SENATE BILL No. 61

January 16, 2013, Introduced by Senators HUNE and SMITH and referred to the Committee on Insurance.

A bill to amend 1980 PA 350, entitled

"The nonprofit health care corporation reform act,"

by amending the title and sections 218, 401e, and 414b (MCL 550.1218, 550.1401e, and 550.1414b), the title as amended by 1994 PA 169, section 218 as added by 2002 PA 559, section 401e as added by 1996 PA 516, and section 414b as added by 2006 PA 413, and by adding sections 201a, 220, 400, 401m, 410b, 501c, and 620 and part 6A.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

TITLE

An act to provide for the incorporation of nonprofit health care corporations; to provide their rights, powers, and immunities; to prescribe the powers and duties of certain state officers relative to the exercise of those rights, powers, and immunities; to prescribe certain conditions for the transaction of business by those corporations in this state; to define the relationship of

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health care providers to nonprofit health care corporations and to specify their rights, powers, and immunities with respect thereto; to provide for a Michigan caring program; to provide for the regulation and supervision of nonprofit health care corporations by the commissioner of insurance; to prescribe powers and duties of certain other state officers with respect to the regulation and supervision of nonprofit health care corporations; to provide for the imposition of a regulatory fee; to regulate the merger or consolidation of certain corporations; to prescribe an expeditious and effective procedure for the maintenance and conduct of certain administrative appeals relative to provider class plans; to provide for certain administrative hearings relative to rates for health care benefits; **TO PROVIDE FOR THE CREATION OF AND THE POWERS AND DUTIES OF A NONPROFIT CORPORATION FOR THE PURPOSE OF RECEIVING AND ADMINISTERING FUNDS FOR THE PUBLIC WELFARE;** to provide for certain causes of action; to prescribe penalties and to provide civil fines for violations of this act; and to repeal ~~certain~~ acts and parts of acts.

SEC. 201A. NOTWITHSTANDING SECTION 201, A HEALTH CARE CORPORATION SHALL NOT BE FORMED IN THIS STATE ON OR AFTER THE EFFECTIVE DATE OF THIS SECTION.

Sec. 218. A health care corporation shall not do any of the following:

(a) Take any action to change its nonprofit status.

(b) ~~Dissolve,~~ **EXCEPT AS OTHERWISE PROVIDED IN SECTION 220, DISSOLVE,** merge, consolidate, mutualize, or take any other action that results in a change in direct or indirect control of the

health care corporation or sell, transfer, lease, exchange, option, or convey assets that results in a change in direct or indirect control of the health care corporation.

SEC. 220. (1) NOTWITHSTANDING ANY PROVISION OF THIS ACT TO THE CONTRARY, A HEALTH CARE CORPORATION MAY ESTABLISH, OWN, OPERATE, AND MERGE WITH A NONPROFIT MUTUAL DISABILITY INSURER FORMED UNDER CHAPTER 58 OF THE INSURANCE CODE OF 1956, 1956 PA 218, MCL 500.5800 TO 500.5840. THE SURVIVING ENTITY OF A MERGER DESCRIBED IN THIS SUBSECTION IS THE NONPROFIT MUTUAL DISABILITY INSURER. A MERGER DESCRIBED IN THIS SUBSECTION IS EXEMPT FROM THE APPLICATION OF SECTIONS 1311 TO 1319 OF THE INSURANCE CODE OF 1956, 1956 PA 218, MCL 500.1311 TO 500.1319.

(2) THE MERGER OF A HEALTH CARE CORPORATION WITH A NONPROFIT MUTUAL DISABILITY INSURER IS EFFECTIVE UPON COMPLETION OF BOTH OF THE FOLLOWING:

