STATE OF MICHIGAN
96TH LEGISLATURE
REGULAR SESSION OF 2012

Introduced by Senators Hune and Smith

ENROLLED SENATE BILL No. 1293

AN ACT to amend 1956 PA 218, entitled "An act to revise, consolidate, and classify the laws relating to the insurance and surety business; to regulate the incorporation or formation of domestic insurance and surety companies and associations and the admission of foreign and alien companies and associations; to provide their rights, powers, and immunities and to prescribe the conditions on which companies and associations organized, existing, or authorized under this act may exercise their powers; to provide the rights, powers, and immunities and to prescribe the conditions on which other persons, firms, corporations, associations, risk retention groups, and purchasing groups engaged in an insurance or surety business may exercise their powers; to provide for the imposition of a privilege fee on domestic insurance companies and associations and the state accident fund; to provide for the imposition of a tax on the business of foreign and alien companies and associations; to provide for the imposition of a tax on risk retention groups and purchasing groups; to provide for the imposition of a tax on the business of surplus line agents; to provide for the imposition of regulatory fees on certain insurers; to provide for assessment fees on certain health maintenance organizations; to modify tort liability arising out of certain accidents; to provide for limited actions with respect to that modified tort liability and to prescribe certain procedures for maintaining those actions; to require security for losses arising out of certain accidents; to provide for the continued availability and affordability of automobile insurance and homeowners insurance in this state and to facilitate the purchase of that insurance by all residents of this state at fair and reasonable rates; to provide for certain reporting with respect to insurance and with respect to certain claims against uninsured or self-insured persons; to prescribe duties for certain state departments and officers with respect to that reporting; to provide for certain assessments; to establish and continue certain state insurance funds; to modify and clarify the status, rights, powers, duties, and operations of the nonprofit malpractice insurance fund; to provide for the departmental supervision and regulation of the insurance and surety business within this state; to provide for regulation over worker's compensation self-insurers; to provide for the conservation, rehabilitation, or liquidation of unsound or insolvent insurers; to provide for the protection of policyholders, claimants, and creditors of unsound or insolvent insurers; to provide for associations of insurers to protect policyholders and claimants in the event of insurer insolvencies; to prescribe educational requirements for insurance agents and solicitors; to provide for the regulation of multiple employer welfare arrangements; to create an automobile theft prevention authority to reduce the number of automobile thefts in this state; to prescribe the powers and duties of the automobile theft prevention authority; to provide certain powers and duties upon certain officials, departments, and authorities of this state; to provide for an appropriation; to repeal acts and parts of acts; and to provide penalties for the violation of this act," by amending sections 2213b, 2242, 3426, 3705, 3712, 5008, 5104, 5209, 5800, and 5824 (MCL 500.2213b, 500.2242, 500.3426, 500.3705, 500.3712, 500.5008, 500.5104, 500.5209, 500.5800, and 500.5824), section 2213b as amended by 1998 PA 457, section 2242 as amended by 1990 PA 305, section 3426 as added by 2006 PA 412, sections 3705 and 3712 as added by 2003 PA 88, section 5008 as amended by 1994 PA 226, section 5104 as amended by 1999 PA 211, and section 5800 as amended by 2000 PA 8, and by adding sections 3405a, 3407c, 3428, 3472, 3474a, 3612a, 5801, 5805, 5825, and 5826.

The People of the State of Michigan enact:

Sec. 2213b. (1) Except as otherwise 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.

(2) Except as otherwise provided in this section, 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) An insurer or health maintenance organization that offers an expense-incurred hospital, medical, or surgical policy under chapter 34 or 36 shall not discontinue offering a particular plan or product in the nongroup or group market unless the insurer or health maintenance organization does all of the following:

(a) Provides notice to the commissioner and to each covered individual or group, as applicable, provided coverage under the plan or product of the discontinuation at least 90 days before the date of the discontinuation.

(b) Offers to each covered individual or group, as applicable, provided coverage under the plan or product the option to purchase any other plan or product currently being offered in the nongroup market or group market, as applicable, by that insurer or health maintenance organization 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 or products.

