

SUBSTITUTE FOR
HOUSE BILL NO. 4935

A bill to amend 1956 PA 218, entitled
"The insurance code of 1956,"
by amending sections 106, 116, 120, 221, 222, 250, 402, 436, 436a,
454, 460, 462, 606, 632, 1001, 2003, 2006, 2059, 2212a, 2212b,
2213, 2213a, 2213b, 2214, 2236, 2237, 3400, 3402, 3403, 3404, 3405,
3405a, 3406a, 3406c, 3406d, 3406e, 3406j, 3406k, 3406l, 3406m,
3406n, 3406o, 3406p, 3406q, 3406r, 3406s, 3407, 3407b, 3408, 3409,
3411, 3412, 3413, 3414, 3416, 3418, 3420, 3422, 3424, 3425, 3426,
3428, 3432, 3438, 3440, 3452, 3472, 3474, 3474a, 3475, 3476, 3501,
3503, 3505, 3507, 3508, 3509, 3511, 3513, 3515, 3517, 3519, 3528,
3533, 3535, 3545, 3547, 3548, 3551, 3553, 3555, 3557, 3559, 3561,
3563, 3569, 3571, 3573, 3701, 3703, 3705, 3711, 3723, 4601, 4701,

6428, 7060, and 7705 (MCL 500.106, 500.116, 500.120, 500.221, 500.222, 500.250, 500.402, 500.436, 500.436a, 500.454, 500.460, 500.462, 500.606, 500.632, 500.1001, 500.2003, 500.2006, 500.2059, 500.2212a, 500.2212b, 500.2213, 500.2213a, 500.2213b, 500.2214, 500.2236, 500.2237, 500.3400, 500.3402, 500.3403, 500.3404, 500.3405, 500.3405a, 500.3406a, 500.3406c, 500.3406d, 500.3406e, 500.3406j, 500.3406k, 500.3406l, 500.3406m, 500.3406n, 500.3406o, 500.3406p, 500.3406q, 500.3406r, 500.3406s, 500.3407, 500.3407b, 500.3408, 500.3409, 500.3411, 500.3412, 500.3413, 500.3414, 500.3416, 500.3418, 500.3420, 500.3422, 500.3424, 500.3425, 500.3426, 500.3428, 500.3432, 500.3438, 500.3440, 500.3452, 500.3472, 500.3474, 500.3474a, 500.3475, 500.3476, 500.3501, 500.3503, 500.3505, 500.3507, 500.3508, 500.3509, 500.3511, 500.3513, 500.3515, 500.3517, 500.3519, 500.3528, 500.3533, 500.3535, 500.3545, 500.3547, 500.3548, 500.3551, 500.3553, 500.3555, 500.3557, 500.3559, 500.3561, 500.3563, 500.3569, 500.3571, 500.3573, 500.3701, 500.3703, 500.3705, 500.3711, 500.3723, 500.4601, 500.4701, 500.6428, 500.7060, and 500.7705), sections 116 and 436a as added and section 436 as amended by 1992 PA 182, section 221 as added by 2001 PA 275, section 222 as amended by 1994 PA 443, section 250 as amended by 2002 PA 684, section 454 as amended by 1987 PA 168, section 632 as amended by 1994 PA 226, section 1001 as amended by 2008 PA 342, section 2006 as amended by 2004 PA 28, section 2059 as amended by 1986 PA 253, section 2212a as amended by 2001 PA 235, section 2212b as amended by 2000 PA 486, section 2213 as amended by 2012 PA 445, section 2213a as amended by 2002 PA 707, sections 2213b, 3426, and 3705 as amended and sections

3405a, 3428, 3472, and 3474a as added by 2013 PA 5, section 2236 as amended by 2014 PA 140, sections 3405 and 3475 as amended by 2014 PA 263, section 3406a as added by 1982 PA 527, section 3406c as amended by 1994 PA 233, sections 3406d and 3406e as added by 1989 PA 59, section 3406j as added by 1998 PA 136, section 3406k as amended by 2004 PA 7, section 3406l as added by 2004 PA 171, section 3406m as added by 1998 PA 402, section 3406n as added by 1999 PA 179, section 3406o as added by 1999 PA 177, section 3406p as added by 2000 PA 425, section 3406q as amended and sections 3701, 3703, 3711, and 3723 as added by 2003 PA 88, section 3406r as added by 2004 PA 375, section 3406s as added by 2012 PA 100, section 3407b as added by 2000 PA 27, section 3409 as amended by 1990 PA 170, section 3418 as amended by 1984 PA 280, section 3425 as added by 1980 PA 429, section 3440 as amended by 1987 PA 52, section 3476 as added by 2012 PA 215, sections 3501, 3505, 3507, 3508, 3509, 3511, 3513, 3535, 3545, 3547, 3548, 3551, 3553, 3555, 3557, 3559, 3561, 3563, 3569, and 3573 as added by 2000 PA 252, section 3503 as amended by 2006 PA 366, sections 3515, 3517, 3519, 3533, and 3571 as amended by 2005 PA 306, section 3528 as amended by 2002 PA 621, sections 4601 and 4701 as added by 2008 PA 29, section 7060 as amended by 1999 PA 82, and section 7705 as amended by 2006 PA 671, and by adding sections 607, 608, 3401a, 3402a, 3402b, 3402c, 3402d, 3402e, 3402f, 3402g, 3402h, 3477, and 3544; and to repeal acts and parts of acts.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

1 Sec. 106. AS USED IN THIS ACT:

2 (A) "HEALTH MAINTENANCE ORGANIZATION" MEANS THAT TERM AS

1 **DEFINED IN SECTION 3501.**

2 (B) "Insurer" ~~as used in this code~~ means ~~any~~ **AN** individual,
3 corporation, association, partnership, reciprocal exchange, inter-
4 insurer, Lloyds organization, fraternal benefit society, ~~and any~~ **OR**
5 other legal entity, engaged or attempting to engage in the business
6 of making insurance or surety contracts. **EXCEPT AS OTHERWISE**
7 **PROVIDED IN SECTION 3503 AND UNLESS THE CONTEXT REQUIRES OTHERWISE,**
8 **INSURER INCLUDES A HEALTH MAINTENANCE ORGANIZATION.**

9 Sec. 116. As used in this act:

10 ~~(a) "Abuse of discretion" means not in the reasonable exercise~~
11 ~~of discretion.~~

12 (A) **"ENROLLEE" MEANS AN INDIVIDUAL WHO IS ENTITLED TO RECEIVE**
13 **HEALTH SERVICES UNDER A HEALTH INSURANCE CONTRACT, UNLESS THE**
14 **CONTEXT REQUIRES OTHERWISE.**

15 (b) "Hazardous to policyholders, creditors, and the public"
16 means that an insurer, with respect to the financial condition of
17 its business, is not safe, reliable, and entitled to public
18 confidence.

19 (c) "In the reasonable exercise of discretion" means that an
20 order, decision, determination, finding, ruling, opinion, action,
21 or inaction was based upon facts reasonably found to exist and was
22 not inconsistent with generally acceptable standards and practices
23 of those knowledgeable in the field in question.

24 (D) **"INSURANCE POLICY" OR "INSURANCE CONTRACT" MEANS A**
25 **CONTRACT OF INSURANCE, INDEMNITY, SURETYSHIP, OR ANNUITY ISSUED OR**
26 **PROPOSED OR INTENDED FOR ISSUANCE BY A PERSON ENGAGED IN THE**
27 **BUSINESS OF INSURANCE. UNLESS THE CONTEXT REQUIRES OTHERWISE,**

1 INSURANCE CONTRACT INCLUDES A HEALTH MAINTENANCE CONTRACT, AS THAT
2 TERM IS DEFINED IN SECTION 3501.

3 (E) "INSURANCE PRODUCER" MEANS THAT TERM AS DEFINED IN SECTION
4 1201.

5 (F) "LARGE EMPLOYER" MEANS AN EMPLOYER THAT IS NOT A SMALL
6 EMPLOYER AS DEFINED IN SECTION 3701.

7 (G) "PARTICIPATING PROVIDER" MEANS A PROVIDER THAT, UNDER
8 CONTRACT WITH AN INSURER THAT ISSUES POLICIES OF HEALTH INSURANCE
9 OR WITH SUCH AN INSURER'S CONTRACTOR OR SUBCONTRACTOR, HAS AGREED
10 TO PROVIDE HEALTH CARE SERVICES TO COVERED INDIVIDUALS WITH AN
11 EXPECTATION OF RECEIVING PAYMENT, OTHER THAN COINSURANCE,
12 COPAYMENTS, OR DEDUCTIBLES, DIRECTLY OR INDIRECTLY FROM THE
13 INSURER.

14 (H) ~~(d)~~—"Safe, reliable, and entitled to public confidence"
15 means that an insurer meets all of the following:

16 (i) With respect to its financial standards and conduct and
17 discharge of its obligations to policyholders and creditors, has
18 complied and continues to comply with the specific requirements of
19 this act and, if relevant, the insurance codes or acts of its state
20 of domicile and other states in which it is authorized to conduct
21 an insurance business.

22 (ii) Has made and continues to make reasonable financial
23 provisions and apply sound insurance principles so as to provide
24 reasonable margins of financial safety with respect to the
25 insurance and other obligations it has assumed and continues to
26 assume such that the insurer will be able to discharge those
27 obligations under any reasonable conditions and contingencies

1 taking into account without limitation reasonably anticipated
 2 contingencies, including those affecting changes in the projections
 3 of liabilities, fluctuations in value of assets, alterations in
 4 projections as to when obligations may become due, and expected and
 5 unexpected new claims with respect to obligations.

6 (I) "SERVICE AREA" MEANS THAT TERM AS DEFINED IN SECTION 3501,
 7 UNLESS THE CONTEXT REQUIRES OTHERWISE.

8 (J) EXCEPT AS USED IN CHAPTERS 24, 26, 72, 76, AND 81,
 9 "SUBSCRIBER" MEANS AN INDIVIDUAL WHO ENTERS INTO AN INSURANCE
 10 CONTRACT FOR HEALTH INSURANCE, OR ON WHOSE BEHALF AN INSURANCE
 11 CONTRACT FOR HEALTH INSURANCE IS ENTERED INTO, WITH AN INSURER.

12 Sec. 120. ~~No~~**A** person shall **NOT** transact an insurance, ~~or~~
 13 surety, **OR HEALTH MAINTENANCE ORGANIZATION** business in ~~Michigan,~~
 14 **THIS STATE**, or relative to a subject resident, located ~~or~~ to be
 15 performed in ~~Michigan,~~**THIS STATE**, without complying with the
 16 applicable provisions of this ~~code.~~**ACT.**

17 Sec. 221. (1) Except as otherwise provided in this section, an
 18 insurance compliance self-evaluative audit document is privileged
 19 information and is not discoverable or admissible as evidence in
 20 ~~any~~**A** civil, criminal, or administrative proceeding.

21 (2) Except as otherwise provided in this section, a person
 22 involved in preparing an insurance compliance self-evaluative audit
 23 or insurance compliance self-evaluative audit document is not
 24 subject to examination concerning ~~that~~**THE** audit or audit document
 25 in ~~any~~**A** civil, criminal, or administrative proceeding. However, if
 26 the insurance compliance self-evaluative audit, insurance
 27 compliance self-evaluative audit document, or ~~any~~**A** portion of the

1 audit or audit document is not privileged, the individual involved
 2 in the preparation of the audit or audit document may be examined
 3 concerning the portion of the audit or audit document that is not
 4 privileged. A person involved in preparing an insurance compliance
 5 self-evaluative audit or insurance compliance self-evaluative audit
 6 document who becomes aware of ~~any~~**AN** alleged criminal violation of
 7 this act shall report ~~that~~**THE** act to the insurer. Within 30 days
 8 after receiving the report, the insurer shall provide the
 9 information to the ~~commissioner~~**DIRECTOR**.

10 (3) ~~An~~**THE DIRECTOR SHALL NOT PROVIDE AN** insurance compliance
 11 self-evaluative audit document, furnished to the ~~commissioner~~
 12 **DIRECTOR** voluntarily or as a result of a request of the
 13 ~~commissioner~~**DIRECTOR** under a claim of authority to compel
 14 disclosure under subsection (7), ~~shall not be provided by the~~
 15 ~~commissioner~~ to any other person. ~~and shall~~**THE INSURANCE**
 16 **COMPLIANCE SELF-EVALUATIVE AUDIT DOCUMENT MUST** be accorded the same
 17 confidentiality and other protections as provided in section 222(7)
 18 without waiving the privileges in subsections (1) and (2). Any use
 19 of an insurance compliance self-evaluative audit document furnished
 20 voluntarily or as a result of a request of the ~~commissioner~~
 21 **DIRECTOR** under a claim of authority to compel disclosure under
 22 subsection (7) is limited to determining whether or not any
 23 disclosed defects in an insurer's policies and procedures or
 24 inappropriate treatment of customers has been remedied or that an
 25 appropriate plan for remedy is in place.

26 (4) An insurance compliance self-evaluative audit document
 27 submitted to the ~~commissioner~~**DIRECTOR** remains subject to all

1 applicable statutory or common law privileges including, but not
2 limited to, the work product doctrine, attorney-client privilege,
3 or the subsequent remedial measures exclusion. An insurance
4 compliance self-evaluative audit document submitted to the
5 ~~commissioner~~**DIRECTOR** remains the property of the insurer and is
6 not subject to disclosure under the freedom of information act,
7 1976 PA 442, MCL 15.231 to 15.246.

8 (5) Disclosure of an insurance compliance self-evaluative
9 audit document to a governmental agency, whether voluntary or
10 pursuant to compulsion of law, does not constitute a waiver of the
11 privileges under subsections (1) and (2) with respect to any other
12 person or other governmental agency.