(A) THE ADOPTION OF A PLAN OF MERGER BY THE MAJORITY OF THE BOARDS OF DIRECTORS OF BOTH THE HEALTH CARE CORPORATION AND THE NONPROFIT MUTUAL DISABILITY INSURER. THE HEALTH CARE CORPORATION SHALL INCLUDE IN THE PLAN OF MERGER THAT BEGINNING IN APRIL 2014 THE SURVIVING ENTITY OF A MERGER DESCRIBED IN SUBSECTION (1) SHALL USE ITS BEST EFFORTS TO MAKE ANNUAL SOCIAL MISSION CONTRIBUTIONS IN AN AGGREGATE AMOUNT OF UP TO $1,560,000,000.00 OVER A PERIOD OF UP TO 18 YEARS BEGINNING IN APRIL 2014 TO THE MICHIGAN HEALTH ENDOWMENT FUND CREATED UNDER PART 6A. IF ADOPTED, THE BOARDS OF DIRECTORS SHALL SUBMIT THE PLAN OF MERGER TO THE COMMISSIONER FOR HIS OR HER CONSIDERATION AS PROVIDED IN SUBDIVISION (B). A NONPROFIT MUTUAL DISABILITY INSURER IS CONSIDERED TO BE MAKING ITS

BEST EFFORT UNDER THIS SUBDIVISION IF IT MAKES THE ANNUAL SOCIAL MISSION CONTRIBUTION TO THE MICHIGAN HEALTH ENDOWMENT FUND CREATED IN PART 6A WHEN THE NONPROFIT MUTUAL DISABILITY INSURER'S SURPLUS IS AT LEAST 375% OF THE AUTHORIZED CONTROL LEVEL UNDER RISK-BASED CAPITAL REQUIREMENTS.

(B) THE APPROVAL OF THE PLAN OF MERGER BY THE COMMISSIONER. THE COMMISSIONER SHALL MAKE A DETERMINATION TO APPROVE OR DISAPPROVE A PLAN OF MERGER WITHIN 90 DAYS OF RECEIPT OF THE PLAN, AND THE COMMISSIONER SHALL NOT UNREASONABLY WITHHOLD APPROVAL OF A PLAN OF MERGER SUBMITTED UNDER SUBDIVISION (A).

(3) NOTWITHSTANDING ANY OTHER PROVISION OF THIS ACT TO THE CONTRARY, THE DIRECTORS OF A HEALTH CARE CORPORATION MAY SERVE AS INCORPORATORS OF THE CORPORATE BODY OF, DIRECTORS OF, OR OFFICERS OF THE NONPROFIT MUTUAL DISABILITY INSURER FORMED THROUGH A MERGER DESCRIBED IN SUBSECTION (1).

(4) A MERGER DESCRIBED IN SUBSECTION (1) IS THE DISSOLUTION OF THE HEALTH CARE CORPORATION, AND THE SURVIVING NONPROFIT MUTUAL DISABILITY INSURER ASSUMES THE PERFORMANCE OF ALL CONTRACTS AND POLICIES OF THE MERGED HEALTH CARE CORPORATION THAT EXIST ON THE DATE OF THE MERGER, INCLUDING THE PARTICIPATING HOSPITAL AGREEMENT, AND ITS DEFINITION OF CERTIFICATE WHICH EXCLUDES AS COVERED SERVICES BENEFITS PROVIDED PURSUANT TO AUTOMOBILE NO-FAULT OR WORKER'S COMPENSATION COVERAGE, AND ALL RELATED CONTRACT OBLIGATIONS THAT RESULT FROM ORDERS RELATING TO HOSPITAL PROVIDER CLASS PLANS THAT ARE ISSUED BY THE COMMISSIONER AFTER JULY 1, 2012. HOWEVER, THE OFFICERS OF A HEALTH CARE CORPORATION MAY PERFORM ANY ACT OR ACTS NECESSARY TO CLOSE THE AFFAIRS OF THE MERGED HEALTH

CARE CORPORATION AFTER THE DATE OF THE MERGER.

SEC. 400. (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, A HEALTH CARE CORPORATION 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, A HEALTH CARE CORPORATION SHALL NOT ENFORCE A MOST FAVORED NATION CLAUSE IN ANY PROVIDER CONTRACT WITHOUT THE PRIOR APPROVAL OF THE COMMISSIONER.

(3) BEGINNING JANUARY 1, 2014, A HEALTH CARE CORPORATION 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 HEALTH CARE CORPORATION 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 HEALTH CARE CORPORATION.

(B) REQUIRES, OR GRANTS A CONTRACTING HEALTH CARE CORPORATION 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 HEALTH CARE

CORPORATION.