(5) An insurer or health maintenance organization shall not discontinue offering all coverage in the nongroup or group market unless the insurer or health maintenance organization does all of the following:

(a) Provides notice to the commissioner and to each covered individual or group, as applicable, of the discontinuation at least 180 days before the date of the expiration of coverage.

(b) Discontinues all health benefit plans issued in the nongroup or group market from which the insurer or health maintenance organization withdrew and does not renew coverage under those plans.

(6) If an insurer or health maintenance organization discontinues coverage under subsection (5), the insurer or health maintenance organization shall not provide for the issuance of any health benefit plans in the nongroup or group market from which the insurer or health maintenance organization withdrew during the 5-year period beginning on the date of the discontinuation of the last plan not renewed under that subsection.

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

(8) 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.

(9) By March 31 each year, 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 to the commissioner a written annual report that discloses both of the following:

(a) 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) 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 subdivision (a).

(10) The commissioner shall maintain copies of reports prepared pursuant to subsection (9) on file with the annual statement of each reporting insurer. The commissioner shall annually compile the reports received under subsection (9). 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 March 31 date for which the reports under subsection (9) are provided.

(11) 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. 2242. (1) Except as otherwise provided in section 2236(8)(d), a group disability policy shall not be issued or delivered in this state unless a copy of the form has been filed with the commissioner and approved by him or her.

(2) Subject to subsection (3), the commissioner may within 30 days after the filing of a disability insurance policy form applicable to individual or family expense coverage, disapprove the form for any of the following, subject to the requirements as to notice, hearing, and appeal set forth in sections 244 and 2236:

(a) The benefits provided under the policy are unreasonable in relation to the premium charged.

(b) The policy contains a provision that is unjust, unfair, inequitable, misleading, or deceptive or that encourages misrepresentation of the policy.

(c) The policy does not comply with other provisions of law.

(3) The commissioner may extend the time period in subsection (2) for an additional period not to exceed 30 days if written notice to the insurer is provided within 30 days after the filing under subsection (2).

(4) The commissioner may at any time withdraw his or her approval of an individual or family expense policy form on any of the grounds stated in subsection (2), subject to the requirements as to notice, hearing, and appeal set forth in sections 244 and 2236. An insurer shall not issue the form after the effective date of the withdrawal of approval.

Sec. 3405a. (1) Notwithstanding any provision of this act to the contrary, this section applies to the use of a most favored nation clause in a provider contract on and after February 1, 2013.

(2) Subject to subsection (3), beginning February 1, 2013, an insurer or a health maintenance organization shall not use a most favored nation clause in any provider contract, including a provider contract in effect on February 1, 2013, unless the most favored nation clause has been filed with and approved by the commissioner. Subject to subsection (3), beginning February 1, 2013, an insurer or a health maintenance organization shall not enforce a most favored nation clause in any provider contract without the prior approval of the commissioner.

(3) Beginning January 1, 2014, an insurer or a health maintenance organization shall not use a most favored nation clause in any provider contract, including a provider contract in effect on January 1, 2014.

(4) As used in this section, "most favored nation clause" means a clause that does any of the following:

(a) Prohibits, or grants a contracting insurer or health maintenance organization an option to prohibit, a provider from contracting with another party to provide health care services at a lower rate than the payment or reimbursement rate specified in the contract with the insurer or health maintenance organization.

(b) Requires, or grants a contracting insurer or health maintenance organization an option to require, a provider to accept a lower payment or reimbursement rate if the provider agrees to provide health care services to any other party at a lower rate than the payment or reimbursement rate specified in the contract with the insurer or health maintenance organization.

(c) Requires, or grants a contracting insurer or health maintenance organization an option to require, termination or renegotiation of an existing provider contract if a provider agrees to provide health care services to any other party at a lower rate than the payment or reimbursement rate specified in the contract with the insurer or health maintenance organization.

(d) Requires a provider to disclose, to the insurer or health maintenance organization or the insurer's or health maintenance organization's designee, the provider's contractual payment or reimbursement rates with other parties.