13 (6) The privileges under subsections (1) and (2) do not apply
14 to the extent that they are expressly waived by the insurer that
15 prepared or caused to be prepared the insurance compliance self-
16 evaluative audit document.

17 (7) The privileges in subsections (1) and (2) do not apply as
18 follows:

19 (a) If a court, after an in camera review, requires disclosure
20 in a civil or administrative proceeding after determining 1 or more
21 of the following:

22 (i) The privilege is asserted for a fraudulent purpose.

23 (ii) The material is not subject to the privilege as provided
24 under subsection (13).

25 (b) If a court, after an in camera review, requires disclosure
26 in a criminal proceeding after determining 1 or more of the
27 following:

1 (i) The privilege is asserted for a fraudulent purpose.

2 (ii) The material is not subject to the privilege as provided
3 under subsection (13).

4 (iii) The material contains evidence relevant to the
5 commission of a criminal offense under this act.

6 (8) Within 14 days after the ~~commissioner~~**DIRECTOR** or the
7 attorney general makes a written request by certified mail for
8 disclosure of an insurance compliance self-evaluative audit
9 document, the insurer that prepared the document or caused the
10 document to be prepared may file with the Ingham ~~county~~**COUNTY**
11 circuit court a petition requesting an in camera hearing on whether
12 the insurance compliance self-evaluative audit document or portions
13 of the audit document are subject to disclosure. Failure by the
14 insurer to file a petition waives the privilege provided by this
15 section for ~~that~~**THE** request. An insurer asserting the insurance
16 compliance self-evaluative privilege in response to a request for
17 disclosure under this subsection shall include in its request for
18 an in camera hearing all of the information listed in subsection
19 (10). Within 30 days after the filing of the petition, the court
20 shall issue an order scheduling an in camera hearing to determine
21 whether the insurance compliance self-evaluative audit document or
22 portions of the audit document are privileged or are subject to
23 disclosure.

24 (9) If the court requires disclosure under subsections (7) and
25 (8), the court may compel the disclosure of only those portions of
26 an insurance compliance self-evaluative audit document relevant to
27 issues in dispute in the underlying proceeding. Information

1 required to be disclosed shall not be considered a public document
2 and shall not be considered to be a waiver of the privilege for any
3 other civil, criminal, or administrative proceeding.

4 (10) An insurer asserting the privilege under this section in
5 response to a request for disclosure under subsection (8) shall
6 provide to the ~~commissioner~~**DIRECTOR** or the attorney general, at
7 the time of filing ~~any~~**AN** objection to the disclosure, all of the
8 following information:

9 (a) The date of the insurance compliance self-evaluative audit
10 document.

11 (b) The identity of the entity or individual conducting the
12 audit.

13 (c) The general nature of the activities covered by the
14 insurance compliance self-evaluative audit.

15 (d) An identification of the portions of the insurance
16 compliance self-evaluative audit document for which the privilege
17 is being asserted.

18 (11) An insurer asserting the privilege under this section has
19 the burden of demonstrating the applicability of the privilege.
20 Once an insurer has established the applicability of the privilege,
21 a party seeking disclosure under subsection (7)(a)(i) has the
22 burden of proving that the privilege is asserted for a fraudulent
23 purpose. The ~~commissioner~~**DIRECTOR** or attorney general seeking
24 disclosure under subsection (7)(b)(iii) has the burden of proving
25 the elements listed in subsection (7)(b)(iii).

26 (12) The parties may at any time stipulate in proceedings
27 under this section to entry of an order directing that specific

1 information contained in an insurance compliance self-evaluative
2 audit document is or is not subject to the privileges provided
3 under subsections (1) and (2). Any such stipulation may be limited
4 to the instant proceeding and, absent specific language to the
5 contrary, is not applicable to any other proceeding.

6 (13) The privileges provided under subsections (1) and (2) do
7 not extend to any of the following:

8 (a) Documents, communications, data, reports, or other
9 information expressly required to be collected, developed,
10 maintained, or reported to a regulatory agency under this act or
11 other federal or state law.

12 (b) Information obtained by observation or monitoring by any
13 regulatory agency.

14 (c) Information obtained from a source independent of the
15 insurance compliance audit.

16 (d) Documents, communication, data, reports, memoranda,
17 drawings, photographs, exhibits, computer records, maps, charts,
18 graphs, and surveys kept or prepared in the ordinary course of
19 business.

20 (14) This section does not limit, waive, or abrogate the scope
21 or nature of any other statutory or common law privilege.

22 (15) As used in this section:

23 (a) "Insurance compliance audit" means a voluntary, internal
24 evaluation, review, assessment, audit, or investigation for the
25 purpose of identifying or preventing noncompliance with or
26 promoting compliance with laws, regulations, orders, or industry or
27 professional standards, conducted by or on behalf of an insurer

1 licensed or regulated under this act or ~~which~~**THAT** involves an
2 activity regulated under this act.

3 (b) "Insurance compliance self-evaluative audit document"
4 means a document prepared as a result of or in connection with an
5 insurance compliance audit. An insurance compliance self-evaluative
6 audit document may include a written response to the findings of an
7 insurance compliance audit. An insurance compliance self-evaluative
8 audit document may include, but is not limited to, field notes and
9 records of observations, findings, opinions, suggestions,
10 conclusions, drafts, memoranda, drawings, photographs, exhibits,
11 computer-generated or electronically recorded information, phone
12 records, maps, charts, graphs, and surveys, if this supporting
13 information is collected or prepared in the course of an insurance
14 compliance audit or attached as an exhibit to the audit. An
15 insurance compliance self-evaluative audit document also includes,
16 but is not limited to, any of the following:

17 (i) An insurance compliance audit report prepared by an
18 auditor, who may be an employee of the insurer or an independent
19 contractor, ~~which~~**THAT** may include the scope of the audit, the
20 information gained in the audit, and conclusions and
21 recommendations, with exhibits and appendices.

22 (ii) Memoranda and documents analyzing portions or all of the
23 insurance compliance audit report and discussing potential
24 implementation issues.

25 (iii) An implementation plan that addresses correcting past
26 noncompliance, improving current compliance, and preventing future
27 noncompliance.

1 (iv) Analytic data generated in the course of conducting the
2 insurance compliance audit.

3 (C) "INSURER" MEANS THAT TERM AS DEFINED IN SECTION 106 AND
4 INCLUDES A NONPROFIT DENTAL CARE CORPORATION OPERATING UNDER 1963
5 PA 125, MCL 550.351 TO 550.373.

6 Sec. 222. (1) The ~~commissioner~~-DIRECTOR, in person or by any
7 of his or her authorized deputies or examiners, may examine any or
8 all of the books, records, documents, and papers of ~~any~~-AN insurer
9 at any time after its articles of incorporation have been executed
10 and filed, or after it has been authorized to do business in this
11 state. The ~~commissioner~~-DIRECTOR in his or her discretion may
12 examine the affairs of ~~any~~-A domestic insurer, and, if he or she
13 considers it expedient to do SO, ~~to~~ examine the affairs of ~~any~~-A
14 foreign or alien insurer doing business in this state.

15 (2) Instead of an examination under this act of ~~any~~-A foreign
16 or alien insurer authorized to do business in this state, the
17 ~~commissioner~~-DIRECTOR may accept an examination report on the
18 insurer as prepared by the insurance regulator for the insurer's
19 state of domicile or port-of-entry state if that state accepts
20 examination reports prepared by the ~~commissioner~~-DIRECTOR. This
21 subsection applies only as follows:

22 (a) Until this state becomes accredited by the ~~national~~
23 ~~association of insurance commissioners'~~-NATIONAL ASSOCIATION OF
24 INSURANCE COMMISSIONERS' financial regulation standards and
25 accreditation program.

26 (b) If this state loses accreditation by the ~~national~~
27 ~~association of insurance commissioners'~~-NATIONAL ASSOCIATION OF

1 **INSURANCE COMMISSIONERS'** financial regulation standards and
 2 accreditation program.

3 (3) Instead of an examination under this act of ~~any~~ **A** foreign
 4 or alien insurer authorized to do business in this state, the
 5 ~~commissioner~~ **DIRECTOR** may accept an examination report on the
 6 insurer as prepared by the insurance regulator for the insurer's
 7 state of domicile or port-of-entry state if that state accepts
 8 examination reports prepared by the ~~commissioner~~ **DIRECTOR** and if
 9 the insurance regulatory agency of the state of domicile or port-
 10 of-entry state was accredited by the ~~national association of~~
 11 ~~insurance commissioners'~~ **NATIONAL ASSOCIATION OF INSURANCE**
 12 **COMMISSIONERS'** financial regulation standards and accreditation
 13 program at the time of the examination or if the examination is
 14 performed under the supervision of an accredited insurance
 15 regulatory agency or with the participation of 1 or more examiners
 16 who are employed by an accredited insurance regulatory agency and
 17 who, after a review of the examination work papers and report,
 18 state under oath that the examination was prepared in a manner
 19 consistent with the standards and procedures required by their
 20 accredited regulatory agency. This subsection only applies during
 21 the time this state is accredited by the ~~national association of~~
 22 ~~insurance commissioners'~~ **NATIONAL ASSOCIATION OF INSURANCE**
 23 **COMMISSIONERS'** financial regulation standards and accreditation
 24 program.

25 (4) The ~~commissioner~~ **DIRECTOR**, in person or by any of his or
 26 her authorized deputies or examiners, shall once every 5 years
 27 examine the books, records, documents, and papers of each

1 authorized insurer. The ~~commissioner~~**DIRECTOR** may examine an
 2 insurer more frequently and ~~upon~~**ON** its request shall examine a
 3 domestic insurer that has not been examined for the 3 years
 4 ~~immediately~~ preceding the request. This section does not authorize
 5 the examination of books, records, documents, or papers if those
 6 items involve matters that are a subject of a currently pending
 7 administrative or judicial proceeding against the insurer from whom
 8 the information is sought, unless the ~~commissioner~~**DIRECTOR** or
 9 judge specifically finds on the record of the proceeding that the
 10 examination is reasonably necessary to protect the interests of
 11 policyholders, creditors, or the public or to make a determination
 12 of whether an insurer is safe, reliable, and entitled to public
 13 confidence.

14 (5) The business affairs, assets, and contingent liabilities
 15 of insurers ~~shall be~~**ARE** subject to examination by the ~~commissioner~~
 16 **DIRECTOR** at any time. The ~~commissioner~~**DIRECTOR** may supervise and
 17 make the same examination of the business and affairs of every
 18 foreign or alien insurer doing business in this state as of
 19 domestic insurers doing the same kind of business and of its
 20 assets, books, accounts, and general condition. ~~Every~~**A** foreign or
 21 alien insurer and ~~its~~**THE** agents and officers **OF THE INSURER** are
 22 subject to the same obligations, ~~and are subject to the same~~
 23 examinations, and, ~~in case of default therein, to~~**IF THE INSURER,**
 24 **AGENT, OR OFFICER DEFAULTS IN AN OBLIGATION,** the same penalties and
 25 liabilities as ~~THAT A domestic insurers~~**INSURER** doing the same kind
 26 of business, ~~or any of~~**AND** the agents ~~or~~**AND** officers thereof, ~~OF~~
 27 **THE INSURER** are ~~or may be liable~~**SUBJECT** to under the laws of this

1 state or the ~~regulations of the insurance bureau of the department~~
2 ~~of commerce.~~ **RULES PROMULGATED BY THE DIRECTOR.** The ~~commissioner~~
3 **DIRECTOR** may, whenever he or she considers it expedient to do so,
4 either in person or by a ~~proper~~ person appointed by him or her,
5 ~~repair~~ **GO** to the general office or other offices of the foreign or
6 alien insurer, wherever ~~the same may be,~~ **LOCATED**, and make an
7 investigation and examination of ~~its~~ **THE INSURER'S** affairs and
8 condition.

9 (6) ~~Upon~~ **ON** an examination under this section, the
10 ~~commissioner,~~ **DIRECTOR**, his or her deputy, or any examiner
11 authorized by him or her may examine in person, by writing, and, if
12 appropriate, under oath the officers or agents of the insurer or
13 all persons considered to have material information regarding the
14 insurer's property, assets, business, or affairs. The ~~commissioner~~
15 **DIRECTOR** may compel the attendance and testimony of witnesses and
16 the production of any books, accounts, papers, records, documents,
17 and files relating to the insurer's business or affairs, and may
18 sign subpoenas, administer oaths and affirmations, examine
19 witnesses, and receive evidence for this purpose. The insurer and
20 its officers and agents shall produce its books and records and all
21 papers in its or their possession relating to its business or
22 affairs, and any other person may be required to produce any books,
23 records, or papers considered relevant to the examination for the
24 inspection of the ~~commissioner,~~ **DIRECTOR**, or his or her deputy or
25 examiners, whenever required. The insurer's officers or agents
26 shall facilitate the examination and aid in making the ~~same~~
27 **EXAMINATION** so far as it is in their power to do so. If the

1 ~~commissioner's~~ **DIRECTOR'S** order or subpoena is not followed, the
 2 ~~commissioner~~ **DIRECTOR** may request the Ingham ~~county~~ **COUNTY** circuit
 3 court to issue an order requiring compliance with the
 4 ~~commissioner's~~ order or subpoena.

