FOR 3 YEARS, AND 3 SHALL SERVE FOR 4 YEARS.

(4) IF A VACANCY OCCURS ON THE BOARD, THE VACANCY SHALL BE FILLED FOR THE UNEXPIRED TERM IN THE SAME MANNER AS THE ORIGINAL APPOINTMENT. AN APPOINTED BOARD MEMBER IS ELIGIBLE FOR REAPPOINTMENT.

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

(6) THE FIRST MEETING OF THE BOARD SHALL BE CALLED BY THE DIRECTOR OF THE DEPARTMENT OF COMMUNITY HEALTH, WHO SHALL SERVE AS CHAIRPERSON. AFTER THE FIRST MEETING, THE BOARD SHALL MEET AT LEAST MONTHLY, OR MORE FREQUENTLY AT THE CALL OF THE CHAIRPERSON OR IF REQUESTED BY 7 OR MORE MEMBERS.

(7) SEVEN MEMBERS OF THE BOARD CONSTITUTE A QUORUM FOR THE TRANSACTION OF BUSINESS AT A MEETING OF THE BOARD. AN AFFIRMATIVE VOTE OF 7 BOARD MEMBERS IS NECESSARY FOR OFFICIAL ACTION OF THE BOARD.

(8) 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.

(9) 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.

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

SEC. 3783. (1) THE BOARD SHALL DEVELOP A STANDARD GUARANTEED ISSUE HEALTH PLAN AND AN ENHANCED GUARANTEED ISSUE HEALTH PLAN. THE STANDARD GUARANTEED ISSUE HEALTH PLAN SHALL APPROXIMATE THE MINIMUM LEVEL OF COVERAGE PROVIDED IN THIS STATE BY ALL CARRIERS ON JANUARY 1, 2009 IN THE INDIVIDUAL HEALTH MARKET, WHICH COVERAGE SATISFIES SUBDIVISIONS (A) TO (C). THE ENHANCED GUARANTEED ISSUE HEALTH PLAN SHALL APPROXIMATE THE AVERAGE LEVEL OF COVERAGE PROVIDED IN THE STATE BY A HEALTH CARE CORPORATION ON JANUARY 1, 2009 IN THE INDIVIDUAL HEALTH MARKET. IN DEVELOPING THE PLANS, THE BOARD SHALL EXAMINE PATIENT-CENTERED MEDICAL HOME MODELS. BOTH PLANS SHALL DO ALL OF THE FOLLOWING:

(A) PROVIDE INPATIENT SERVICES.

(B) PROVIDE OUTPATIENT SERVICES AND PREVENTIVE CARE.

(C) PROVIDE A VALUE-BASED PHARMACEUTICAL BENEFIT.

(D) MINIMIZE NONEMERGENCY EMERGENCY ROOM USE.

(E) ENCOURAGE HEALTH AND WELLNESS AND INCORPORATE THE PRINCIPLES OF VALUE-BASED INSURANCE DESIGN, PROMOTE HEALTHY BEHAVIORS, AND STRIVE FOR IMPROVEMENTS IN BOTH HEALTH OUTCOMES AND HEALTH CARE COST CONTAINMENTS.

(F) USE INCENTIVES TO PROVIDE HEALTH PROMOTION, INCLUDING, BUT NOT LIMITED TO, SMOKING CESSATION PROGRAMS; PROGRAMS 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, COINSURANCES, 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.

(2) A STANDARD GUARANTEED ISSUE HEALTH PLAN AND AN ENHANCED GUARANTEED ISSUE HEALTH PLAN SHALL MEET ALL REQUIREMENTS OF HEALTH COVERAGE PLANS REQUIRED UNDER STATE LAW, RULE, AND REGULATION EXCEPT THAT, IN ORDER TO SATISFY THE GOAL OF UNIVERSAL HEALTH CARE COVERAGE IN THIS STATE, THE BOARD MAY PERMIT A STANDARD GUARANTEED ISSUE HEALTH PLAN AND AN ENHANCED GUARANTEED ISSUE HEALTH PLAN TO NOT PROVIDE FOR THE COVERAGES OR OFFERINGS REQUIRED UNDER SECTION 3406A, 3406B, 3406C, 3406D, 3406E, 3406M, 3406N, 3406P, 3406Q, 3406R, 3425, 3609A, 3613, 3614, 3615, 3616, OR 3616A OF THE INSURANCE CODE OF 1956, 1956 PA 218, MCL 500.3406A, 500.3406B, 500.3406C, 500.3406D, 500.3406E, 500.3406M, 5003406N, 500.3406P, 500.3406Q, 500.3604R, 500.3425, 500.3609A, 500.3613, 500.3614, 500.3615, 500.3616, AND 500.3616A, OR SECTION 401B, 401F, 401G, 414A, 415, 416, 416A, 416B, 416C, 416D, OR 417 OF THE NONPROFIT HEALTH CARE CORPORATION REFORM ACT OF 1980, 1980 PA 350, MCL 550.1401B, 550.1401F, 550.1401G, 550.1414A, 550.1415, 550.1416, 550.1416A, 550.1416B, 550.1416C, 550.1416D, AND 550.1417. IN MAKING THE DETERMINATION OF WHICH PROVISIONS OF SECTION 3406A, 3406B, 3406C, 3406D, 3406E, 3406M, 3406N, 3406P, 3406Q, 3406R, 3425, 3609A, 3613, 3614, 3615, 3616, OR 3616A OF THE INSURANCE CODE OF 1956, 1956 PA 218, MCL 500.3406A, 500.3406B, 500.3406C, 500.3406D, 500.3406E, 500.3406M, 500.3406N, 500.3406P, 500.3406Q, 500.3604R, 500.3425, 500.3609A, 500.3613, 500.3614, 500.3615, 500.3616, AND 500.3616A, OR SECTION 401B, 401F, 401G, 414A, 415, 416, 416A, 416B, 416C, 416D, OR 417 OF THE NONPROFIT HEALTH CARE CORPORATION REFORM