Sec. 3407c. (1) A qualified health plan offered through an American health benefit exchange in this state pursuant to the patient protection and affordable care act, Public Law 111-148, as amended by the health care and education reconciliation act of 2010, Public Law 111-152, shall not provide coverage for elective abortion. This section does not prohibit an individual, organization, or employer participating in a qualified health plan offered through an American health benefit exchange in this state from purchasing optional supplemental coverage for elective abortion outside of the exchange as provided in subsection (2).

(2) An expense-incurred hospital, medical, or surgical policy or certificate delivered, issued for delivery, or renewed in this state and a health maintenance organization group or individual contract offered outside of an American health benefit exchange shall not provide coverage for elective abortions except by an optional rider for which an additional premium has been paid by the purchaser.

(3) An employer may purchase an optional rider to provide coverage for an elective abortion if the employer provides notice to each employee that elective abortion will be included as a rider to his or her health coverage and that the coverage may be used by a covered dependent without notice to the employee.

(4) This section does not require an insurer, health maintenance organization, or employer to provide or offer to provide an optional rider for elective abortion coverage.

(5) This section does not apply to benefits provided under title XIX of the social security act, 42 USC 1396 to 1396w-5.

(6) This section does not create a right to abortion.

(7) Notwithstanding any other provision of this section, a person shall not perform an abortion that is prohibited by law.

(8) This section applies to policies, certificates, or contracts delivered, issued for delivery, or renewed in this state on and after the effective date of this section.

(9) As used in this section:

(a) "Elective abortion" means the intentional use of an instrument, drug, or other substance or device to terminate a woman's pregnancy for a purpose other than to increase the probability of a live birth, to preserve the life or health of the child after live birth, or to remove a dead fetus. Elective abortion does not include either of the following:

(*i*) The prescription of or use of a drug or device intended as a contraceptive.

(*ii*) The intentional use of an instrument, drug, or other substance or device by a physician to terminate a woman's pregnancy if the woman's physical condition, in the physician's reasonable medical judgment, necessitates the termination of the woman's pregnancy to avert her death.

(b) "Qualified health plan" means that term as defined in section 1301 of the patient protection and affordable care act, Public Law 111-148.

(c) "Physician" means an individual licensed or otherwise authorized to engage in the practice of medicine or the practice of osteopathic medicine and surgery under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838.

Sec. 3426. (1) Each insurer providing a group expense-incurred hospital, medical, or surgical certificate delivered, issued for delivery, or renewed in this state and each health maintenance organization may offer group wellness coverage. Wellness coverage may provide for an appropriate rebate or reduction in premiums or for reduced copayments, coinsurance, or deductibles, or a combination of these incentives, for participation in any health behavior wellness, maintenance, or improvement program offered by the employer. The employer shall provide evidence of demonstrative maintenance or improvement of the insureds' or enrollees' health behaviors as determined by assessments of agreed-upon health status indicators between the employer and the insurer or health maintenance organization. Any rebate of premium provided by the insurer or health maintenance organization is presumed to be appropriate unless credible data demonstrate otherwise, but shall not exceed 30% of paid premiums, unless otherwise approved by the commissioner. Each insurer and each health maintenance organization shall make available to employers all wellness coverage plans that the insurer or health maintenance organization markets to employers in this state.

(2) Each insurer providing an individual or family expense-incurred hospital, medical, or surgical policy delivered, issued for delivery, or renewed in this state and each health maintenance organization may offer individual and family wellness coverage. Wellness coverage may provide for an appropriate rebate or reduction in premiums or for reduced copayments, coinsurance, or deductibles, or a combination of these incentives, for participation in any health behavior wellness, maintenance, or improvement program approved by the insurer or health maintenance organization. The insured or enrollee shall provide evidence of demonstrative maintenance or improvement of the individual's or family's health behaviors as determined by assessments of agreed-upon health status indicators between the insured or enrollee and the insurer or health maintenance organization. Any rebate of premium provided by the insurer or health maintenance organization is presumed to be appropriate unless credible data demonstrate otherwise, but shall not exceed 30% of paid premiums, unless otherwise approved by the commissioner. Each insurer and each health maintenance organization shall make available to individuals and families all wellness coverage plans that the insurer or health maintenance organization markets to individuals and families in this state.

(3) An insurer and a health maintenance organization are not required to continue any health behavior wellness, maintenance, or improvement program or to continue any incentive associated with a health behavior wellness, maintenance, or improvement program.