5 (7) Not later than 60 days ~~following completion of the~~ **AFTER**
 6 **COMPLETING AN** examination **UNDER THIS SECTION**, the deputy or
 7 examiners shall make a full and true report, and furnish the
 8 insurer a copy of the examination report, that shall comprise only
 9 facts appearing on the insurer's books, records, or documents or
 10 ascertained from examination of its officers or agents or other
 11 persons concerning its affairs and the conclusions and
 12 recommendations as may be reasonably warranted from the facts
 13 disclosed. ~~An~~ **ON REQUEST BY AN** insurer examined **UNDER THIS SECTION**,
 14 ~~upon its request, THE DIRECTOR shall be granted~~ **GRANT THE INSURER** a
 15 hearing before the ~~commissioner~~ **DIRECTOR** or his or her designee
 16 before the report is filed. ~~Upon~~ **ON** request of the insurer, the
 17 **DIRECTOR SHALL CLOSE THE** hearing ~~shall be closed~~ to the public. A
 18 hearing under this subsection is not subject to the administrative
 19 procedures act of 1969, ~~Act No. 306 of the Public Acts of 1969,~~
 20 ~~being sections 24.201 to 24.328 of the Michigan Compiled Laws. 1969~~
 21 **PA 306, MCL 24.201 TO 24.328.** Each examination report ~~shall~~ **MUST** be
 22 withheld from public inspection until the report is final and filed
 23 with the ~~commissioner~~ **DIRECTOR**. In addition, the ~~commissioner~~
 24 **DIRECTOR** may withhold any examination report or any analysis of an
 25 insurer's financial condition from public inspection for ~~such~~ **ANY**
 26 time ~~as~~ **THAT** he or she ~~may consider~~ **CONSIDERS** proper. In any event,
 27 **THE DEPARTMENT SHALL WITHHOLD FROM PUBLIC INSPECTION** all

1 information and testimony furnished to the ~~insurance bureau~~
2 **DEPARTMENT** and the ~~insurance bureau's~~ **DEPARTMENT'S** work papers,
3 correspondence, memoranda, reports, records, and other written or
4 oral information related to an examination report or an
5 investigation ~~shall be withheld from public inspection, shall be~~
6 **AND THESE ITEMS ARE** confidential, ~~shall ARE~~ not be subject to
7 subpoena, and ~~shall MUST~~ not be divulged to any person, except as
8 provided in this section. If assurances are provided that the
9 information will be kept confidential, the ~~commissioner~~ **DIRECTOR**
10 may disclose confidential work papers, correspondence, memoranda,
11 reports, records, or other information as follows:

12 (a) To the governor or the attorney general.

13 (b) To any relevant regulatory agency **OR AUTHORITY**, including
14 regulatory agencies **OR AUTHORITIES** of other states, ~~or~~ the federal
15 government, **OR OTHER COUNTRIES**.

16 (c) In connection with an enforcement action brought pursuant
17 ~~to~~ **UNDER** this or another applicable act.

18 (d) To law enforcement officials.

19 (e) To persons authorized by the Ingham ~~county~~ **COUNTY** circuit
20 court to receive the information.

21 (f) To persons entitled to receive ~~such~~ **THE** information in
22 order to discharge duties specifically provided for in this act.

23 (8) **THE CONFIDENTIALITY REQUIREMENTS OF SUBSECTION (7) APPLY**
24 **TO A NONPROFIT DENTAL CARE CORPORATION OPERATING UNDER 1963 PA 125,**
25 **MCL 550.351 TO 550.373.** The confidentiality requirements of
26 subsection (7) do not apply in any proceeding or action brought
27 against or by the insurer under this act or any other applicable

1 act of this state, any other state, or the United States.

2 (9) Notwithstanding the other provisions of this section, the
3 ~~commissioner~~**DIRECTOR** is not required to finalize and file an
4 examination report for an insurer for a year in which an
5 examination report was not finalized and filed, if the insurer is
6 currently undergoing an examination subsequent to the year for
7 which an examination report was not finalized and filed. ~~Nothing~~
8 ~~contained in this~~**THIS** section ~~shall be construed to~~**DOES NOT** limit
9 the ~~commissioner's~~**DIRECTOR'S** authority to terminate or suspend any
10 examination ~~in order to~~ pursue other legal or regulatory action
11 ~~pursuant to~~**UNDER** the insurance laws of this state. Findings of
12 fact and conclusions made ~~pursuant to~~**IN CONNECTION WITH** any
13 examination ~~shall be~~**UNDER THIS SECTION ARE** prima facie evidence in
14 any legal or regulatory action.

15 (10) The examination of an alien insurer is limited to its
16 United States business, except as otherwise required by the
17 ~~commissioner~~**DIRECTOR**.

18 Sec. 250. (1) All insurers licensed to do business in this
19 state shall notify the ~~commissioner~~**DIRECTOR** within 30 days of any
20 transfer of stock that results in any 1 person holding 10% or more
21 of the voting shares of an insurer. In addition, a domestic insurer
22 shall notify the ~~commissioner~~**DIRECTOR** within 30 days of the
23 appointment or election of any new officers or directors.

24 (2) If, after proceedings under section 249, the ~~commissioner~~
25 **DIRECTOR** has reason to believe that an officer or director is
26 untrustworthy or has abused his or her trust and that continuation
27 as an officer or director is hazardous or injurious to the insurer,

1 the policyholders, or the public, the ~~commissioner~~**DIRECTOR** shall
 2 hold a hearing. After the hearing and after written findings that
 3 the officer or director is untrustworthy or has abused his or her
 4 trust and that continuation as an officer or director is hazardous
 5 or injurious to the insurer, the policyholders, or the public, the
 6 ~~commissioner~~**DIRECTOR** may order the removal of the officer or
 7 director.

8 (3) If the insurer does not comply with a removal order under
 9 subsection (2) within 30 days, the ~~commissioner~~**DIRECTOR** may
 10 suspend or revoke the insurer's certificate of authority until the
 11 insurer complies with the order.

12 (4) Any action under this section taken by an insurer ~~or~~**OR** its
 13 directors ~~or~~ officers pursuant to an order of the ~~commissioner~~
 14 **DIRECTOR** under this act ~~shall~~**MUST** be considered to be in good
 15 faith and ~~shall not~~ be the basis for subjecting the insurer ~~or~~
 16 its directors ~~or~~ officers to civil liabilities.

17 (5) ~~Any~~**AN** order of the ~~commissioner~~**DIRECTOR** issued under
 18 this section is subject to review as provided in section 244.

19 (6) **AS USED IN THIS SECTION, "INSURER" INCLUDES A NONPROFIT**
 20 **DENTAL CARE CORPORATION OPERATING UNDER 1963 PA 125, MCL 550.351 TO**
 21 **550.373.**

22 Sec. 402. ~~No~~**A** person shall **NOT** act as an insurer and ~~no~~**AN**
 23 insurer shall **NOT** issue ~~any~~**A** policy or otherwise transact
 24 insurance in this state except as authorized by a subsisting
 25 certificate of authority granted to it by the ~~commissioner~~ pursuant
 26 ~~to~~**DIRECTOR UNDER this code.ACT.**

27 Sec. 436. (1) The ~~commissioner~~**DIRECTOR** may suspend, revoke,

1 or limit the certificate of authority of an insurer if he or she
2 determines that any of the following conditions exist:

3 (a) The insurer no longer meets the requirements of this act
4 respecting capital, surplus, deposits, or assets.

5 (b) The insurer's condition is such that it is no longer safe,
6 reliable, or entitled to public confidence or is unsound, or the
7 insurer is using financial methods and practices in the conduct of
8 its business that render further transaction of insurance by the
9 insurer in this state hazardous to policyholders, creditors, or the
10 public.

11 (c) The insurer's certificate of authority to transact
12 business in its state of domicile, or in the case of an alien
13 insurer, in its state of entry, has been suspended or revoked.

14 (d) The insurer has failed, after written request by the
15 ~~commissioner~~, **DIRECTOR**, to remove or discharge an officer or
16 director whose record of business conduct does not satisfy the
17 requirements of section 436a(1)(k) or 1315(1)(f) or who has been
18 convicted of any crime involving fraud, dishonesty, or like moral
19 turpitude.

20 (e) The insurer fails to promptly comply with sections 222 or
21 438.

22 (f) The insurer has failed for an unreasonable period to pay
23 any final judgment rendered against it in this state on any policy,
24 bond, recognizance, or undertaking issued or guaranteed by it.

25 (g) The insurer has failed, within 30 days after notice of
26 delinquency from the ~~commissioner~~, **DIRECTOR**, to cure its failure to
27 pay the taxes, fees, assessments, or expenses required by this act.

1 (h) The insurer has violated any other provision of this act
2 that provides for suspension or revocation of its certificate of
3 authority.

4 (2) AS USED IN THIS SECTION, "INSURER" INCLUDES A NONPROFIT
5 DENTAL CARE CORPORATION OPERATING UNDER 1963 PA 125, MCL 550.351 TO
6 550.373.

7 Sec. 436a. (1) In addition to any other relevant standards,
8 the ~~commissioner~~-DIRECTOR may consider 1 or more of the following
9 to determine whether the continued operation of an insurer
10 transacting an insurance business in this state OR A NONPROFIT
11 DENTAL CARE CORPORATION OPERATING UNDER 1963 PA 125, MCL 550.351 TO
12 550.373, is safe, reliable, and entitled to public confidence or is
13 considered hazardous to policyholders, creditors, or the public:

14 (a) Affirmative or adverse findings reported in financial
15 condition and market conduct examination reports.

16 (b) The ~~national association of insurance commissioners~~
17 NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS insurance
18 regulatory information system and its related reports.

19 (c) Whether the ratios of commission expense, general
20 insurance expense, policy benefits, and reserve increases as to
21 annual premium and net investment income could likely lead to an
22 impairment of capital and surplus.

23 (d) Whether the insurer's asset portfolio, when viewed in
24 light of current economic conditions, is of sufficient value,
25 liquidity, or diversity to assure the insurer's ability to meet its
26 outstanding obligations as they mature.

27 (e) Whether the ability of an assuming reinsurer to perform

1 and whether the insurer's reinsurance program provides sufficient
2 protection for the insurer's remaining surplus after taking into
3 account the insurer's cash flow, the classes of business written,
4 and the financial condition of the assuming reinsurer.

5 (f) The insurer's operating loss in the last 12-month period
6 or any shorter period of time, including, but not limited to, net
7 capital gain or loss, change in assets, and cash dividends paid to
8 shareholders, in relation to the insurer's remaining capital and
9 surplus in excess of the amount required to comply with section
10 403.

11 (g) Whether any affiliate, subsidiary, or reinsurer is
12 insolvent, threatened with insolvency, or delinquent in payment of
13 its monetary or other obligation.

14 (h) Contingent liabilities, pledges, or guaranties that either
15 individually or collectively involve a total amount that in the
16 ~~commissioner's~~**DIRECTOR'S** opinion may affect the insurer's
17 solvency.

18 (i) Whether any controlling person of an insurer is delinquent
19 ~~in the transmitting to, or~~ **THE** payment of ~~net premiums to that~~
20 **THE** insurer or has caused the insurer to divert assets, make
21 investments, or assume liabilities with respect to the affiliates
22 of the insurer that have had a material adverse effect on the
23 insurer's financial solidity.

24 (j) The age and collectibility of receivables.

25 (k) Whether the management of an insurer, including officers,
26 directors, or any other person who directly or indirectly controls
27 the operation of the insurer, possesses and demonstrates the

1 competence, fitness, and character considered necessary to serve
2 the insurer in such a position.

3 (l) Whether management of an insurer has failed to respond to
4 inquiries relative to the insurer's condition or has furnished
5 false and misleading information concerning an inquiry.

6 (m) Whether management of an insurer has filed ~~any-A~~
7 materially false or misleading financial statement, has released
8 ~~any-A~~ materially false or misleading financial statement to lending
9 institutions or to the general public, or has made a materially
10 false or misleading entry or has omitted an entry of material
11 amount in the insurer's books.

12 (n) Whether the insurer has grown so rapidly and to such an
13 extent that it lacks adequate financial and administrative capacity
14 to timely meet its obligations.

15 (o) Whether the ~~company-INSURER~~ has experienced or will
16 experience in the foreseeable future cash flow or liquidity
17 problems.

18 (p) Subject to subsection ~~(2), (3)~~, ratings and rating reports
19 concerning the insurer from rating organizations that meet all of
20 the following **REQUIREMENTS**:

21 (i) Are registered under the investment advisors act of 1940,
22 ~~title II of chapter 686, 54 Stat. 789, 15 U.S.C. USC 80b-1 to 80b-~~
23 21.

24 (ii) Have adequate training, supervision, and continuing
25 education for its analysts.

26 (iii) Make a determination as to whether the company being
27 rated has the ability to service and repay its debts.

1 (iv) Assign a credit committee to each rated company, members
2 of which are changed annually.

3 (v) Give rated companies a right of appeal as to the rating
4 received prior to publication.

5 (vi) Maintain continuous monitoring as to the rating in the
6 event of significant developments.

7 (vii) Maintain an employee code of ethics and an internal
8 procedure to prevent misuse of information, such as a prohibition
9 against conflict of interest.

10 (q) Whether the insurer demonstrates material adverse
11 deviations from industry averages with respect to significant
12 indicators of financial solidity such as leverage, liquidity,
13 profitability, reinsurance, investment risk, and reserve adequacy.

14 (r) The extent to which the insurer meets standards of
15 financial solidity such as risk based capital requirements as
16 developed by organizations with recognized expertise in evaluating
17 the financial condition of insurers such as the ~~national~~
18 ~~association of insurance commissioners.~~ **NATIONAL ASSOCIATION OF**
19 **INSURANCE COMMISSIONERS.**

20 (s) The size of the insurer as measured by its assets, capital
21 and surplus reserves, premium writings, insurance in force, and
22 other appropriate criteria.

23 (t) The extent to which the insurer's business is diversified
24 among the several lines of insurance, the number and size of risks
25 insured in each line of business, and the extent of the
26 geographical dispersion of the insurer's insured risks.

27 (u) The nature and extent of the insurer's reinsurance

1 program.

2 (v) The quality, diversification, and liquidity of the
3 insurer's investment portfolio.

