SENATE BILL No. 580

May 14, 2009, Introduced by Senators PAPPAGEORGE, GEORGE, BIRKHOLZ, PATTERSON, HARDIMAN, BARCIA, JANSEN, CROPSEY, BROWN and CASSIS 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, and 3539 (MCL 500.2213b, 500.3406f, 500.3501, 500.3503, 500.3519, and 500.3539), section 2213b as amended by 1998 PA 457, section 3406f as added by 1996 PA 517, section 3501 as added by 2000 PA 252, section 3503 as amended by 2006 PA 366, and sections 3519 and 3539 as amended by 2005 PA 306, and by adding section 3406s and chapter 37A.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Sec. 2213b. (1) Except as provided in this section, an insurer that delivers, issues for delivery, or renews in this state an expense-incurred hospital, medical, or surgical individual policy under chapter 34 shall renew or continue in force the policy at the option of the individual. **THIS SUBSECTION DOES NOT APPLY TO A HEALTH BENEFIT PLAN AS DEFINED IN SECTION 3751.**

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(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. 3406S. (1) IF THE COVER MICHIGAN 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 8 OF THE MI-HEALTH ACT, THEN THE SECTIONS SO IDENTIFIED BY THE COVER MICHIGAN BOARD ARE NOT REQUIRED TO BE PROVIDED OR OFFERED IN AN ELIGIBLE HEALTH COVERAGE PLAN.

(2) AS USED IN THIS SECTION:

(A) "COVER MICHIGAN BOARD" MEANS THE COVER MICHIGAN BOARD CREATED IN SECTION 5 OF THE MI-HEALTH ACT.

(B) "ELIGIBLE HEALTH COVERAGE PLAN" MEANS THAT TERM AS DEFINED IN SECTION 3 OF THE MI-HEALTH ACT.

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,~~ **EXCEPT FOR HEALTH MAINTENANCE ORGANIZATION CONTRACTS THAT ARE ELIGIBLE HEALTH COVERAGE PLANS UNDER THE MI-HEALTH ACT, A HEALTH MAINTENANCE CONTRACT SHALL INCLUDE,** 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 health maintenance organization contracts**, EXCEPT HEALTH MAINTENANCE ORGANIZATION CONTRACTS THAT ARE ELIGIBLE HEALTH COVERAGE PLANS UNDER THE MI-HEALTH ACT,** shall include, at a minimum, basic health services.

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 BENEFIT PLANS

SEC. 3751. AS USED IN THIS CHAPTER:

(A) "BOARD" MEANS THE MICHIGAN CLAIMS BOARD CREATED IN SECTION 3771.

(B) "CARRIER" MEANS A PERSON THAT PROVIDES HEALTH BENEFITS, COVERAGE, OR INSURANCE TO AN INDIVIDUAL IN THIS STATE. FOR THE PURPOSES OF THIS CHAPTER, CARRIER INCLUDES A HEALTH INSURANCE COMPANY AUTHORIZED TO DO BUSINESS IN THIS STATE, A NONPROFIT HEALTH CARE CORPORATION, A HEALTH MAINTENANCE ORGANIZATION, OR ANY OTHER PERSON PROVIDING A PLAN OF HEALTH BENEFITS, COVERAGE, OR INSURANCE

SUBJECT TO STATE INSURANCE REGULATION. CARRIER DOES NOT INCLUDE A HEALTH MAINTENANCE ORGANIZATION THAT PROVIDES ONLY MEDICAID COVERAGE.

(C) "COMMERCIAL CARRIER" MEANS AN INDIVIDUAL CARRIER OTHER THAN A NONPROFIT HEALTH CARE CORPORATION OR HEALTH MAINTENANCE ORGANIZATION.

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

(E) "ELIGIBLE HEALTH COVERAGE PLAN" MEANS THAT TERM AS DEFINED IN SECTION 3 OF THE MI-HEALTH ACT.

(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 AN ELIGIBLE HEALTH COVERAGE PLAN. 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.

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

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

(I) "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.

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

(*i*) IS ISSUED TO PROVIDE COVERAGE FOR A PERIOD OF 185 DAYS OR LESS, EXCEPT THAT THE HEALTH BENEFIT PLAN MAY PERMIT A LIMITED EXTENSION OF BENEFITS AFTER THE DATE THE PLAN ENDED SOLELY FOR EXPENSES ATTRIBUTABLE TO A CONDITION FOR WHICH A COVERED PERSON INCURRED EXPENSES DURING THE TERM OF THE PLAN.

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

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

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

SEC. 3753. THIS CHAPTER APPLIES TO ANY INDIVIDUAL HEALTH BENEFIT PLAN 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, LACK OF PAYMENT, 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 EACH COVERED INDIVIDUAL PROVIDED COVERAGE UNDER THE PLAN OF THE DISCONTINUATION AT LEAST 90 DAYS PRIOR TO THE DATE OF THE DISCONTINUATION.

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

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

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

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

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

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

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

SEC. 3763. (1) 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 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 MICHIGAN CLAIMS 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 NONPROFIT HEALTH CARE CORPORATIONS.

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

(C) ONE MEMBER REPRESENTING COMMERCIAL CARRIERS.

(D) ONE MEMBER REPRESENTING THE GENERAL PUBLIC.

(E) ONE MEMBER WHO IS A HEALTH ECONOMIST.

(F) ONE MEMBER WHO IS IN GOOD STANDING WITH THE AMERICAN ACADEMY OF ACTUARIES.

(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) MONEY SHALL BE EXPENDED 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 $25,000.00 AND $250,000.00 IN A CALENDAR YEAR 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 $250,000.00 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 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 THEIR RESPECTIVE SHARES OF THE TOTAL PREMIUMS. 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, 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 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. 581.

(b) Senate Bill No. 579.

(c) Senate Bill No. 582.