Sec. 3428. Beginning January 1, 2014, an insurer shall establish and maintain a provider network that, at a minimum, satisfies any network adequacy requirements imposed by the commissioner pursuant to federal law.

Sec. 3472. (1) Beginning January 1, 2014, during an applicable open enrollment period, an insurer shall not deny or condition the issuance or effectiveness of a policy and shall not discriminate in the pricing of a policy on the basis of health status, claims experience, receipt of health care, or medical condition.

(2) Subject to prior approval of the commissioner, an insurer shall establish reasonable open enrollment periods for all disability policies offered, delivered, issued for delivery, or renewed in this state on or after January 1, 2014.

(3) The commissioner shall establish minimum standards for the frequency and duration of open enrollment periods established under subsection (2). The commissioner shall uniformly apply the minimum standards for the frequency and duration of open enrollment periods established under this subsection to all insurers.

Sec. 3474a. The premium rate charged by an insurer, health maintenance organization, or nonprofit health care corporation for health insurance coverage offered through a policy or certificate delivered, issued for delivery, or renewed in this state on or after January 1, 2014 in the individual or small group market shall vary based on the following factors only:

(a) Whether the policy or certificate covers an individual or family.

(b) The rating area.

(c) Age, except that the premium rate shall not vary by more than 3 to 1 for adults for all plans other than child-only plans.

(d) Tobacco use, except that the premium rate shall not vary by more than 1.5 to 1.

Sec. 3612a. Notwithstanding section 3612(8), for a policy delivered, issued for delivery, or renewed in this state on or after January 1, 2014, the premium for an individual conversion policy under section 3612 shall be determined only by using the rating factors set forth in section 3474a.

Sec. 3705. (1) For adjusting premiums for health benefit plans subject to this chapter, a carrier may establish up to 10 geographic areas in this state. A nonprofit health care corporation shall establish geographic areas that cover all counties in this state.

(2) Premiums for a health benefit plan under this chapter are subject to the following:

(a) For a nonprofit health care corporation, only industry and age may be used for determining the premiums within a geographic area for a small employer or sole proprietor located in that geographic area. For a health maintenance organization, only industry, age, and group size may be used for determining the premiums within a geographic area for a small employer or sole proprietor located in that geographic area. For a commercial carrier, only industry, age, group size, and health status may be used for determining the premiums within a geographic area for a small employer or sole proprietor located in that geographic area.

(b) For a health benefit plan delivered, issued for delivery, or renewed in this state on or after January 1, 2014, the premiums charged during a rating period to small employers shall be determined only by using the rating factors set forth in section 3474a.

(c) The premiums charged during a rating period by a nonprofit health care corporation, health maintenance organization, or commercial carrier for a health benefit plan in a geographic area to small employers or sole proprietors located in that geographic area shall not vary from the index rate for that health benefit plan by more than 45% of the index rate.

(d) For a sole proprietor, a small employer carrier may charge an additional premium of up to 25% above the premiums in subdivision (b).

(e) Except as otherwise provided in this section, the percentage increase in the premiums charged to a small employer or sole proprietor in a geographic area for a new rating period shall not exceed the sum of the annual percentage adjustment in the geographic area's index rate for the health benefit plan and an adjustment pursuant to subdivision (a). The adjustment pursuant to subdivision (a) shall not exceed 15% annually and shall be adjusted pro rata for rating periods of less than 1 year. This subdivision does not prohibit an adjustment due to change in coverage.

(3) Beginning January 23, 2005, if a small employer had been covered by a self-insured health benefit plan immediately preceding application for a health benefit plan subject to this chapter, a carrier may charge an additional premium of up to 33% above the premium in subsection (2)(b) for no more than 2 years.

(4) Health benefit plan options, number of family members covered, and medicare eligibility may be used in establishing a small employer's or sole proprietor's premium.

(5) A small employer carrier shall apply all rating factors consistently with respect to all small employers and sole proprietors in a geographic area. Except as otherwise provided in subsection (4), a small employer carrier shall bill a small employer group only with a composite rate and shall not bill so that 1 or more employees in a small employer group are charged a higher premium than another employee in that small employer group.