ACT OF 1980, 1980 PA 350, MCL 550.1401B, 550.1401F, 550.1401G, 550.1414A, 550.1415, 550.1416, 550.1416A, 550.1416B, 550.1416C, 550.1416D, AND 550.1417, ARE NOT REQUIRED TO BE PROVIDED IN A STANDARD GUARANTEED ISSUE HEALTH PLAN AND AN ENHANCED GUARANTEED ISSUE HEALTH PLAN, THE BOARD SHALL DETERMINE WHETHER REAL COST SAVINGS WILL BE ACHIEVED AND AFFORDABILITY MAXIMIZED.

(3) THE RATES CHARGED TO INDIVIDUALS FOR A STANDARD GUARANTEED ISSUE HEALTH PLAN AND AN ENHANCED GUARANTEED ISSUE HEALTH PLAN SHALL BE ESTABLISHED ANNUALLY BY THE BOARD AND SHALL BE BASED ON SOUND ACTUARIAL PRINCIPLES. THE RATES ESTABLISHED MAY INCLUDE RATE DIFFERENTIALS BASED ONLY ON GEOGRAPHIC AREA, AGE, TOBACCO USE, BODY MASS INDEX, AND OTHER HEALTHY BEHAVIORS 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. THE VARIATION IN RATES BASED ON AGE SHALL NOT EXCEED A 4 TO 1 RATIO.

(4) EACH STANDARD GUARANTEED ISSUE HEALTH PLAN AND ENHANCED GUARANTEED ISSUE HEALTH PLAN SHALL CONTAIN A DETAILED DESCRIPTION OF BENEFITS OFFERED, INCLUDING MAXIMUMS, LIMITATIONS, EXCLUSIONS, AND OTHER BENEFIT LIMITS. EACH STANDARD GUARANTEED ISSUE HEALTH PLAN AND ENHANCED GUARANTEED ISSUE HEALTH PLAN SHALL REIMBURSE HEALTH CARE PROFESSIONALS AND HEALTH FACILITIES AT NOT LESS THAN 100% OF MEDICARE REIMBURSEMENT RATES.

(5) A STANDARD GUARANTEED ISSUE HEALTH PLAN AND AN ENHANCED GUARANTEED ISSUE HEALTH PLAN SHALL NOT EXCLUDE AN INDIVIDUAL FROM COVERAGE BASED ON RACE, COLOR, RELIGION, NATIONAL ORIGIN, SEX, SEXUAL ORIENTATION, MARITAL STATUS, HEALTH STATUS, PERSONAL

APPEARANCE, POLITICAL AFFILIATION, SOURCE OF INCOME, OR AGE.

SEC. 3785. (1) AS A CONDITION OF TRANSACTING BUSINESS IN THIS STATE, EACH CARRIER PROVIDING HEALTH BENEFIT PLANS IN THIS STATE SHALL MAKE AVAILABLE AND OFFER THE STANDARD GUARANTEED ISSUE HEALTH PLAN AND THE ENHANCED GUARANTEED ISSUE HEALTH PLAN DEVELOPED UNDER SECTION 3783 TO INDIVIDUALS IN THIS STATE.

(2) A HEALTH PLAN OFFERED PURSUANT TO THIS SECTION SHALL BE CLEARLY IDENTIFIED AS A "STANDARD GUARANTEED ISSUE HEALTH PLAN" OR AN "ENHANCED GUARANTEED ISSUE HEALTH PLAN".

(3) A CARRIER SHALL GUARANTEE ISSUE TO AN INDIVIDUAL THE STANDARD GUARANTEED ISSUE HEALTH PLAN AND THE ENHANCED GUARANTEED ISSUE HEALTH PLAN OFFERED BY THE CARRIER AND SHALL NOT REFUSE TO ISSUE THE HEALTH PLAN 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 PREMIUM 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.