4 (w) The recent past and projected future trend in the size of
5 the insurer's surplus as regards policyholders and the surplus as
6 regards policyholders maintained by other comparable insurers.

7 (x) The adequacy of the insurer's reserves.

8 (y) The quality and liquidity of investments in affiliates.

9 (z) Compliance by the insurer with section 901.

10 **(2) FOR PURPOSES OF THE STANDARDS SET FORTH IN SUBSECTION (1),**
11 **THE DIRECTOR MAY CONSIDER A NONPROFIT DENTAL CARE CORPORATION IN**
12 **THE SAME MANNER AS AN INSURER.**

13 **(3) ~~(2)~~The commissioner-DIRECTOR** shall not require an insurer
14 to subscribe to ~~any~~**A** private rating organization.

15 **(4) ~~(3)~~The commissioner-DIRECTOR** may do any of the following
16 in making a determination of an insurer's financial condition under
17 this section:

18 (a) Disregard any credit or amount receivable resulting from
19 transactions with a reinsurer that has totally ceased writing new
20 business or that is insolvent, impaired, or otherwise subject to a
21 delinquency proceeding.

22 (b) Make appropriate adjustments including disallowance to
23 asset values attributable to investments in or transactions with
24 parents, subsidiaries, or affiliates.

25 (c) Refuse to recognize the stated value of accounts
26 receivable if the ability to collect receivables is highly
27 speculative in view of the account's age or the debtor's financial

1 condition.

2 (d) Increase the insurer's liability in an amount equal to any
3 contingent liability, pledge, or guarantee not otherwise included
4 if there is a substantial risk that the insurer will be called upon
5 to meet the obligation undertaken.

6 (5) ~~(4)~~—If the ~~commissioner~~**DIRECTOR** determines that an
7 insurer authorized to transact business in this state has ceased to
8 be safe, reliable, and entitled to public confidence or that the
9 insurer's continued operation may be hazardous to policyholders,
10 creditors, or the public, ~~then the commissioner,~~**DIRECTOR**, in
11 addition to his or her authority under section 437 and chapter 81,
12 may issue an order requiring the insurer to do any of the
13 following:

14 (a) Reduce the total amount of present and potential liability
15 for policy benefits by sound reinsurance transactions approved by
16 the ~~commissioner~~**DIRECTOR**.

17 (b) Reduce, suspend, or limit the volume of business being
18 accepted or renewed.

19 (c) Reduce general insurance and commission expenses by
20 specified methods.

21 (d) Increase the insurer's capital and surplus.

22 (e) Suspend or limit the declaration and payment of dividends
23 by an insurer to its stockholders or to its policyholders.

24 (f) File reports in a form acceptable to the ~~commissioner~~
25 **DIRECTOR** concerning the market value of an insurer's assets.

26 (g) Limit or withdraw from certain investments or discontinue
27 certain investment practices.

1 (h) Document the adequacy of premium rates in relation to the
2 risks insured.

3 (i) File, in addition to regular annual statements, interim
4 financial reports on the form or in the format promulgated by the
5 ~~commissioner~~**DIRECTOR**.

6 (6) ~~(5)~~An insurer subject to an order under subsection ~~(4)~~
7 (5) may request a hearing as in a contested case pursuant to the
8 administrative procedures act of 1969, ~~Act No. 306 of the Public~~
9 ~~Acts of 1969, being sections 24.201 to 24.328 of the Michigan~~
10 ~~Compiled Laws, 1969 PA 306, MCL 24.201 TO 24.328,~~ to review ~~that~~
11 **THE** order. The notice of hearing ~~shall~~**MUST** be served ~~upon~~**ON** the
12 insurer and ~~shall~~ state the time and place of hearing and the
13 conduct, conditions, or grounds ~~upon~~**ON** which the ~~commissioner~~
14 **DIRECTOR** based the order. Unless mutually agreed between the
15 ~~commissioner~~**DIRECTOR** and the insurer, the hearing ~~shall~~**MUST** occur
16 not less than 10 days or more than 30 days after notice is served.
17 The ~~commissioner~~**DIRECTOR** shall hold all hearings under this
18 subsection privately unless the insurer requests a public hearing,
19 in which case the hearing ~~shall~~**MUST** be public.

20 Sec. 454. (1) Except as otherwise provided in this section,
21 **THE DEPARTMENT SHALL NOT AUTHORIZE** an insurer ~~shall not be~~
22 ~~authorized~~ to do business in this state if its name is the same as
23 or closely resembles the name of ~~any other~~**ANOTHER** insurer
24 organized under or authorized to do business under the laws of this
25 state. However, **THE DEPARTMENT MAY AUTHORIZE** an insurer ~~may be~~
26 ~~authorized~~ to do business in this state ~~by adding~~**IF IT ADDS** to its
27 corporate name a word, abbreviation, or other distinctive and

1 distinguishing element.

2 (2) The **DEPARTMENT SHALL ISSUE A** certificate of authority
 3 ~~issued to the AN insurer shall be issued in the name applied for,~~
 4 and the insurer shall use that name in all its dealings with the
 5 ~~commissioner~~ **DEPARTMENT** and in the conduct of its affairs in this
 6 state. ~~Any document used or advertising offered in this state AN~~
 7 **INSURER** shall identify the incorporated name of the insurer **IN ANY**
 8 **DOCUMENT USED OR ADVERTISING OFFERED IN THIS STATE.**

9 (3) The ~~commissioner~~ **DIRECTOR** may disapprove **THE** use of any ~~A~~
 10 name of an insurer **OR HEALTH MAINTENANCE ORGANIZATION** if the
 11 ~~commissioner~~ **DIRECTOR** determines that the name is deceptive or
 12 misleading.

13 Sec. 460. ~~An~~ **EXCEPT AS OTHERWISE PROVIDED IN SECTION 1202, AN**
 14 insurer authorized to transact business in this state shall not
 15 write, place, or cause to be written or placed ~~, any~~ **AN INSURANCE**
 16 policy or **INSURANCE** contract ~~of insurance in this state, except~~
 17 through an ~~agent duly licensed by the commissioner.~~ **INSURANCE**
 18 **PRODUCER.**

19 Sec. 462. ~~An~~ **EXCEPT AS OTHERWISE PROVIDED IN THIS SECTION, AN**
 20 application for life or disability insurance ~~shall~~ **MUST** bear the
 21 signature of a ~~licensed agent.~~ **AN INSURANCE PRODUCER. THIS SECTION**
 22 **DOES NOT APPLY TO AN APPLICATION FOR INSURANCE THROUGH THE**
 23 **INSURER'S INTERNET WEBSITE IF THE WEBSITE CONTAINS A STATEMENT THAT**
 24 **THE APPLICANT MAY USE AN INSURANCE PRODUCER TO ASSIST WITH THE**
 25 **APPLICATION AT NO COST TO THE APPLICANT.**

26 Sec. 606. (1) "Disability" insurance is insurance ~~of any~~
 27 ~~person~~ against bodily injury or death by accident, or against

1 disability on account of sickness or accident. ~~including also the~~
 2 ~~granting of specific hospital benefits and medical, surgical and~~
 3 ~~sick care benefits~~ **UNLESS SPECIFICALLY EXCLUDED IN CHAPTER 34,**
 4 **DISABILITY INSURANCE INCLUDES HEALTH INSURANCE ISSUED** to any
 5 ~~person,~~ **AN INDIVIDUAL**, family, or group, subject to such
 6 limitations as ~~may be~~ **THAT ARE** prescribed with respect thereto.
 7 ~~Provided, The~~ **TO THE INSURANCE.**

8 (2) **AN** insured under **A DISABILITY INSURANCE POLICY AS**
 9 **DESCRIBED IN** this section may be an employee of any ~~A person~~ **THAT**
 10 **IS** not subject to the ~~provisions of the workmen's~~ **WORKER'S**
 11 **DISABILITY** compensation law and in such case **ACT OF 1969, 1969 PA**
 12 **317, MCL 418.101 TO 418.941. IF THE PERSON IS NOT SUBJECT TO THE**
 13 **WORKER'S DISABILITY COMPENSATION ACT OF 1969, 1969 PA 317, MCL**
 14 **418.101 TO 418.941,** the liability may be limited to such as may
 15 ~~arise~~ **LIABILITY ARISING** out of and in the course of **THE** employee's
 16 employment and the premium may be paid by the employer under an
 17 agreement with the employee.

18 **SEC. 607. (1) AS USED IN THIS ACT, "GROUP DISABILITY**
 19 **INSURANCE" MEANS VOLUNTARY DISABILITY INSURANCE THAT COVERS 2 OR**
 20 **MORE EMPLOYEES OR MEMBERS, WITH OR WITHOUT THEIR ELIGIBLE**
 21 **DEPENDENTS, WRITTEN UNDER A MASTER POLICY ISSUED TO A GOVERNMENTAL**
 22 **CORPORATION, UNIT, AGENCY, OR DEPARTMENT OF A GOVERNMENTAL ENTITY,**
 23 **TO A CORPORATION, COPARTNERSHIP, OR INDIVIDUAL EMPLOYER, OR, ON**
 24 **APPLICATION OF AN EXECUTIVE OFFICER OR TRUSTEE OF THE ASSOCIATION,**
 25 **TO AN ASSOCIATION THAT HAS A CONSTITUTION OR BYLAWS AND THAT IS**
 26 **FORMED IN GOOD FAITH FOR PURPOSES OTHER THAN THAT OF OBTAINING**
 27 **INSURANCE, AND UNDER WHICH OFFICERS, MEMBERS, EMPLOYEES, OR CLASSES**

1 OR DEPARTMENTS OF THE ASSOCIATION MAY BE INSURED FOR THEIR
2 INDIVIDUAL BENEFIT.

3 (2) NOTWITHSTANDING SUBSECTION (1), A GROUP DISABILITY
4 INSURANCE POLICY MAY BE ISSUED TO A TRUST OR TRUSTEES OF A FUND
5 ESTABLISHED BY 2 OR MORE EMPLOYERS TO INSURE 1 OR MORE EMPLOYEES OF
6 THE EMPLOYERS.

7 SEC. 608. AS USED IN THIS ACT:

8 (A) "HEALTH" INSURANCE IS INSURANCE PROVIDED UNDER A HEALTH
9 INSURANCE POLICY.

10 (B) "HEALTH INSURANCE POLICY" MEANS AN EXPENSE-INCURRED
11 HOSPITAL, MEDICAL, OR SURGICAL POLICY, CERTIFICATE, OR CONTRACT.

12 Sec. 632. (1) ~~Every~~ ~~AN~~ insurer shall be entitled to ~~MAY~~
13 reinsure any risk authorized to be undertaken by it ~~, and to grant~~
14 reinsurance ~~upon~~ ~~ON~~ any similar risk undertaken by any other
15 insurer. **A NONPROFIT DENTAL CARE CORPORATION OPERATING UNDER 1963**
16 **PA 125, MCL 550.351 TO 550.373, MAY REINSURE ANY RISK AUTHORIZED TO**
17 **BE UNDERTAKEN BY IT AND GRANT REINSURANCE ON ANY SIMILAR RISK**
18 **UNDERTAKEN BY ANOTHER LEGAL ENTITY.**

19 (2) Subject to chapter 58, ~~any~~ ~~A~~ mutual insurance company
20 other than life may, by policy, treaty, or other agreement, cede to
21 or accept from any insurance company or insurer reinsurance ~~upon~~ ~~ON~~
22 the whole or any part of any risk, which reinsurance ~~shall~~ ~~MUST~~ be
23 without contingent liability or participation or membership unless
24 provided otherwise. Reinsurance ~~shall~~ ~~MUST~~ not be effected with any
25 company or insurer disapproved by written order of the ~~commissioner~~
26 **DIRECTOR** filed in his or her office.

27 (3) An insurer authorized to transact multiple lines of

1 insurance may, except with respect to policies of life and
2 endowment insurance and contracts for the payment of annuities and
3 pure endowments, reinsure risks of every kind or description.

4 (4) Reinsurance ~~shall~~**MUST** not be ceded to or accepted by any
5 insurer operating under the cooperative or assessment plan.

6 Reinsurance of any insurer operating under the cooperative or
7 assessment plan ~~shall~~**MUST** be ceded only to insurers authorized
8 under this act to transact a similar kind of insurance in this
9 state and to accept reinsurance.

10 (5) An insurer may be specifically authorized to accept
11 reinsurance for kinds of risks that it does not have authority to
12 insure directly.

13 Sec. 1001. As used in this chapter:

14 (a) "Audited financial report" means the report required in
15 section 1005 and furnished pursuant to section 1007.

16 (b) "Audit committee" means a committee or equivalent body
17 established by the board of directors of an entity to oversee the
18 accounting and financial reporting processes and audits of the
19 financial statements of an insurer or group of insurers. The audit
20 committee of an entity that controls a group of insurers may be the
21 audit committee for 1 or more of these controlled insurers solely
22 for the purposes of compliance with this chapter at the election of
23 the controlling person as permitted in section 1027(6). If an audit
24 committee is not designated by an insurer, the insurer's entire
25 board of directors ~~shall~~**WILL** constitute the audit committee.

26 (c) "Group of insurers" means those licensed insurers included
27 in the reporting requirements of chapter 13, or a set of insurers

1 as identified by management, for the purpose of assessing the
2 effectiveness of internal control over financial reporting.

3 (d) "Indemnification agreement" means an agreement of
4 indemnity or a release from liability ~~where~~ **AS TO WHICH** the intent
5 or effect is to shift or limit in any manner the potential
6 liability of the person or firm for failure to adhere to applicable
7 auditing or professional standards, whether or not resulting in
8 part from knowing of other misrepresentations made by the insurer
9 or its representatives.

10 (e) "Independent board member" has the same meaning as
11 described in section 1027(4).