(C) REQUIRES, OR GRANTS A CONTRACTING HEALTH CARE CORPORATION 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 HEALTH CARE CORPORATION.

(D) REQUIRES A PROVIDER TO DISCLOSE, TO THE HEALTH CARE CORPORATION OR ITS DESIGNEE, THE PROVIDER'S CONTRACTUAL PAYMENT OR REIMBURSEMENT RATES WITH OTHER PARTIES.

Sec. 401e. (1) Except as **OTHERWISE** provided in this section, a health care corporation that has issued a nongroup certificate shall renew or continue in force the certificate at the option of the individual.

(2) Except as **OTHERWISE** provided in this section, a health care corporation that has issued a group certificate shall renew or continue in force the 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 health care corporation no longer offers that particular type of coverage in the market, or if the individual or group moves outside the service area.

(4) A HEALTH CARE CORPORATION SHALL NOT DISCONTINUE OFFERING A PARTICULAR PLAN OR PRODUCT IN THE NONGROUP OR GROUP MARKET UNLESS THE HEALTH CARE CORPORATION 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 HEALTH CARE CORPORATION 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) A HEALTH CARE CORPORATION SHALL NOT DISCONTINUE OFFERING ALL COVERAGE IN THE NONGROUP OR GROUP MARKET UNLESS THE HEALTH CARE CORPORATION 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 HEALTH CARE CORPORATION WITHDREW AND DOES NOT RENEW COVERAGE UNDER THOSE PLANS.

(6) IF A HEALTH CARE CORPORATION DISCONTINUES COVERAGE UNDER SUBSECTION (5), THE HEALTH CARE CORPORATION SHALL NOT PROVIDE FOR THE ISSUANCE OF ANY HEALTH BENEFIT PLANS IN THE NONGROUP OR GROUP MARKET FROM WHICH THE HEALTH CARE CORPORATION WITHDREW DURING THE 5-YEAR PERIOD BEGINNING ON THE DATE OF THE DISCONTINUATION OF THE

LAST PLAN NOT RENEWED UNDER THAT SUBSECTION.

SEC. 401M. UNTIL JANUARY 1, 2014, A HEALTH CARE CORPORATION ESTABLISHED, MAINTAINED, OR OPERATING IN THIS STATE SHALL OFFER HEALTH CARE BENEFITS TO ALL RESIDENTS OF THIS STATE REGARDLESS OF HEALTH STATUS.

SEC. 410B. NOTWITHSTANDING SECTION 410A(8), FOR A CERTIFICATE DELIVERED, ISSUED FOR DELIVERY, OR RENEWED IN THIS STATE ON OR AFTER JANUARY 1, 2014, THE PREMIUM FOR A GROUP CONVERSION CERTIFICATE UNDER SECTION 410A SHALL BE DETERMINED ONLY BY USING THE RATING FACTORS SET FORTH IN SECTION 3474A OF THE INSURANCE CODE OF 1956, 1956 PA 218, MCL 500.3474A.

Sec. 414b. (1) A health care corporation 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 members' health behaviors as determined by assessments of agreed-upon health status indicators between the employer and the health care corporation. Any rebate or premium provided by the health care corporation is presumed to be appropriate unless credible data demonstrate otherwise, but shall not exceed ~~10%~~ **30%** of paid premiums**, UNLESS OTHERWISE APPROVED BY THE COMMISSIONER**. A health care corporation shall make available to employers all wellness coverage plans that it markets to employers in this state.

(2) A health care corporation may offer nongroup 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 health care corporation. The member 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 member and the health care corporation. Any rebate of premium provided by the health care corporation is presumed to be appropriate unless credible data demonstrate otherwise, but shall not exceed ~~10%~~ **30%** of paid premiums**, UNLESS OTHERWISE APPROVED BY THE COMMISSIONER**. A health care corporation shall make available to individuals all wellness coverage plans that it markets to individuals in this state.