Sec. 3712. (1) If a small employer carrier decides to discontinue offering all small employer health benefit plans in a geographic area, all of the following apply:

(a) The small employer carrier shall provide notice to the commissioner and to each small employer covered by the small employer carrier in the geographic area of the discontinuation at least 180 days prior to the date of the discontinuation of the coverage.

(b) All small employer health benefit plans issued or delivered for issuance in the geographic area are discontinued and all current health benefit plans in the geographic area are not renewed.

(c) The small employer carrier shall not issue or deliver for issuance any small employer health benefit plans in the geographic area for 5 years beginning on the date the last small employer health benefit plan in the geographic area is not renewed under subdivision (b).

(d) The small employer carrier shall not issue or deliver for issuance for 5 years any small employer health benefit plans in an area that was not a geographic area where the small employer carrier was issuing or delivering for issuance small employer health benefit plans on the date notice was given under subdivision (a). The 5-year period under this subdivision begins on the date notice was given under subdivision (a).

(2) A small employer carrier shall not discontinue offering a particular plan or product in the small employer group market unless the small employer carrier does all of the following:

(a) Provides notice to the commissioner and to each small employer provided coverage under the plan or product of the discontinuation at least 90 days before the date of the discontinuation.

(b) Offers to each small employer provided coverage under the plan or product the option to purchase any other plan or product currently being offered in the small employer group market by that small employer 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 or products.

Sec. 5008. (1) The commissioner shall prepare and keep on hand blank forms of articles of incorporation for insurers desiring to incorporate under this act, which forms may be had on application.

(2) The incorporators shall subscribe articles of incorporation in duplicate, which articles shall contain all of the following:

(a) The names of the incorporators and their places of residence respectively.

(b) The location of the principal office for the transaction of business in this state.

(c) The name by which the incorporation shall be known, which if it be upon the mutual plan shall contain the word "mutual". However, a nonprofit mutual disability insurer into which a nonprofit health care corporation that is organized under the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1101 to 550.1704, is merged or consolidated may retain and use trade names in use by the nonprofit health care corporation before the merger or consolidation.

(d) The purposes of the incorporation and the reference to the chapter of this act under which the purposes are enumerated and under which the company intends to operate.

(e) The manner in which the corporate powers are to be exercised; the number of directors and other officers; the manner of electing the directors and other officers, and how many of the directors constitute a quorum, and the manner of filling all vacancies; and, in the case of mutual life or life and disability insurers, the names and mailing addresses of the directors who shall serve until the first annual meeting of the corporation.

(f) The amount of capital stock, if any, what proportion is to be paid in before the corporation commences business, and the value of the stock, as provided in section 5014.

(g) The term of existence of the corporation, subject to section 5010.

(h) The time for the holding of the annual meetings of the corporation.

(i) Any terms and conditions of membership that the incorporators have agreed upon and which they consider important to have set forth in the articles.

(j) Any other terms and conditions prescribed by law for that class of insurer.

(k) If a mutual company operating on the assessment plan, the number of classes or divisions of members and the object or purpose of the classification or division, all of which shall be definitely and correctly stated; and in what manner assessments, premiums, or payments are to be required from the members, the purpose and objects for which the money so realized are to be appropriated, and the names and objects of each fund into which any the money shall be paid.

(3) The articles of any stock insurer formed or existing under this act may contain, or may be amended to contain, a provision that the shareholders shall have no preemptive rights to subscribe for any additional shares of capital stock and authorizing the board of directors to prescribe the terms and conditions upon which additional shares of capital stock shall be offered for subscription including the price of the stock, which shall not be less than the par value of the stock; and to offer shares that have not been subscribed by stockholders within the time duly fixed by the board of directors for subscription to any other person or persons at a price and upon terms not less favorable than those offered to the stockholders.

(4) The articles of incorporation may contain a provision providing that a director is not personally liable to the corporation or its shareholders or policyholders for monetary damages for a breach of the director's fiduciary duty. However, the provision does not eliminate or limit the liability of a director for any of the following:

(a) A breach of the director's duty of loyalty to the corporation or its shareholders or policyholders.