12 (f) "Independent public accountant" means an independent
13 certified public accountant or accounting firm in good standing
14 with the American ~~institute of certified public accountants~~
15 **INSTITUTE OF CERTIFIED PUBLIC ACCOUNTANTS** and in good standing in
16 all states in which ~~they are~~ **THE ACCOUNTANT OR ACCOUNTING FIRM IS**
17 licensed to practice. For Canadian and British companies,
18 "independent public accountant" means a Canadian-chartered or
19 British-chartered accountant.

20 (G) **"INSURER" MEANS THAT TERM AS DEFINED IN SECTION 106 AND**
21 **INCLUDES A NONPROFIT DENTAL CARE CORPORATION OPERATING UNDER 1963**
22 **PA 125, MCL 550.351 TO 550.373.**

23 (H) ~~(g)~~ "Internal control over financial reporting" means a
24 process effected by an entity's board of directors, management, and
25 other personnel designed to provide reasonable assurance regarding
26 the reliability of the financial statements filed with the
27 ~~commissioner,~~ **DIRECTOR**, and includes the following:

1 (i) Policies and procedures pertaining to the maintenance of
 2 records that, in reasonable detail, accurately and fairly reflect
 3 the transactions and dispositions of assets.

4 (ii) Policies and procedures providing reasonable assurance
 5 that transactions are recorded as necessary to permit preparation
 6 of the financial statements filed with the ~~commissioner~~**DIRECTOR**
 7 and that receipts and expenditures are being made only in
 8 accordance with authorizations of management and directors.

9 (iii) Policies and procedures providing reasonable assurance
 10 regarding prevention or timely detection of unauthorized
 11 acquisition, use, or disposition of assets that could have a
 12 material effect on the financial statements filed with the
 13 ~~commissioner~~**DIRECTOR**.

14 (I) ~~(h)~~"SEC" means the United States ~~securities and exchange~~
 15 ~~commission~~**SECURITIES AND EXCHANGE COMMISSION**.

16 (J) ~~(i)~~"Section 404" means section 404 of the Sarbanes-Oxley
 17 act of 2002, **15 USC 7262**, and the SEC's rules and regulations
 18 promulgated ~~thereunder~~**UNDER THAT SECTION**.

19 (K) ~~(j)~~"Section 404 report" means management's report on
 20 "internal control over financial reporting" as defined by the SEC
 21 and the related attestation report of the independent certified
 22 public accountant.

23 (L) ~~(k)~~"SOX compliant entity" means an entity that either is
 24 required to be compliant with, or voluntarily is compliant with,
 25 all of the following provisions of the Sarbanes-Oxley act of 2002
 26 **AND THE REGULATIONS PROMULGATED UNDER THAT ACT:**

27 (i) The preapproval requirements of section 201, section

1 10A(i) of the securities exchange act of 1934, **15 USC 78J-1.**

2 (ii) The audit committee independence requirements of section
3 301, section 10A(m)(3) of the securities exchange act of 1934, **15**
4 **USC 78J-1.**

5 (iii) The internal control over financial reporting
6 requirements of section 404, **15 USC 7262, AS PRESCRIBED BY** item 308
7 of SEC regulation S-K, **17 CFR 229.308.**

8 Sec. 2003. (1) A person shall not engage in a trade practice
9 ~~which~~**THAT** is defined **OR DESCRIBED** in this ~~uniform trade practices~~
10 ~~act~~**CHAPTER** or is determined pursuant to ~~UNDER~~ this act ~~CHAPTER~~ to
11 be ~~, an~~ unfair method of competition or an unfair or deceptive act
12 or practice in the business of insurance.

13 (2) ~~"Person"~~**EXCEPT AS OTHERWISE PROVIDED IN THIS SUBSECTION,**
14 **"PERSON"** means ~~a person~~**THAT TERM AS** defined in section 114 and
15 includes an ~~agent,~~**INSURANCE PRODUCER,** solicitor, counselor, ~~or~~
16 adjuster, **OR NONPROFIT DENTAL CARE CORPORATION OPERATING UNDER 1963**
17 **PA 125, MCL 550.351 TO 550.373. , but excludes**PERSON DOES NOT**
18 **INCLUDE** the property and casualty guaranty association.**

19 ~~—— (3) "Insurance policy" or "insurance contract" means a~~
20 ~~contract of insurance, indemnity, suretyship, or annuity issued or~~
21 ~~proposed or intended for issuance by a person engaged in the~~
22 ~~business of insurance.~~

23 Sec. 2006. (1) A person must pay on a timely basis to its
24 insured, ~~an individual or entity~~**A PERSON** directly entitled to
25 benefits under its insured's **INSURANCE** contract, ~~of insurance,~~ or a
26 third party tort claimant the benefits provided under the terms of
27 its policy, or, in the alternative, the person must pay to its

1 insured, ~~an individual or entity~~ **A PERSON** directly entitled to
 2 benefits under its insured's **INSURANCE** contract, ~~of insurance,~~ or a
 3 third party tort claimant 12% interest, as provided in subsection
 4 (4), on claims not paid on a timely basis. Failure to pay claims on
 5 a timely basis or to pay interest on claims as provided in
 6 subsection (4) is an unfair trade practice unless the claim is
 7 reasonably in dispute.

8 (2) A person shall not be found to have committed an unfair
 9 trade practice under this section if the person is found liable for
 10 a claim pursuant to a judgment rendered by a court of law, and the
 11 person pays to its insured, ~~individual or entity~~ **THE PERSON**
 12 directly entitled to benefits under its insured's **INSURANCE**
 13 contract, ~~of insurance,~~ or **THE** third party tort claimant interest
 14 as provided in subsection (4).

15 (3) An insurer shall specify in writing the materials that
 16 constitute a satisfactory proof of loss not later than 30 days
 17 after receipt of a claim unless the claim is settled within the 30
 18 days. If proof of loss is not supplied as to the entire claim, the
 19 amount supported by proof of loss ~~shall be~~ **IS** considered paid on a
 20 timely basis if paid within 60 days after receipt of proof of loss
 21 by the insurer. Any part of the remainder of the claim that is
 22 later supported by proof of loss ~~shall be~~ **IS** considered paid on a
 23 timely basis if paid within 60 days after receipt of the proof of
 24 loss by the insurer. If the proof of loss provided by the claimant
 25 contains facts that clearly indicate the need for additional
 26 medical information by the insurer in order to determine its
 27 liability under a policy of life insurance, the claim ~~shall be~~ **IS**

1 considered paid on a timely basis if paid within 60 days after
2 receipt of necessary medical information by the insurer. Payment of
3 a claim ~~shall~~**IS** not ~~be~~ untimely during any period in which the
4 insurer is unable to pay the claim ~~when~~**IF** there is no recipient
5 who is legally able to give a valid release for the payment, or
6 ~~where~~**IF** the insurer is unable to determine who is entitled to
7 receive the payment, if the insurer has promptly notified the
8 claimant of that inability and has offered in good faith to
9 promptly pay the claim upon determination of who is entitled to
10 receive the payment.

11 (4) If benefits are not paid on a timely basis, the benefits
12 paid ~~shall~~ bear simple interest from a date 60 days after
13 satisfactory proof of loss was received by the insurer at the rate
14 of 12% per annum, if the claimant is the insured or ~~an individual~~
15 ~~or entity~~**A PERSON** directly entitled to benefits under the
16 insured's **INSURANCE** contract. ~~of insurance.~~ If the claimant is a
17 third party tort claimant, ~~then~~ the benefits paid ~~shall~~ bear
18 interest from a date 60 days after satisfactory proof of loss was
19 received by the insurer at the rate of 12% per annum if the
20 liability of the insurer for the claim is not reasonably in
21 dispute, the insurer has refused payment in bad faith, and the bad
22 faith was determined by a court of law. The interest ~~shall~~**MUST** be
23 paid in addition to and at the time of payment of the loss. If the
24 loss exceeds the limits of insurance coverage available, interest
25 ~~shall be~~**IS** payable based ~~upon~~**ON** the limits of insurance coverage
26 rather than the amount of the loss. If payment is offered by the
27 insurer but is rejected by the claimant, and the claimant does not

1 subsequently recover an amount in excess of the amount offered,
 2 interest is not due. Interest paid ~~pursuant to~~ **AS PROVIDED IN** this
 3 section ~~shall~~ **MUST** be offset by any award of interest that is
 4 payable by the insurer ~~pursuant to~~ **AS PROVIDED IN** the award.

5 (5) If a person contracts to provide benefits and reinsures
 6 all or a portion of the risk, the person contracting to provide
 7 benefits is liable for interest due to an insured, ~~an individual or~~
 8 ~~entity~~ **A PERSON** directly entitled to benefits under its insured's
 9 **INSURANCE** contract, ~~of insurance,~~ or a third party tort claimant
 10 under this section ~~where~~ **IF** a reinsurer fails to pay benefits on a
 11 timely basis.

12 (6) If there is any specific inconsistency between this
 13 section and ~~sections 3101 to 3177~~ **CHAPTER 31** or the worker's
 14 disability compensation act of 1969, 1969 PA 317, MCL 418.101 to
 15 418.941, the provisions of this section do not apply. Subsections
 16 (7) to (14) do not apply to ~~an entity~~ **A PERSON** regulated under the
 17 worker's disability compensation act of 1969, 1969 PA 317, MCL
 18 418.101 to 418.941. Subsections (7) to (14) do not apply to the
 19 processing and paying of ~~medicaid~~ **MEDICAID** claims that are covered
 20 under section 111i of the social welfare act, 1939 PA 280, MCL
 21 400.111i.

22 (7) Subsections (1) to (6) do not apply and subsections (8) to
 23 (14) do apply to health plans when paying claims to health
 24 professionals, health facilities, home health care providers, and
 25 durable medical equipment providers, that are not pharmacies and
 26 that do not involve claims arising out of ~~sections 3101 to 3177~~
 27 **CHAPTER 31** or the worker's disability compensation act of 1969,

1 1969 PA 317, MCL 418.101 to 418.941. This section does not affect a
2 health plan's ability to prescribe the terms and conditions of its
3 contracts, other than as provided in this section for timely
4 payment.

5 (8) Each health professional, health facility, home health
6 care provider, and durable medical equipment provider in billing
7 for services rendered and each health plan in processing and paying
8 claims for services rendered shall use the following timely
9 processing and payment procedures:

10 (a) A clean claim ~~shall~~**MUST** be paid within 45 days after
11 receipt of the claim by the health plan. A clean claim that is not
12 paid within 45 days ~~shall bear~~**BEARS** simple interest at a rate of
13 12% per annum.

14 (b) A health plan shall notify the health professional, health
15 facility, home health care provider, or durable medical equipment
16 provider within 30 days after receipt of the claim by the health
17 plan of all known reasons that prevent the claim from being a clean
18 claim.

19 (c) A health professional, health facility, home health care
20 provider, ~~and~~**OR** durable medical equipment provider ~~have~~**HAS** 45
21 days, and any additional time the health plan permits, after
22 receipt of a notice under subdivision (b) to correct all known
23 defects. The 45-day time period in subdivision (a) is tolled from
24 the date of receipt of a notice to a health professional, health
25 facility, home health care provider, or durable medical equipment
26 provider under subdivision (b) to the date of the health plan's
27 receipt of a response from the health professional, health

1 facility, home health care provider, or durable medical equipment
2 provider.

3 (d) If a health professional's, health facility's, home health
4 care provider's, or durable medical equipment provider's response
5 under subdivision (c) makes the claim a clean claim, the health
6 plan shall pay the health professional, health facility, home
7 health care provider, or durable medical equipment provider within
8 the 45-day time period under subdivision (a), excluding any time
9 period tolled under subdivision (c).

10 (e) If a health professional's, health facility's, home health
11 care provider's, or durable medical equipment provider's response
12 under subdivision (c) does not make the claim a clean claim, the
13 health plan shall notify the health professional, health facility,
14 home health care provider, or durable medical equipment provider of
15 an adverse claim determination and of the reasons for the adverse
16 claim determination within the 45-day time period under subdivision
17 (a), excluding any time period tolled under subdivision (c).

18 (f) A health professional, health facility, home health care
19 provider, or durable medical equipment provider ~~shall~~**MUST** bill a
20 health plan within 1 year after the date of service or the date of
21 discharge from the health facility in order for a claim to be a
22 clean claim.

23 (g) A health professional, health facility, home health care
24 provider, or durable medical equipment provider shall not resubmit
25 the same claim to the health plan unless the time ~~frame in~~**PERIOD**
26 **UNDER** subdivision (a) has passed or as provided in subdivision (c).

27 **(H) A HEALTH PLAN THAT IS A QUALIFIED HEALTH PLAN FOR THE**

1 PURPOSES OF 45 CFR 156.270 AND THAT, AS REQUIRED IN 45 CFR
2 156.270(D), PROVIDES A 3-MONTH GRACE PERIOD TO AN ENROLLEE WHO IS
3 RECEIVING ADVANCE PAYMENTS OF THE PREMIUM TAX CREDIT AND WHO HAS
4 PAID 1 FULL MONTH'S PREMIUM MAY PEND CLAIMS FOR SERVICES RENDERED
5 TO THE ENROLLEE IN THE SECOND AND THIRD MONTHS OF THE GRACE PERIOD.
6 A CLAIM DURING THE SECOND AND THIRD MONTHS OF THE GRACE PERIOD IS
7 NOT A CLEAN CLAIM UNDER THIS SECTION, AND INTEREST IS NOT PAYABLE
8 UNDER SUBDIVISION (A) ON THAT CLAIM IF THE HEALTH PLAN HAS COMPLIED
9 WITH THE NOTICE REQUIREMENTS OF 45 CFR 155.430 AND 45 CFR 156.270.

10 (9) Notices required under subsection (8) ~~shall~~**MUST** be made
11 in writing or electronically.