(3) A health care corporation is 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. 501C. BEGINNING JANUARY 1, 2014, A HEALTH CARE CORPORATION 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. 620. (1) NOTWITHSTANDING ANY PROVISION OF THIS ACT TO THE CONTRARY, A CERTIFICATE DELIVERED, ISSUED FOR DELIVERY, OR RENEWED IN THIS STATE ON OR AFTER JANUARY 1, 2014 BY A HEALTH CARE CORPORATION IS SUBJECT TO THE POLICY AND CERTIFICATE ISSUANCE AND

RATE FILING REQUIREMENTS OF THE INSURANCE CODE OF 1956, 1956 PA 218, MCL 500.100 TO 500.8302, INCLUDING THE RATING FACTOR REQUIREMENTS OF SECTION 3474A OF THE INSURANCE CODE OF 1956, 1956 PA 218, MCL 500.3474A.

(2) FOR A CERTIFICATE DELIVERED, ISSUED FOR DELIVERY, OR RENEWED IN THIS STATE ON OR AFTER JANUARY 1, 2014, SUBJECT TO THE PRIOR APPROVAL OF THE COMMISSIONER, A HEALTH CARE CORPORATION MAY ESTABLISH REASONABLE OPEN ENROLLMENT PERIODS.

(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 HEALTH CARE CORPORATIONS.

(4) A HEALTH CARE CORPORATION OFFERING COVERAGE DURING AN OPEN ENROLLMENT PERIOD ESTABLISHED UNDER SUBSECTION (2) SHALL NOT DENY OR CONDITION THE ISSUANCE OR EFFECTIVENESS OF A CERTIFICATE AND SHALL NOT DISCRIMINATE IN THE PRICING OF THE CERTIFICATE ON THE BASIS OF HEALTH STATUS, CLAIMS EXPERIENCE, RECEIPT OF HEALTH CARE, OR MEDICAL CONDITION.

PART 6A

MICHIGAN HEALTH ENDOWMENT FUND

SEC. 651. AS USED IN THIS PART:

(A) "BOARD" MEANS THE MICHIGAN HEALTH ENDOWMENT FUND BOARD CREATED IN SECTION 652.

(B) "EXECUTIVE DIRECTOR" MEANS THE EXECUTIVE DIRECTOR OF THE FUND APPOINTED BY THE BOARD UNDER SECTION 654.

(C) "FUND" MEANS THE MICHIGAN HEALTH ENDOWMENT FUND ORGANIZED

AS A NONPROFIT CORPORATION UNDER SECTION 653.

SEC. 652. (1) THE MICHIGAN HEALTH ENDOWMENT FUND BOARD IS CREATED TO ORGANIZE AND GOVERN THE FUND. THE BOARD IS THE INCORPORATOR OF THE FUND FOR THE PURPOSES OF THE NONPROFIT CORPORATION ACT, 1982 PA 162, MCL 450.2101 TO 450.3192.

(2) THE BOARD SHALL ADOPT A CONFLICT OF INTEREST POLICY. A BOARD MEMBER WITH A DIRECT OR INDIRECT INTEREST IN ANY MATTER BEFORE THE FUND SHALL DISCLOSE THE MEMBER'S INTEREST TO THE BOARD BEFORE THE BOARD TAKES ANY ACTION ON THE MATTER. THE BOARD SHALL RECORD THE MEMBER'S DISCLOSURE IN THE MINUTES OF THE BOARD MEETING. IF A BOARD MEMBER OR A MEMBER OF HIS OR HER IMMEDIATE FAMILY, ORGANIZATIONALLY OR INDIVIDUALLY, WOULD DERIVE A DIRECT AND SPECIFIC BENEFIT FROM A DECISION OF THE BOARD, THAT MEMBER SHALL RECUSE HIMSELF OR HERSELF FROM THE DISCUSSION AND VOTE ON THE ISSUE.