(b) Acts or omissions not in good faith or that involve intentional misconduct or knowing violation of law.

(c) A violation of section 5036, 5276, or 5280.

(d) A transaction from which the director derived an improper personal benefit.

(e) An act or omission occurring before January 1, 1989.

(5) The articles shall be acknowledged by the person signing the articles before some officer of this state authorized to take acknowledgments of deeds, who shall attach his or her certificate of acknowledgment.

Sec. 5104. (1) Subject to the requirements of this act applicable to domestic stock insurers, domestic mutual insurers, reciprocals, or inter-insurance exchanges, and the further requirements of this chapter, 13 or more persons may organize a stock insurer or 20 or more persons may organize a mutual insurer for the purpose of transacting any or all of the following kinds of insurance: property, marine, inland navigation and transportation, casualty, or fidelity and surety, all as defined in chapter 6. Once organized and authorized, the acquiring insurer is subject to all applicable provisions of this act.

(2) During the period that the acquiring insurer is a domestic stock insurer owned by a nonprofit health care corporation formed pursuant to the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1101 to 550.1704, then for insurance products and services the acquiring insurer under this chapter whether directly or indirectly shall only transact worker's compensation insurance and employer's liability insurance, transact disability insurance limited to replacement of loss of earnings, and act as an administrative services organization for an approved self-insured worker's compensation plan or a disability insurance plan limited to replacement of loss of earnings. This subsection does not preclude the acquiring insurer from providing either directly or indirectly noninsurance products and services as otherwise provided by law.

Sec. 5209. Except as otherwise provided in this section, an insurer shall transact its business under its own name and shall not adopt any assumed name. An insurer, by amending its articles of incorporation, may change its name or take a new name. A nonprofit mutual disability insurer into which a nonprofit health care corporation that is organized under the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1101 to 550.1704, is merged or consolidated may retain and use trade names in use by the nonprofit health care corporation before the merger or consolidation.

Sec. 5800. (1) This chapter applies only to domestic mutual insurers transacting property, casualty, disability, and other insurances, to mutual holding companies resulting from the reorganization of those mutual insurers, and to nonprofit mutual disability insurers.

(2) This chapter does not apply to any domestic insurer doing business on August 10, 1917, unless the insurer fully complies with this chapter and by resolution of its board of directors duly certified to by the president and secretary and filed with and approved by the commissioner elects to adopt the provisions of this chapter, in which case the insurer may thereafter effect such kind or kinds of insurance as specified in its articles of incorporation as then or thereafter amended or as may be specified in the resolution.

(3) A person incorporating under this chapter after January 1, 1984, is subject to the minimum financial requirements of sections 408 and 410. Any corporation incorporated under this chapter on or before January 1, 1984, continues to be subject to the provisions of section 5810(3).

(4) Except as otherwise provided in section 5801(2), a domestic mutual insurer transacting property, casualty, disability, and other insurances may be reorganized pursuant to chapters 59 and 60.

Sec. 5801. (1) A domestic mutual insurer may be formed with nonprofit status.

(2) A nonprofit mutual disability insurer has all powers of a mutual insurer organized under this chapter unless expressly reserved. A nonprofit mutual disability insurer that has merged with a nonprofit health care corporation as provided in section 5805(1) shall not convert its status to a stock insurer under chapter 59 or reorganize under chapter 60.

Sec. 5805. (1) As set forth in section 220 of the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1220, a nonprofit health care corporation may merge with a nonprofit mutual disability insurer where the surviving entity is governed by this chapter. A merger described in this section is exempt from the application of sections 1311 to 1319. Notwithstanding any provision of this act to the contrary, the resulting nonprofit mutual disability insurer shall continue as a nonprofit entity and shall continue to provide coverage to the individual and small group health markets in this state.

(2) A nonprofit mutual disability insurer that has merged with a nonprofit health care corporation as described in subsection (1) may, at its option, continue to offer any product that was offered to the subscribers of the nonprofit health care corporation.