12 (10) If a health plan determines that 1 or more services
13 listed on a claim are payable, the health plan shall pay for those
14 services and shall not deny the entire claim because 1 or more
15 other services listed on the claim are defective. This subsection
16 does not apply if a health plan and health professional, health
17 facility, home health care provider, or durable medical equipment
18 provider have an overriding contractual reimbursement arrangement.

19 (11) A health plan shall not terminate the affiliation status
20 or the participation of a health professional, health facility,
21 home health care provider, or durable medical equipment provider
22 with a health maintenance organization provider panel or otherwise
23 discriminate against a health professional, health facility, home
24 health care provider, or durable medical equipment provider because
25 the health professional, health facility, home health care
26 provider, or durable medical equipment provider claims that a
27 health plan has violated subsections (7) to (10).

1 (12) A health professional, health facility, home health care
2 provider, durable medical equipment provider, or health plan
3 alleging that a timely processing or payment procedure under
4 subsections (7) to (11) has been violated may file a complaint with
5 the ~~commissioner~~**DIRECTOR** on a form approved by the ~~commissioner~~
6 **DIRECTOR** and has a right to a determination of the matter by the
7 ~~commissioner~~**DIRECTOR** or his or her designee. This subsection does
8 not prohibit a health professional, health facility, home health
9 care provider, durable medical equipment provider, or health plan
10 from seeking court action. ~~A health plan described in subsection~~
11 ~~(14) (c) (iv) is subject only to the procedures and penalties~~
12 ~~provided for in subsection (13) and section 402 of the nonprofit~~
13 ~~health care corporation reform act, 1980 PA 350, MCL 550.1402, for~~
14 ~~a violation of a timely processing or payment procedure under~~
15 ~~subsections (7) to (11).~~

16 (13) In addition to any other penalty provided for by law, the
17 ~~commissioner~~**DIRECTOR** may impose a civil fine of not more than
18 \$1,000.00 for each violation of subsections (7) to (11) not to
19 exceed \$10,000.00 in the aggregate for multiple violations.

20 (14) As used in subsections (7) to (13):

21 (a) "Clean claim" means a claim that does all of the
22 following:

23 (i) Identifies the health professional, health facility, home
24 health care provider, or durable medical equipment provider that
25 provided service sufficiently to verify, if necessary, affiliation
26 status and includes any identifying numbers.

27 (ii) Sufficiently identifies the patient and health plan

1 subscriber.

2 (iii) Lists the date and place of service.

3 (iv) Is a claim for covered services for an eligible
4 individual.

5 (v) If necessary, substantiates the medical necessity and
6 appropriateness of the service provided.

7 (vi) If prior authorization is required for certain patient
8 services, contains information sufficient to establish that prior
9 authorization was obtained.

10 (vii) Identifies the service rendered using a generally
11 accepted system of procedure or service coding.

12 (viii) Includes additional documentation based ~~upon~~ **ON**
13 services rendered as reasonably required by the health plan.

14 (b) "Health facility" means a health facility or agency
15 licensed under article 17 of the public health code, 1978 PA 368,
16 MCL 333.20101 to 333.22260.

17 (c) "Health plan" means all of the following:

18 (i) An insurer providing benefits under ~~an expense-incurred~~
19 ~~hospital, medical, surgical, vision, or dental~~ **A HEALTH INSURANCE**
20 ~~policy, or certificate, including any~~ **A policy, or certificate, OR**
21 **CONTRACT** that provides coverage for specific diseases or accidents
22 only, **AN EXPENSE-INCURRED VISION OR DENTAL POLICY**, or ~~any~~ **A**
23 hospital indemnity, ~~medicare~~ **MEDICARE** supplement, long-term care,
24 or 1-time limited duration policy or certificate, but not to
25 payments made to an administrative services only or cost-plus
26 arrangement.

27 (ii) A MEWA regulated under chapter 70 that provides hospital,

1 medical, surgical, vision, dental, and sick care benefits.

2 ~~—— (iii) A health maintenance organization licensed or issued a~~
3 ~~certificate of authority in this state.~~

4 ~~—— (iv) A health care corporation for benefits provided under a~~
5 ~~certificate issued under the nonprofit health care corporation~~
6 ~~reform act, 1980 PA 350, MCL 550.1101 to 550.1704, but not to~~
7 ~~payments made pursuant to an administrative services only or cost~~
8 ~~plus arrangement.~~

9 (d) "Health professional" means ~~a health professional~~ **AN**
10 **INDIVIDUAL** licensed, ~~or~~ registered, **OR OTHERWISE AUTHORIZED TO**
11 **ENGAGE IN A HEALTH PROFESSION** under article 15 of the public health
12 code, 1978 PA 368, MCL 333.16101 to 333.18838.

13 **(15) THIS SECTION DOES NOT APPLY TO A NONPROFIT DENTAL CARE**
14 **CORPORATION OPERATING UNDER 1963 PA 125, MCL 550.351 TO 550.373.**

15 Sec. 2059. (1) ~~No~~ **EXCEPT AS OTHERWISE PROVIDED IN THIS ACT, A**
16 person shall **NOT** maintain or operate ~~any~~ **AN** office in this state
17 for the transaction of the business of insurance ~~, except as~~
18 ~~provided for in this code,~~ or use the name of ~~any~~ **AN** insurer,
19 fictitious or otherwise, in conducting or advertising ~~any~~ **A**
20 business **THAT IS** not related or connected with the business of
21 insurance as ~~governed by the provisions of~~ **REGULATED IN** this code
22 ~~except as otherwise provided in subsection (2).~~ **ACT.**

23 (2) Subsection (1) ~~shall~~ **DOES** not be construed to prohibit an
24 agent licensed under chapter 12 **INSURANCE PRODUCER** from marketing
25 or transacting any of the following:

26 ~~—— (a) Subject to the health benefit agent act, health care~~
27 ~~coverage provided by a health care corporation regulated pursuant~~

~~to the nonprofit health care corporation reform act, Act No. 350 of the Public Acts of 1980, being sections 550.1101 to 550.1704 of the Michigan Compiled Laws.~~

(A) ~~(b)~~ Subject to the health benefit agent act, **1986 PA 252, MCL 550.1001 TO 550.1020**, health care coverage provided by a health maintenance organization. ~~regulated pursuant to part 210 of the public health code, Act No. 368 of the Public Acts of 1978, being sections 333.21001 to 333.21098 of the Michigan Compiled Laws.~~

(B) ~~(c)~~ Subject to the health benefit agent act, **1986 PA 252, MCL 550.1001 TO 550.1020**, dental care coverage provided by a dental care corporation regulated ~~pursuant to Act No. UNDER 1963 PA 125, of the Public Acts of 1963, being sections MCL 550.351 to 550.373. of the Michigan Compiled Laws.~~

(C) ~~(d)~~ Administrative services of a third party administrator regulated ~~pursuant to UNDER the third party administrator act, Act No. 1984 PA 218, of the Public Acts of 1984, being sections MCL 550.901 to 550.962 of the Michigan Compiled Laws.~~ **550.960.**

Sec. 2212a. (1) An insurer that delivers, issues for delivery, or renews in this state ~~an expense incurred hospital, medical, or surgical~~ **A policy or certificate issued under chapter 34 or 36 OF HEALTH INSURANCE** shall provide a written form in plain English to insureds upon enrollment that describes the terms and conditions of the insurer's policies. ~~and certificates.~~ The form ~~shall~~ **MUST** provide a clear, complete, and accurate description of all of the following, as applicable:

(a) The service area.

(b) Covered benefits, including prescription drug coverage,

1 with specifications regarding requirements for the use of generic
2 drugs.

3 (c) Emergency health coverages and benefits.

4 (d) Out-of-area coverages and benefits.

5 (e) An explanation of the insured's financial responsibility
6 for copayments, deductibles, and any other out-of-pocket expenses.

7 (f) Provision for continuity of treatment if a provider's
8 participation terminates during the course of an insured person's
9 treatment by ~~that~~ **THE** provider.

10 (g) The telephone number to call to receive information
11 concerning grievance procedures.

12 (h) How the covered benefits apply in the evaluation and
13 treatment of pain.

14 (i) A summary listing of the information available ~~pursuant to~~
15 **UNDER** subsection (2).

16 (2) An insurer shall provide upon request to insureds covered
17 under a policy ~~or certificate~~ issued under section 3405 ~~or 3631~~ a
18 clear, complete, and accurate description of any of the following
19 information that has been requested:

20 (a) The current provider network in the ~~policy or~~
21 ~~certificate's~~ service area, including names and locations of
22 **AFFILIATED OR** participating providers by specialty or type of
23 practice, a statement of limitations of accessibility and referrals
24 to specialists, and a disclosure of which providers will not accept
25 new subscribers.

26 (b) The professional credentials of **AFFILIATED OR**
27 participating ~~health professionals,~~ **PROVIDERS**, including, but not

1 limited to, **AFFILIATED OR** participating ~~health professionals~~
2 **PROVIDERS** who are board certified in the specialty of pain medicine
3 and the evaluation and treatment of pain and have reported that
4 certification to the insurer, including all of the following:

5 (i) Relevant professional degrees.

6 (ii) Date of certification by the applicable nationally
7 recognized boards and other professional bodies.

8 (iii) The names of licensed facilities on the provider panel
9 where the ~~health professional presently~~ **PROVIDER CURRENTLY** has
10 privileges for the treatment, illness, or procedure that is the
11 subject of the request.

12 (c) The licensing verification telephone number for the
13 ~~Michigan department of consumer~~ **LICENSING** and ~~industry services~~
14 **REGULATORY AFFAIRS** that can be accessed for information as to
15 whether any disciplinary actions or open formal complaints have
16 been taken or filed against a health care provider in the
17 immediately preceding 3 years.

18 (d) Any prior authorization requirements and any limitations,
19 restrictions, or exclusions, including, but not limited to, drug
20 formulary limitations and restrictions by category of service,
21 benefit, and provider, and, if applicable, by specific service,
22 benefit, or type of drug.

23 (e) ~~Indication of the~~ **THE** financial relationships between the
24 insurer and any closed provider panel, including all of the
25 following as applicable:

26 (i) Whether a fee-for-service arrangement exists, under which
27 the provider is paid a specified amount for each covered service

1 rendered to the participant.

2 (ii) Whether a capitation arrangement exists, under which a
3 fixed amount is paid to the provider for all covered services that
4 are or may be rendered to each covered individual or family.

5 (iii) Whether payments to providers are made based on
6 standards relating to cost, quality, or patient satisfaction.

7 (f) A telephone number and address to obtain from the insurer
8 additional information concerning the items described in
9 subdivisions (a) to (e).

10 (3) Upon request, any of the information provided under
11 subsection (2) ~~shall~~**MUST** be provided in writing. An insurer may
12 require that a request under subsection (2) be submitted in
13 writing.

14 (4) **A HEALTH INSURER SHALL NOT DELIVER OR ISSUE FOR DELIVERY A**
15 **POLICY OF INSURANCE TO ANY PERSON IN THIS STATE UNLESS ALL OF THE**
16 **FOLLOWING REQUIREMENTS ARE MET:**

17 (A) **THE STYLE, ARRANGEMENT, AND OVERALL APPEARANCE OF THE**
18 **POLICY DO NOT GIVE UNDUE PROMINENCE TO ANY PORTION OF THE TEXT.**
19 **EVERY PRINTED PORTION OF THE TEXT OF THE POLICY AND OF ANY**
20 **ENDORSEMENTS OR ATTACHED PAPERS MUST BE PLAINLY PRINTED IN LIGHT-**
21 **FACED TYPE OF A STYLE IN GENERAL USE, THE SIZE OF WHICH MUST BE**
22 **UNIFORM AND NOT LESS THAN 10-POINT WITH A LOWERCASE UNSPACED**
23 **ALPHABET LENGTH, NOT LESS THAN 120-POINT IN LENGTH OF LINE. AS USED**
24 **IN THIS SUBDIVISION, "TEXT" INCLUDES ALL PRINTED MATTER EXCEPT THE**
25 **NAME AND ADDRESS OF THE INSURER, NAME OR TITLE OF THE POLICY, THE**
26 **BRIEF DESCRIPTION, IF ANY, AND CAPTIONS AND SUBCAPTIONS.**

27 (B) **EXCEPT AS OTHERWISE PROVIDED IN THIS SUBDIVISION OR EXCEPT**

1 AS PROVIDED IN SECTIONS 3406 TO 3452, EXCEPTIONS AND REDUCTIONS OF
2 INDEMNITY ARE SET FORTH IN THE POLICY AND ARE PRINTED, AT THE
3 INSURER'S OPTION, WITH THE BENEFIT PROVISION TO WHICH THEY APPLY OR
4 UNDER AN APPROPRIATE CAPTION SUCH AS "EXCEPTIONS" OR "EXCEPTIONS
5 AND REDUCTIONS". IF AN EXCEPTION OR REDUCTION OF INDEMNITY
6 SPECIFICALLY APPLIES ONLY TO A PARTICULAR BENEFIT OF THE POLICY, A
7 STATEMENT OF THE EXCEPTION OR REDUCTION MUST BE INCLUDED WITH THE
8 BENEFIT PROVISION TO WHICH IT APPLIES.

9 (C) EACH FORM, INCLUDING RIDERS AND ENDORSEMENTS, ARE
10 IDENTIFIED BY A FORM NUMBER IN THE LOWER LEFT-HAND CORNER OF THE
11 FIRST PAGE OF THE FORM.

12 (D) THE POLICY CONTAINS NO PROVISION THAT PURPORTS TO MAKE ANY
13 PORTION OF THE CHARTER, RULES, CONSTITUTION, OR BYLAWS OF THE
14 INSURER A PART OF THE POLICY UNLESS THE PORTION IS SET FORTH IN
15 FULL IN THE POLICY. THIS SUBDIVISION DOES NOT APPLY TO THE
16 INCORPORATION OF OR REFERENCE TO A STATEMENT OF RATES,
17 CLASSIFICATION OF RISKS, OR SHORT-RATE TABLE FILED WITH THE
18 DIRECTOR.