(3) SUBJECT TO THIS SUBSECTION, THE GOVERNOR SHALL APPOINT THE MEMBERS OF THE BOARD WITH THE ADVICE AND CONSENT OF THE SENATE. <<AN INDIVIDUAL WHO IS AN EMPLOYEE, OFFICER, OR BOARD MEMBER OF A HEALTH CARE CORPORATION; A LOBBYIST AFFILIATED WITH A HEALTH CARE CORPORATION; OR AN EMPLOYEE OF A HEALTH INSURER, HEALTH CARE PROVIDER, OR THIRD PARTY ADMINISTRATOR IS NOT ELIGIBLE TO AND SHALL NOT BE APPOINTED TO THE BOARD UNDER THIS SUBSECTION.>> ON OR BEFORE THE EXPIRATION OF 60 DAYS AFTER THE EFFECTIVE DATE OF THIS SECTION, THE GOVERNOR SHALL APPOINT THE FOLLOWING INITIAL MEMBERS OF THE BOARD WITH THE ADVICE AND CONSENT OF THE SENATE:

(A) ONE MEMBER FROM A LIST OF 3 OR MORE INDIVIDUALS RECOMMENDED BY THE SENATE MAJORITY LEADER.

(B) ONE MEMBER FROM A LIST OF 3 OR MORE INDIVIDUALS RECOMMENDED BY THE SPEAKER OF THE HOUSE OF REPRESENTATIVES.

(C) ONE MEMBER REPRESENTING THE INTERESTS OF MINOR CHILDREN.

(D) ONE MEMBER REPRESENTING THE INTERESTS OF SENIOR CITIZENS.

(E) TWO MEMBERS OF THE GENERAL PUBLIC.

(F) ONE MEMBER REPRESENTING THE BUSINESS COMMUNITY.

(G) ONE MEMBER FROM A LIST OF 3 OR MORE INDIVIDUALS RECOMMENDED BY THE HOUSE MINORITY LEADER.

(H) ONE MEMBER FROM A LIST OF 3 OR MORE INDIVIDUALS RECOMMENDED BY THE SENATE MINORITY LEADER.

(4) A VACANCY IN THE BOARD SHALL BE FILLED IN THE SAME MANNER AS THE INITIAL APPOINTMENT OF THAT MEMBER UNDER SUBSECTION (3). EXCEPT AS OTHERWISE PROVIDED IN THIS SUBSECTION, A BOARD MEMBER SHALL SERVE FOR A TERM OF 4 YEARS OR UNTIL A SUCCESSOR IS APPOINTED, WHICHEVER IS LATER. FOR AN INITIAL MEMBER APPOINTED TO THE BOARD UNDER SUBSECTION (3), 3 MEMBERS SHALL SERVE FOR 2-YEAR TERMS, 3 MEMBERS SHALL SERVE FOR 3-YEAR TERMS, AND 3 MEMBERS SHALL SERVE FOR 4-YEAR TERMS.

(5) SIX MEMBERS OF THE BOARD CONSTITUTE A QUORUM FOR THE TRANSACTION OF BUSINESS AT A MEETING OF THE BOARD. AN AFFIRMATIVE VOTE OF 5 BOARD MEMBERS IS NECESSARY FOR OFFICIAL ACTION OF THE BOARD.

(6) THE BUSINESS THAT THE BOARD MAY PERFORM SHALL BE CONDUCTED AT A MEETING OF THE BOARD THAT IS HELD IN THIS STATE, IS OPEN TO THE PUBLIC, AND IS HELD IN A PLACE THAT IS AVAILABLE TO THE GENERAL PUBLIC. HOWEVER, THE BOARD MAY ESTABLISH REASONABLE RULES AND REGULATIONS TO MINIMIZE DISRUPTION OF A MEETING OF THE BOARD. AT LEAST 10 DAYS AND NOT MORE THAN 60 DAYS BEFORE A MEETING, THE BOARD SHALL PROVIDE PUBLIC NOTICE OF ITS MEETING AT ITS PRINCIPAL OFFICE AND ON ITS INTERNET WEBSITE. THE BOARD SHALL INCLUDE IN THE PUBLIC NOTICE OF ITS MEETING THE ADDRESS WHERE BOARD MINUTES REQUIRED UNDER SUBSECTION (7) MAY BE INSPECTED BY THE PUBLIC. THE BOARD MAY

MEET IN A CLOSED SESSION FOR ANY OF THE FOLLOWING PURPOSES:

(A) TO CONSIDER THE HIRING, DISMISSAL, SUSPENSION, OR DISCIPLINING OF BOARD MEMBERS OR ITS EMPLOYEES OR AGENTS.