(4) THE NUMBER OF INDIVIDUALS REQUIRED TO BE COVERED UNDER THE STANDARD GUARANTEED ISSUE HEALTH PLAN AND ENHANCED GUARANTEED ISSUE HEALTH PLAN BY EACH CARRIER SHALL BE DETERMINED BY THE COMMISSIONER ON AN EQUITABLE BASIS IN PROPORTION TO EACH CARRIER'S SHARE OF THE INDIVIDUAL HEALTH COVERAGE MARKET.

SEC. 3787. (1) A HEALTH CARE AFFORDABILITY FUND 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.

(2) EACH HEALTH CARE CORPORATION SHALL PRESENT TO THE COMMISSIONER BY APRIL 1, 2011 AND ANNUALLY THEREAFTER THE AMOUNT OF LOCAL TAX AND TAX LEVIED UNDER THE MICHIGAN BUSINESS TAX ACT, 2007 PA 36, MCL 208.1101 TO 208.1601, AS CERTIFIED BY AN INDEPENDENT CERTIFIED PUBLIC ACCOUNTANT, THAT THE HEALTH CARE CORPORATION WOULD HAVE BEEN REQUIRED TO PAY IN THE IMMEDIATELY PRECEDING CALENDAR YEAR IF THE HEALTH CARE CORPORATION WAS SUBJECT TO THOSE TAXES. THE COMMISSIONER MAY RETAIN LEGAL, FINANCIAL, AND EXAMINATION SERVICES FROM OUTSIDE THE OFFICE OF FINANCIAL AND INSURANCE REGULATION TO EXAMINE AND INVESTIGATE THE AMOUNT SUBMITTED BY THE HEALTH CARE CORPORATION, THE REASONABLE COST OF WHICH MAY BE CHARGED TO THE CORPORATION. BY MAY 1, 2011 AND ANNUALLY THEREAFTER, THE COMMISSIONER SHALL ASSESS EACH HEALTH CARE CORPORATION 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 HEALTH CARE CORPORATION WOULD HAVE BEEN REQUIRED TO PAY IN THE IMMEDIATELY PRECEDING CALENDAR YEAR IF THE CORPORATION WAS SUBJECT TO THOSE TAXES. HOWEVER, IN DETERMINING THE

AMOUNT OF THE ASSESSMENT UNDER THIS SUBSECTION, THE COMMISSIONER SHALL CONSIDER THE AMOUNT OF COST TRANSFERS INCURRED BY THE HEALTH CARE CORPORATION PURSUANT TO SECTION 609(6) OF THE NONPROFIT HEALTH CARE CORPORATION REFORM ACT, 1980 PA 350, MCL 550.1609.

(3) A HEALTH CARE CORPORATION 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 STANDARD GUARANTEED ISSUE HEALTH PLANS AND ENHANCED GUARANTEED ISSUE HEALTH 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 STANDARD GUARANTEED ISSUE HEALTH PLANS OR ENHANCED GUARANTEED ISSUE HEALTH PLANS AS DESCRIBED IN SUBSECTION (4) AND SHALL NOT BE USED AS FOLLOWS:

(A) IF THE INDIVIDUAL HAS NOT BEEN A RESIDENT OF THE STATE FOR THE PREVIOUS 6 MONTHS.

(B) IF THE INDIVIDUAL IS ELIGIBLE FOR ANY GOVERNMENT PROGRAM PROVIDING HEALTH COVERAGE, MEDICAID, MEDICARE, OR THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM AUTHORIZED UNDER TITLE XXI OF THE SOCIAL SECURITY ACT, 42 USC 1397AA TO 1397JJ.

(C) IF THE INDIVIDUAL'S OR FAMILY MEMBER'S EMPLOYER HAS PROVIDED HEALTH COVERAGE IN THE LAST 6 MONTHS FOR WHICH THE

INDIVIDUAL IS ELIGIBLE. THIS SUBDIVISION DOES NOT APPLY IF HEALTH COVERAGE WAS NOT PROVIDED DUE TO THE INDIVIDUAL'S OR FAMILY MEMBER'S LOSS OF EMPLOYMENT, LOSS OF ELIGIBILITY FOR COVERAGE DUE TO LOSS OF EMPLOYMENT HOURS, OR LOSS OF DEPENDENCY STATUS.

(D) IF THE INDIVIDUAL HAS ACCEPTED A FINANCIAL INCENTIVE FROM HIS OR HER EMPLOYER TO DECLINE HIS OR HER EMPLOYER'S SUBSIDIZED HEALTH COVERAGE PLAN.

(6) THE COMMISSIONER SHALL REPORT BY NOVEMBER 1, 2011 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. 3788. A CARRIER THAT ISSUES ONLY SHORT-TERM OR 1-TIME LIMITED DURATION PLANS OF NO LONGER THAN 6 MONTHS IS NOT SUBJECT TO THIS CHAPTER.

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

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

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

(f) Senate Bill No.____ or House Bill No. 6035(request no. 06473'10).

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