19 (5) ~~(4)~~As used in this section, "board certified" means
20 certified to practice in a particular medical or other health
21 professional specialty by the American ~~board of medical specialties~~
22 **BOARD OF MEDICAL SPECIALTIES** or another appropriate national health
23 professional organization.

24 Sec. 2212b. (1) This section applies to a policy ~~or~~
25 ~~certificate~~ issued under section 3405 ~~or 3631~~ and to a health
26 maintenance organization contract.

27 (2) If **AFFILIATION OR** participation between a primary care

1 physician and an insurer terminates, the physician may provide
2 written notice of this termination within 15 days after the
3 physician becomes aware of the termination to each insured who has
4 chosen the physician as his or her primary care physician. If an
5 insured is in an ongoing course of treatment with any other
6 physician that is **AFFILIATED OR** participating with the insurer and
7 the **AFFILIATION OR** participation between the physician and the
8 insurer terminates, the physician may provide written notice of
9 this termination to the insured within 15 days after the physician
10 becomes aware of the termination. The notices under this subsection
11 may also describe the procedure for continuing care under
12 subsections (3) and (4).

13 (3) If **AFFILIATION OR** participation between an insured's
14 current physician and an insurer terminates, the insurer shall
15 permit the insured to continue an ongoing course of treatment with
16 that physician as follows:

17 (a) For 90 days ~~from~~ **AFTER** the date of notice to the insured
18 by the physician of the physician's termination with the insurer.

19 (b) If the insured is in her second or third trimester of
20 pregnancy at the time of the physician's termination, through
21 postpartum care directly related to the pregnancy.

22 (c) If the insured is determined to ~~be terminally ill prior to~~
23 **HAVE AN ADVANCED ILLNESS BEFORE** a physician's termination or
24 knowledge of the termination and the physician was treating the
25 ~~terminal~~ **ADVANCED** illness before the date of termination or
26 knowledge of the termination, for the remainder of the insured's
27 life for care directly related to the treatment of the ~~terminal~~

1 **ADVANCED** illness.

2 (4) Subsection (3) applies only if the physician agrees to all
3 of the following:

4 (a) To continue to accept as payment in full reimbursement
5 from the insurer at the rates applicable ~~prior to~~ **BEFORE** the
6 termination.

7 (b) To adhere to the insurer's standards for maintaining
8 quality health care and to provide to the insurer necessary medical
9 information related to the care.

10 (c) To otherwise adhere to the insurer's policies and
11 procedures, including, but not limited to, those concerning
12 utilization review, referrals, preauthorizations, and treatment
13 plans.

14 (5) An insurer shall provide written notice to each **AFFILIATED**
15 **OR** participating physician that if **AFFILIATION OR** participation
16 between the physician and the insurer terminates, the physician may
17 do both of the following:

18 (a) Notify the insurer's insureds under the care of the
19 physician of the termination if the physician does so within 15
20 days after the physician becomes aware of the termination.

21 (b) Include in the notice under subdivision (a) a description
22 of the procedures for continuing care under subsections (3) and
23 (4).

24 (6) This section does not create an obligation for an insurer
25 to provide to an insured coverage beyond the maximum coverage
26 limits permitted by the insurer's policy or certificate with the
27 insured. This section does not create an obligation for an insurer

1 to expand who may be a primary care physician under a policy or
2 certificate.

3 (7) As used in this section:

4 (A) "ADVANCED ILLNESS" MEANS THAT TERM AS DEFINED IN SECTION
5 5653 OF THE PUBLIC HEALTH CODE, 1978 PA 368, MCL 333.5653.

6 (B) ~~(a)~~ "Physician" means an allopathic physician, osteopathic
7 physician, or podiatric physician.

8 ~~—— (b) "Terminal illness" means that term as defined in section~~
9 ~~5653 of the public health code, 1978 PA 368, MCL 333.5653.~~

10 (c) "Terminates" or "termination" includes the nonrenewal,
11 expiration, or ending for any reason of a participation agreement
12 or **AFFILIATED PROVIDER** contract between a physician and an insurer,
13 but does not include a termination by the insurer for failure to
14 meet applicable quality standards or for fraud.

15 Sec. 2213. (1) Except as otherwise provided in subsection (4),
16 ~~each AN insurer and health maintenance organization THAT DELIVERS,~~
17 **ISSUES FOR DELIVERY, OR RENEWS IN THIS STATE A POLICY OF HEALTH**
18 **INSURANCE** shall establish an internal formal grievance procedure
19 for approval by the ~~commissioner~~ **DIRECTOR** for persons covered under
20 ~~a THE policy , certificate, or contract issued under chapter 34,~~
21 ~~35, or 36~~ that provides for all of the following:

22 (a) A designated person responsible for administering the
23 grievance system.

24 (b) A designated person or telephone number for receiving
25 grievances.

26 (c) A method that ensures full investigation of a grievance.

27 (d) Timely notification ~~in plain English~~ to the insured or

1 enrollee as to the progress of an investigation of a grievance.

2 (e) The right of an insured or enrollee to appear before a
3 designated person or committee to present a grievance.

4 (f) Notification ~~in plain English~~ to the insured or enrollee
5 of the results of the insurer's ~~or health maintenance~~
6 ~~organization's~~ investigation of the ~~A~~ grievance and of the right to
7 have the grievance reviewed by the ~~commissioner~~ **DIRECTOR** or by an
8 independent review organization under the patient's right to
9 independent review act, 2000 PA 251, MCL 550.1901 to 550.1929.

10 (g) A method for providing summary data on the number and
11 types of ~~complaints and~~ grievances filed under this section. The
12 insurer or health maintenance organization shall annually file the
13 summary data for the prior calendar year with the ~~commissioner~~
14 **DIRECTOR** on forms provided by the ~~commissioner~~ **DIRECTOR**.

15 (h) Periodic management and governing body review of the data
16 to ~~assure~~ **ENSURE** that appropriate actions have been taken.

17 (i) That copies of all ~~complaints~~ **GRIEVANCES** and responses are
18 available at the principal office of the insurer ~~or health~~
19 ~~maintenance organization~~ for inspection by the ~~commissioner~~
20 **DIRECTOR** for 2 years following the year the grievance was filed.

21 (j) That when an adverse determination is made, a written
22 statement ~~in plain English~~ containing the reasons for the adverse
23 determination is provided to the insured or enrollee along with
24 written notifications as required under the patient's right to
25 independent review act, 2000 PA 251, MCL 550.1901 to 550.1929.

26 (k) That a final determination will be made in writing by the
27 insurer ~~or health maintenance organization~~ not later than ~~35~~ **30**

1 calendar days after a formal **PRESERVICE** grievance is submitted OR
2 **60 CALENDAR DAYS AFTER A FORMAL POSTSERVICE GRIEVANCE IS SUBMITTED**
3 in writing by the insured or enrollee. The ~~timing for the 35-~~
4 ~~calendar day period~~ **30-CALENDAR-DAY PERIOD OR 60-CALENDAR-DAY**
5 **PERIOD, AS APPLICABLE,** may be tolled, however, for any period of
6 time the insured or enrollee is permitted to take under the
7 grievance procedure and for a period of time that ~~shall~~ **MUST** not
8 exceed 10 business days if the insurer ~~or health maintenance~~
9 ~~organization~~ has not received requested information from a health
10 care facility or health professional. **IF THE INSURER'S PROCEDURE**
11 **FOR INSURED OR ENROLLEES COVERED UNDER A GROUP POLICY OR PLAN**
12 **INCLUDES 2 STEPS TO RESOLVE THE GRIEVANCE, THE TIME FOR THE FIRST**
13 **STEP MUST BE NO LONGER THAN 15 CALENDAR DAYS FOR A PRESERVICE**
14 **GRIEVANCE OR 30 CALENDAR DAYS FOR A POSTSERVICE GRIEVANCE.**

15 (l) That a determination will be made by the insurer ~~or health~~
16 ~~maintenance organization~~ not later than 72 hours after receipt of
17 an expedited grievance. Within 10 days after receipt of a
18 determination, the insured or enrollee may request a determination
19 of the matter by the ~~commissioner~~ **DIRECTOR** or his or her designee
20 or by an independent review organization under the patient's right
21 to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929.
22 If the determination by the insurer ~~or health maintenance~~
23 ~~organization~~ is made orally, the insurer ~~or health maintenance~~
24 ~~organization~~ shall provide a written confirmation of the
25 determination to the insured or enrollee not later than 2 business
26 days after the oral determination. An expedited grievance under
27 this subdivision applies if a grievance is submitted and a

1 physician, orally or in writing, substantiates that the time frame
 2 for a grievance under subdivision (k) would seriously jeopardize
 3 the life or health of the insured or enrollee or would jeopardize
 4 the insured's or enrollee's ability to regain maximum function.

5 (m) That the insured or enrollee has the right to a
 6 determination of the matter by the ~~commissioner~~**DIRECTOR** or his or
 7 her designee or by an independent review organization under the
 8 patient's right to independent review act, 2000 PA 251, MCL
 9 550.1901 to 550.1929.

10 (2) An insured or enrollee may authorize in writing any
 11 person, including, but not limited to, a physician, to act on his
 12 or her behalf at any stage in a grievance proceeding under this
 13 section.

14 (3) This section does not apply to a provider's complaint
 15 concerning claims payment, handling, or reimbursement for health
 16 care services.

17 (4) This section does not apply to a policy, certificate,
 18 care, coverage, or insurance listed in section 5(2) of the
 19 patient's right to independent review act, 2000 PA 251, MCL
 20 550.1905, as not being subject to the patient's right to
 21 independent review act, 2000 PA 251, MCL 550.1901 to 550.1929.

22 **(5) A WRITTEN NOTICE REQUIRED TO BE GIVEN UNDER THIS SECTION**
 23 **MUST BE PROVIDED IN A CULTURALLY AND LINGUISTICALLY APPROPRIATE**
 24 **MANNER, AS REQUIRED UNDER 45 CFR 147.136(B)(2)(II)(E).**

25 (6) ~~(5)~~As used in this section:

26 (a) "Adverse determination" means ~~a~~**ANY OF THE FOLLOWING:**

27 **(i) A determination that an admission, availability of care,**

1 ~~continued stay, or other health care service has been reviewed and~~
2 ~~denied, reduced, or terminated.~~ BY AN INSURER OR ITS DESIGNEE
3 UTILIZATION REVIEW ORGANIZATION THAT A REQUEST FOR A BENEFIT, ON
4 APPLICATION OF ANY UTILIZATION REVIEW TECHNIQUE, DOES NOT MEET THE
5 INSURER'S REQUIREMENTS FOR MEDICAL NECESSITY, APPROPRIATENESS,
6 HEALTH CARE SETTING, LEVEL OF CARE, OR EFFECTIVENESS OR IS
7 DETERMINED TO BE EXPERIMENTAL OR INVESTIGATIONAL AND THE REQUESTED
8 BENEFIT IS THEREFORE DENIED, REDUCED, OR TERMINATED OR PAYMENT IS
9 NOT PROVIDED OR MADE, IN WHOLE OR IN PART, FOR THE BENEFIT.

10 (ii) THE DENIAL, REDUCTION, TERMINATION, OR FAILURE TO PROVIDE
11 OR MAKE PAYMENT, IN WHOLE OR IN PART, FOR A BENEFIT BASED ON A
12 DETERMINATION BY AN INSURER OR ITS DESIGNEE UTILIZATION REVIEW
13 ORGANIZATION OF A COVERED PERSON'S ELIGIBILITY FOR COVERAGE FROM
14 THE INSURER.

15 (iii) A PROSPECTIVE REVIEW OR RETROSPECTIVE REVIEW
16 DETERMINATION THAT DENIES, REDUCES, OR TERMINATES OR FAILS TO
17 PROVIDE OR MAKE PAYMENT, IN WHOLE OR IN PART, FOR A BENEFIT.

18 (iv) A RESCISSION OF COVERAGE DETERMINATION.

19 (v) Failure to respond in a timely manner to a request for a
20 determination. ~~constitutes an adverse determination.~~

21 (b) "Grievance" means a **FORMAL** complaint on behalf of an
22 insured or enrollee submitted by an insured or enrollee concerning
23 any of the following:

24 (i) The availability, delivery, or quality of health care
25 services, including a complaint regarding an adverse determination
26 made pursuant to utilization review.

27 (ii) Benefits or claims payment, handling, or reimbursement

1 for health care services.

2 (iii) Matters pertaining to the contractual relationship
3 between an insured or enrollee and the insurer. ~~or health~~
4 ~~maintenance organization.~~

5 (C) "INSURER" INCLUDES A NONPROFIT DENTAL CARE CORPORATION
6 OPERATING UNDER 1963 PA 125, MCL 550.351 TO 550.373.

7 (D) "POSTSERVICE GRIEVANCE" MEANS A GRIEVANCE RELATING TO
8 SERVICES THAT HAVE ALREADY BEEN RECEIVED BY THE INSURED OR
9 ENROLLEE.

10 (E) "PRESERVICE GRIEVANCE" MEANS A GRIEVANCE RELATING TO
11 SERVICES FOR WHICH THE INSURER CONDITIONS RECEIPT OF THE SERVICES,
12 IN WHOLE OR IN PART, ON APPROVAL OF THE SERVICES IN ADVANCE OF
13 RECEIVING THE SERVICE.