(B) TO CONSULT WITH ITS ATTORNEY.

(C) TO COMPLY WITH STATE OR FEDERAL LAW, RULES, OR REGULATIONS REGARDING PRIVACY OR CONFIDENTIALITY.

(7) THE BOARD SHALL KEEP MINUTES OF EACH MEETING. BOARD MINUTES SHALL BE OPEN TO PUBLIC INSPECTION, AND THE BOARD SHALL MAKE THE MINUTES AVAILABLE AT THE ADDRESS DESIGNATED ON THE PUBLIC NOTICE OF ITS MEETING UNDER SUBSECTION (6). THE BOARD SHALL MAKE COPIES OF THE MINUTES AVAILABLE TO THE PUBLIC AT THE REASONABLE ESTIMATED COST FOR PRINTING AND COPYING. THE BOARD SHALL INCLUDE ALL OF THE FOLLOWING IN ITS BOARD MINUTES:

(A) THE DATE, TIME, AND PLACE OF THE MEETING.

(B) BOARD MEMBERS WHO ARE PRESENT AND ABSENT.

(C) BOARD DECISIONS MADE AT A MEETING OPEN TO THE PUBLIC.

(D) ALL ROLL CALL VOTES TAKEN AT THE MEETING.

(8) 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. 653. (1) THE BOARD SHALL ORGANIZE A NONPROFIT CORPORATION, ON A NONSTOCK, DIRECTORSHIP BASIS, UNDER THE NONPROFIT CORPORATION ACT, 1982 PA 162, MCL 450.2101 TO 450.3192. THE NONPROFIT CORPORATION SHALL BE KNOWN AS THE MICHIGAN HEALTH ENDOWMENT FUND AND IS ORGANIZED TO RECEIVE AND ADMINISTER FUNDS FOR THE PUBLIC WELFARE. <<AS SOON AS PRACTICABLE AFTER ORGANIZATION OF THE NONPROFIT CORPORATION UNDER THIS SUBSECTION, THE BOARD SHALL APPLY FOR AND MAKE ITS BEST EFFORT TO OBTAIN TAX-EXEMPT STATUS FOR THE FUND UNDER SECTION 501(C)(3) OF THE INTERNAL REVENUE CODE, 26 USC 501.>>

(2) THE PURPOSE OF THE FUND IS TO <<SUPPORT PROGRAMS THAT IMPROVE THE QUALITY OF HEALTH CARE WHILE REDUCING COSTS TO RESIDENTS OF THIS STATE AND TO>> BENEFIT THE HEALTH AND WELLNESS OF MINOR CHILDREN AND SENIORS THROUGHOUT THIS STATE WITH A SIGNIFICANT FOCUS IN THE FOLLOWING AREAS:

(A) INFANT MORTALITY.

(B) WELLNESS PROGRAMS AND FITNESS PROGRAMS.

(C) ACCESS TO HEALTHY FOOD.

(D) TECHNOLOGY ENHANCEMENTS.

(E) HEALTH-RELATED TRANSPORTATION NEEDS.

(F) FOODBORNE ILLNESS PREVENTION.

(3) THE FUND MAY AWARD GRANTS FOR PROJECTS THAT WILL PROMOTE THE PURPOSE OF THE FUND DESCRIBED IN SUBSECTION (2). THE BOARD SHALL ESTABLISH A COMPREHENSIVE AND COMPETITIVE PROCESS TO AWARD GRANTS. THE BOARD SHALL NOT AWARD A GRANT THAT IS LONGER THAN 3 YEARS IN DURATION.

(4) THE FUND HAS THE POWER AND DUTIES OF A NONPROFIT CORPORATION UNDER THE NONPROFIT CORPORATION ACT, 1982 PA 162, MCL 450.2101 TO 450.3192. IF A CONFLICT BETWEEN A POWER OR DUTY OF THE FUND UNDER THIS SECTION CONFLICTS WITH A POWER OR DUTY UNDER OTHER STATE LAW, THIS SECTION CONTROLS.