(3) A nonprofit mutual disability insurer that has merged with a nonprofit health care corporation as described in subsection (1) may offer supplemental coverage to medicare enrollees as provided in chapter 38. Notwithstanding any other provision of this act to the contrary and until July 31, 2016, both of the following apply to an insurer described in this subsection:

(a) The insurer shall continue to offer to current or new eligible policyholders who are residents of this state, at the same rates as offered to subscribers by the nonprofit health care corporation on the effective date of this section, the supplemental coverage to medicare enrollees.

(b) The insurer offering supplemental coverage under subdivision (a) shall continue all cost transfers as authorized under section 609(5) of the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1609, on the effective date of this section.

(4) Benefits paid by a nonprofit mutual disability insurer that has merged with a nonprofit health care corporation as described in subsection (1) to an insured or provider by way of a check or other similar written instrument for the transmission or payment of money, that is not cashed within the period prescribed in the uniform unclaimed property act, 1995 PA 29, MCL 567.221 to 567.265, shall escheat to this state pursuant to the uniform unclaimed property act, 1995 PA 29, MCL 567.221 to 567.265.

Sec. 5824. Every member of the company is entitled to 1 vote, or to a number of votes based upon the insurance in force, the number of policies held, or the amount of premiums paid, as may be provided in the bylaws. A nonprofit mutual disability insurer may permit entities holding administrative services agreements with it to be members and may provide in its bylaws the basis for the number of votes the entities will have as members.

Sec. 5825. (1) A member of a nonprofit mutual disability insurer that has merged with a nonprofit health care corporation as provided in section 5805(1) shall have no interest in, or residual rights to, the assets of the nonprofit mutual disability insurer; shall not receive policy or surplus dividends; and shall not be required to pay capital assessments by the nonprofit mutual disability insurer.

(2) In the event of the dissolution or winding up of a nonprofit mutual disability insurer described in subsection (1), any residual value remaining after satisfaction of claims filed under section 8142(1)(a) to (h), shall be distributed for the benefit of the people of this state to the Michigan health endowment fund created under part 6A of the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1651 to 550.1655, and shall be administered in a manner consistent with the supervision of trustees for charitable purposes act, 1961 PA 101, MCL 14.251 to 14.266.

(3) In the event of a transaction or series of transactions pursuant to which the nonprofit mutual disability insurer demutualizes under chapter 59; converts to a mutual holding company under chapter 60; sells, transfers, or otherwise disposes of all or substantially all of its assets; merges into an entity and the nonprofit mutual disability insurer is not the surviving entity; moves its principal executive office out of this state; redomesticates to another state; or allows or permits a person or a group of persons acting in concert to beneficially own greater than 50% of the voting power associated with ownership interests in the nonprofit mutual disability insurer, whether by merger, dividend, or any other means, then the nonprofit mutual disability insurer or the acquiring person or entity shall make payment for the benefit of the people of this state to the Michigan health endowment fund created under part 6A of the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1651 to 550.1655, in an amount equal to the greater of the acquisition price or the fair market value of the nonprofit mutual disability insurer and its subsidiaries, considered on a consolidated holding company basis as of the time of the closing of the transaction or series of transactions, as determined by an independent valuation by a person or entity mutually agreed upon by the attorney general, the commissioner, and the nonprofit mutual disability insurer. The cost of the independent valuation shall be paid by the nonprofit mutual disability insurer or the acquiring person or entity. The payment for the benefit of the people of this state shall be administered in a manner consistent with the supervision of trustees for charitable purposes act, 1961 PA 101, MCL 14.251 to 14.266, and shall be in satisfaction of any claim or assertion that consideration is due with respect to the charitable assets of the nonprofit mutual disability insurer.

(4) As used in this section, "beneficially own" means actual ownership or the right, directly or indirectly, to control voting power associated with ownership interests in the nonprofit mutual disability insurer.

Sec. 5826. Until January 1, 2014, a nonprofit mutual disability insurer that has merged with a nonprofit health care corporation as described in section 5805(1) shall offer health care benefits to all residents of this state regardless of health status.

Enacting section 1. This amendatory act does not take effect unless Senate Bill No. 1294 of the 96th Legislature is enacted into law.

This act is ordered to take immediate effect.

Carol Morey Viventi

Secretary of the Senate

Larry E Randall

Clerk of the House of Representatives

Approved .....

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Governor