(5) THE BOARD SHALL IMPLEMENT A PROGRAM THAT DISBURSES FOUNDATION MONEY TO SUBSIDIZE THE COST OF INDIVIDUAL MEDIGAP COVERAGE TO SENIOR CITIZENS IN THIS STATE WHO DEMONSTRATE A FINANCIAL NEED IN ORDER TO BE ABLE TO PURCHASE INDIVIDUAL MEDIGAP COVERAGE. SUBJECT TO APPROVAL BY THE ATTORNEY GENERAL, THE COMMISSIONER SHALL DEVELOP A MEANS TEST TO DETERMINE IF A SENIOR CITIZEN APPLICANT IS ELIGIBLE FOR THE MEDIGAP COVERAGE SUBSIDY PROVIDED FOR IN THIS SUBSECTION.

(6) BEGINNING AUGUST 1, 2016 AND ENDING DECEMBER 31, 2021, THE BOARD SHALL DISBURSE $120,000,000.00 TO SUBSIDIZE THE COST OF INDIVIDUAL MEDIGAP COVERAGE PURCHASED BY SENIOR CITIZENS IN THIS STATE, SUBJECT TO THE MEANS TEST REQUIRED IN SUBSECTION (5).

SEC. 654. (1) THE BOARD SHALL APPOINT AN EXECUTIVE DIRECTOR OF THE FUND. THE EXECUTIVE DIRECTOR IS THE CHIEF EXECUTIVE OFFICER OF THE FUND AND SERVES AT THE PLEASURE OF THE BOARD. THE EXECUTIVE DIRECTOR MAY EMPLOY STAFF AND HIRE CONSULTANTS AS NECESSARY WITH THE APPROVAL OF THE BOARD. THE BOARD SHALL DETERMINE COMPENSATION FOR THE EXECUTIVE DIRECTOR AND STAFF EMPLOYED UNDER THIS SUBSECTION AND SHALL APPROVE CONTRACTS UNDER THIS SUBSECTION.

(2) THE EXECUTIVE DIRECTOR SHALL DISPLAY ON THE FUND INTERNET WEBSITE INFORMATION RELEVANT TO THE PUBLIC, AS DEFINED BY THE BOARD, CONCERNING THE FUND'S OPERATIONS AND EFFICIENCIES, AS WELL AS THE BOARD'S ASSESSMENTS OF THOSE ACTIVITIES.

SEC. 655. (1) SUBJECT TO THIS SECTION, THE BOARD MAY DISBURSE MONEY CONTRIBUTED TO THE FUND EACH YEAR, NOT INCLUDING ANY INTEREST, EARNINGS, OR UNREALIZED GAINS OR LOSSES ON THOSE CONTRIBUTIONS, FOR THE PURPOSES OF THE FUND AS DESCRIBED IN SECTION 653. THE BOARD MAY EXPEND A PORTION OF THE MONEY CONTRIBUTED TO THE FUND IN EACH YEAR ACCORDING TO THE FOLLOWING SCHEDULE:

(A) YEARS 1 THROUGH 4, 80%.

(B) YEARS 5 THROUGH 8, 67%.

(C) YEARS 9 THROUGH 12, 60%.

(D) YEARS 13 THROUGH 18, 25%.

(2) ON AND AFTER THE DATE THAT THE ACCUMULATED PRINCIPAL IN THE FUND REACHES $750,000,000.00, THE BOARD SHALL MAINTAIN THAT

AMOUNT FOR INVESTMENT TO PROVIDE AN ONGOING INCOME TO THE FUND. ON AND AFTER THE DATE THAT THE ACCUMULATED PRINCIPAL IN THE FUND REACHES $750,000,000.00, THE BOARD SHALL NOT ALLOW THE ACCUMULATED PRINCIPAL OF THE FUND TO FALL BELOW $750,000,000.00 DUE TO EXPENDITURES MADE FOR THE PURPOSES OF THE FUND AS DESCRIBED IN SECTION 653.

(3) THE BOARD MAY EXPEND MONEY RECEIVED BY THE FUND FROM ANY SOURCE IN A FISCAL YEAR THAT IS IN EXCESS OF THE AMOUNT REQUIRED TO MAINTAIN THE ACCUMULATED PRINCIPAL GOALS AS DESCRIBED IN SUBSECTION (2), NOT INCLUDING ANY INTEREST, EARNINGS, OR UNREALIZED GAINS OR LOSSES ON THOSE FUNDS, ON THE REASONABLE ADMINISTRATIVE COSTS OF THE FUND AND FOR THE PURPOSES OF THE FUND AS DESCRIBED IN SECTION 653. THE INVESTMENT OF FUND MONEY AND DONATIONS BY THE FUND ARE UNDER THE EXCLUSIVE CONTROL AND DISCRETION OF THE EXECUTIVE DIRECTOR AND THE BOARD.

(4) THE BOARD MAY INVEST ACCUMULATED PRINCIPAL IN THE FUND ONLY IN SECURITIES PERMITTED BY THE LAWS OF THIS STATE FOR THE INVESTMENT OF ASSETS OF LIFE INSURANCE COMPANIES, AS DESCRIBED IN CHAPTER 9 OF THE INSURANCE CODE OF 1956, 1956 PA 218, MCL 500.901 TO 500.947.

(5) THE BOARD SHALL PROVIDE IN THE FUND'S ARTICLES OF INCORPORATION OR BYLAWS FOR A SYSTEM OF FINANCIAL ACCOUNTING, CONTROLS, AUDITS, AND REPORTS. THE BOARD ANNUALLY SHALL HAVE AN AUDIT OF THE FUND CONDUCTED BY AN INDEPENDENT PUBLIC ACCOUNTANT FIRM, AND THE AUDITOR'S AUDIT REPORT AND FINDINGS SHALL BE SUBMITTED TO THE BOARD. THE EXPENSE OF AN AUDIT REQUIRED UNDER THIS SUBSECTION IS CONSIDERED A REASONABLE ADMINISTRATIVE COST UNDER

SUBSECTION (3).

(6) THE BOARD SHALL APPOINT FROM ITS MEMBERS AN AUDIT COMMITTEE CONSISTING OF NO LESS THAN 3 MEMBERS. AT A MINIMUM, THE AUDIT COMMITTEE SHALL CONTRACT WITH AN INDEPENDENT AUDITING FIRM TO PROVIDE AN ANNUAL FINANCIAL AUDIT IN ACCORDANCE WITH APPLICABLE AUDITING STANDARDS.

(7) THE EXECUTIVE DIRECTOR SHALL DO ALL OF THE FOLLOWING:

(A) REVIEW AND CERTIFY THE REPORTS OF THE EXTERNAL AUDITOR.

(B) MAKE THE EXTERNAL AUDITOR REPORTS AVAILABLE TO THE BOARD AND TO THE GENERAL PUBLIC.

(C) DEVELOP AND IMPLEMENT CORRECTIVE ACTIONS TO ADDRESS WEAKNESSES IDENTIFIED IN AN AUDIT REPORT.

(8) THE FUND SHALL MEET ALL OF THE FOLLOWING FINANCIAL TRANSPARENCY REQUIREMENTS:

(A) KEEP AN ACCURATE ACCOUNTING OF ALL ACTIVITIES, RECEIPTS, AND EXPENDITURES AND ANNUALLY SUBMIT TO THE GOVERNOR, THE SENATE AND HOUSE OF REPRESENTATIVES APPROPRIATIONS COMMITTEES, AND THE SENATE AND HOUSE OF REPRESENTATIVES STANDING COMMITTEES ON HEALTH POLICY A REPORT REGARDING THOSE ACCOUNTINGS.

(B) FULLY COOPERATE WITH ANY INVESTIGATION CONDUCTED BY THIS STATE OR A FEDERAL AGENCY UNDER ITS AUTHORITY UNDER STATE OR FEDERAL LAW, TO DO ANY OF THE FOLLOWING:

(*i*) INVESTIGATE THE AFFAIRS OF THE FUND.

(*ii*) EXAMINE THE ASSETS AND RECORDS OF THE FUND.

(*iii*) REQUIRE PERIODIC REPORTS IN RELATION TO THE ACTIVITIES UNDERTAKEN BY THE FUND.

Enacting section 1. This amendatory act does not take effect

unless Senate Bill No. 62

of the 97th Legislature is enacted into law.