14 Sec. 2213a. (1) ~~All~~ **THE DIRECTOR SHALL CALCULATE** actual and
15 necessary expenses incurred by the ~~commissioner~~ **DIRECTOR** under
16 section 2213 ~~shall be calculated by the commissioner~~ by June 30 of
17 each year for the immediately preceding fiscal year. Except as
18 otherwise provided in subsection (2), the ~~commissioner~~ **DIRECTOR**
19 shall divide these expenses among all insurers ~~who~~ **THAT** issue a
20 policy or certificate under chapter 34 or ~~36~~ **35** in this state on a
21 pro rata basis according to the direct written premiums **OF EACH**
22 **INSURER AS** reported in ~~each~~ **THE** insurer's annual statement for the
23 immediately preceding calendar year. ~~by each of those insurers.~~
24 ~~This~~ **AN INSURER SHALL PAY THE** assessment ~~shall be paid~~ within 30
25 days after receipt of the assessment. ~~and~~ **THE ASSESSMENT** is in
26 addition to the regulatory fee provided for in section 224.

27 (2) This section does not apply to a policy, certificate,

1 care, coverage, or insurance listed in section 5(2) of the
 2 patient's right to independent review act, 2000 PA 251, MCL
 3 550.1905, as not being subject to the patient's right to
 4 independent review act, 2000 PA 251, MCL 550.1901 to 550.1929.

5 (3) AS USED IN THIS SECTION, "INSURER" INCLUDES A NONPROFIT
 6 DENTAL CARE CORPORATION OPERATING UNDER 1963 PA 125, MCL 550.351 TO
 7 550.373.

8 Sec. 2213b. (1) Except as otherwise provided in this section,
 9 an insurer that delivers, issues for delivery, or renews in this
 10 state ~~an expense incurred hospital, medical, or surgical individual~~
 11 **A HEALTH INSURANCE** policy ~~under chapter 34~~ shall renew **THE POLICY**
 12 or continue **THE POLICY** in force ~~the policy~~ at the option of the
 13 individual **OR, FOR A GROUP PLAN, AT THE OPTION OF THE PLAN SPONSOR.**

14 ~~—— (2) Except as otherwise provided in this section, an insurer~~
 15 ~~that delivers, issues for delivery, or renews in this state an~~
 16 ~~expense incurred hospital, medical, or surgical group policy or~~
 17 ~~certificate under chapter 36 shall renew or continue in force the~~
 18 ~~policy or certificate at the option of the sponsor of the plan.~~

19 (2) AT THE TIME OF RENEWAL OF AN INDIVIDUAL HEALTH INSURANCE
 20 POLICY, THE INSURER MAY MODIFY THE POLICY IF THE MODIFICATION IS
 21 CONSISTENT WITH STATE AND FEDERAL LAW AND IS EFFECTIVE ON A UNIFORM
 22 BASIS AMONG ALL INDIVIDUALS WITH COVERAGE UNDER THE POLICY.

23 (3) AT THE TIME OF RENEWAL OF A GROUP HEALTH INSURANCE POLICY
 24 ISSUED UNDER CHAPTER 34, THE INSURER MAY MODIFY THE POLICY.

25 (4) ~~(3)~~ Guaranteed renewal **OF A HEALTH INSURANCE POLICY** is not
 26 required in cases of fraud, intentional misrepresentation of
 27 material fact, lack of payment, **NONCOMPLIANCE WITH MINIMUM**

1 **CONTRIBUTION REQUIREMENTS, OR NONCOMPLIANCE WITH MINIMUM**

2 **PARTICIPATION REQUIREMENTS,** if the insurer no longer offers that
3 particular type of coverage in the market, or if the individual or
4 group moves outside the service area.

5 (5) ~~(4) An insurer or health maintenance organization that~~
6 ~~offers an expense incurred hospital, medical, or surgical~~ **DELIVERS,**
7 **ISSUES FOR DELIVERY, OR RENEWS IN THIS STATE A HEALTH INSURANCE**
8 ~~policy under chapter 34 or 36~~ shall not discontinue offering a
9 particular plan or product in the nongroup or group market unless
10 the insurer ~~or health maintenance organization~~ does all of the
11 following:

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

16 (b) Offers to each covered individual or group, as applicable,
17 provided coverage under the plan or product the option to purchase
18 any other plan or product currently being offered in the nongroup
19 market or group market, as applicable, by that insurer ~~or health~~
20 ~~maintenance organization~~ without excluding or limiting coverage for
21 a preexisting condition or providing a waiting period.

22 (c) Acts uniformly without regard to any health status factor
23 of enrolled individuals or individuals who may become eligible for
24 coverage in making the determination to discontinue coverage and in
25 offering other plans or products.

26 (6) ~~(5) An insurer or health maintenance organization shall~~
27 not discontinue offering all coverage in the nongroup or group

1 market unless the insurer ~~or health maintenance organization~~ does
 2 all of the following:

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

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

10 (7) ~~(6)~~ If an insurer ~~or health maintenance organization~~
 11 discontinues coverage under subsection ~~(5)~~, ~~(6)~~, the insurer ~~or~~
 12 ~~health maintenance organization~~ shall not provide for the issuance
 13 of any health benefit plans in the nongroup or group market from
 14 which the insurer ~~or health maintenance organization~~ withdrew
 15 during the 5-year period beginning on the date of the
 16 discontinuation of the last plan not renewed under that subsection.

17 (8) ~~(7)~~ Subsections (1) to ~~(6)~~ ~~(7)~~ do not apply to a short-
 18 term or 1-time limited duration policy or certificate of no longer
 19 than 6 months.

20 (9) ~~(8)~~ For the purposes of this section, ~~and section 3406f,~~ a
 21 short-term or 1-time limited duration policy or certificate of no
 22 longer than 6 months is an individual health policy that meets all
 23 of the following:

24 (a) Is issued to provide coverage for a period of 185 days or
 25 less, except that the health policy may permit a limited extension
 26 of benefits after the date the policy ended solely for expenses
 27 attributable to a condition for which a covered person incurred

1 expenses during the term of the policy.

2 (b) Is nonrenewable, provided that the health insurer may
3 provide coverage for 1 or more subsequent periods that satisfy
4 subdivision (a), if the total of the periods of coverage do not
5 exceed a total of 185 days out of any 365-day period, plus any
6 additional days permitted by the policy for a condition for which a
7 covered person incurred expenses during the term of the policy.

8 (c) Does not cover any preexisting conditions.

9 (d) Is available with an immediate effective date, without
10 underwriting, upon receipt by the insurer of a completed
11 application indicating eligibility under the ~~health~~-insurer's
12 eligibility requirements, except that coverage that includes
13 optional benefits may be offered on a basis that does not meet this
14 requirement.

15 (10) ~~(9)~~ By March 31 each year, an insurer that delivers,
16 issues for delivery, or renews in this state a short-term or 1-time
17 limited duration policy or certificate of no longer than 6 months
18 shall provide to the ~~commissioner~~-**DIRECTOR** a written annual report
19 that discloses both of the following:

20 (a) The gross written premium for short-term or 1-time limited
21 duration policies or certificates issued in this state during the
22 preceding calendar year.

23 (b) The gross written premium for all individual ~~expense~~-
24 ~~incurred hospital, medical, or surgical~~-**HEALTH INSURANCE** policies
25 ~~or certificates~~ issued or delivered in this state during the
26 preceding calendar year other than policies or certificates
27 described in subdivision (a).

1 (11) ~~(10)~~ The ~~commissioner~~ **DIRECTOR** shall maintain copies of
 2 reports prepared pursuant to ~~UNDER~~ subsection ~~(9)~~ **(10)** on file with
 3 the annual statement of each reporting insurer. The ~~commissioner~~
 4 **DIRECTOR** shall annually compile the reports received under
 5 subsection ~~(9)~~ **(10)**. The ~~commissioner~~ **DIRECTOR** shall provide this
 6 annual compilation to the senate and house of representatives
 7 standing committees on insurance issues ~~no later than the~~ **BY** June 1
 8 ~~immediately following~~ **AFTER** the ~~March 31~~ date ~~for~~ **ON** which the
 9 reports under subsection ~~(9)~~ **(10)** are ~~provided~~ **DUE**.

10 (12) ~~(11)~~ In each calendar year, a ~~health~~ **AN** insurer shall not
 11 continue to issue short-term or 1-time limited duration policies or
 12 certificates if to do so the collective gross written premiums on
 13 those policies or certificates would total more than 10% of the
 14 collective gross written premiums for all individual ~~expense~~
 15 ~~incurred hospital, medical, or surgical~~ **HEALTH INSURANCE** policies
 16 ~~or certificates~~ issued or delivered in this state either directly
 17 by ~~that~~ **THE** insurer or through a ~~corporation~~ **PERSON** that owns or is
 18 owned by ~~that~~ **THE** insurer.

19 Sec. 2214. (1) ~~The~~ **AN** insured ~~shall~~ **IS** not be bound by ~~any~~ **A**
 20 statement made in an application for a disability insurance policy
 21 unless ~~a copy of such~~ **THE** application is ~~attached to or endorsed on~~
 22 **INCLUDED IN** the policy when **THE POLICY IS** issued. ~~as a part~~
 23 ~~thereof.~~ **FOR PURPOSES OF THIS SUBSECTION, AN APPLICATION IS NOT**
 24 **INCLUDED IN A POLICY UNLESS THE POLICY SPECIFICALLY STATES THAT IT**
 25 **INCLUDES THE APPLICATION.**

26 (2) If ~~any such~~ **A** policy **DESCRIBED IN SUBSECTION (1) THAT WAS**
 27 delivered or issued for delivery to ~~any~~ **A** person in this state

1 ~~shall be~~ **IS** reinstated or renewed ~~and the insured or the~~ **A**
 2 beneficiary or assignee of ~~such~~ **THE** policy ~~shall make~~ **MAKES** a
 3 written request to the insurer for a copy of ~~the~~ **ANY** application ~~and~~
 4 ~~if any, for such~~ reinstatement or renewal, the insurer shall,
 5 within 15 days after ~~the receipt of such~~ **RECEIVING THE** request at
 6 ~~its~~ **THE** home office or ~~any~~ **A** branch office of the insurer, deliver
 7 or mail to the person making ~~such~~ **THE** request ~~a copy of such~~ **THE**
 8 application. If ~~such~~ **THE** copy ~~shall~~ **IS** not ~~be so~~ delivered or
 9 mailed **AS REQUIRED BY THIS SUBSECTION**, the insurer ~~shall be~~ **IS**
 10 precluded from introducing ~~such~~ **THE** application as evidence in any
 11 **AN** action or proceeding based ~~upon~~ **ON** or involving ~~such~~ **THE** policy
 12 or ~~its~~ **THE** reinstatement or renewal.

13 Sec. 2236. (1) ~~A~~ **EXCEPT AS OTHERWISE PROVIDED IN THIS SECTION,**
 14 **AN INSURER SHALL NOT DELIVER OR ISSUE FOR DELIVERY IN THIS STATE A**
 15 basic insurance policy form or annuity contract form; ~~shall not be~~
 16 ~~issued or delivered to any person in this state, and an insurance~~
 17 ~~or annuity application form if a written application is required~~
 18 ~~and is to be made a part of the policy or contract, a printed rider~~
 19 or indorsement form or form of renewal certificate; ~~and~~ **OR** a
 20 group certificate in connection with the policy or contract ~~shall~~
 21 ~~not be issued or delivered to a person in this state, until~~ **UNLESS**
 22 a copy of the form is filed with the department ~~of insurance and~~
 23 ~~financial services and approved by the director of the department~~
 24 ~~of insurance and financial services as conforming with the~~
 25 requirements of this act and not inconsistent with the law. ~~Failure~~
 26 ~~of~~ **A FORM IS CONSIDERED APPROVED IF** the director ~~of the department~~
 27 ~~of insurance and financial services~~ **FAILS** to act within 30 days

1 after ITS submittal ~~constitutes approval. A form described in this~~
 2 ~~section, except a policy of disability insurance as defined UNDER~~
 3 **THIS SECTION. EXCEPT FOR DISABILITY INSURANCE AS DESCRIBED** in
 4 section 3400, ~~must be~~ **AN INSURER SHALL** plainly ~~printed~~ **PRINT THE**
 5 **FORM** with **A** type size **OF** not less than 8-point unless the director
 6 ~~of the department of insurance and financial services determines~~
 7 that portions of the form **THAT ARE** printed with type less than 8-
 8 point ~~is~~ **ARE** not deceptive or misleading.

9 (2) An insurer may satisfy its obligations to make form
 10 filings by becoming a member of, or a subscriber to, a rating
 11 organization licensed under section 2436 or 2630 that makes ~~these~~
 12 **THE** filings and by filing **THAT ARE REQUIRED UNDER THIS SECTION. AN**
 13 **INSURER DESCRIBED IN THIS SUBSECTION SHALL FILE** with the director
 14 ~~of the department of insurance and financial services a copy of its~~
 15 authorization of the rating organization to make the filings on its
 16 behalf. ~~Every~~ **EXCEPT AS OTHERWISE PROVIDED IN THIS SUBSECTION, AN**
 17 **INSURER THAT IS A** member of or subscriber to a rating organization
 18 shall adhere to the form filings made on its behalf by the
 19 organization. ~~except that an~~ **AN** insurer may file with the director
 20 ~~of the department of insurance and financial services a substitute~~
 21 form, ~~and thereafter~~ if a subsequent form filing by the rating
 22 organization **AFTER THE FILLING OF A SUBSTITUTE FORM** affects the use
 23 of the substitute form, the insurer shall review its use and notify
 24 the director ~~of the department of insurance and financial services~~
 25 whether to withdraw its substitute form.

26 (3) ~~Beginning January 1, 1992, the~~ **THE** director ~~of the~~
 27 ~~department of insurance and financial services shall not approve a~~

1 form filed under this section ~~providing~~ **THAT PROVIDES** for or
2 ~~relating~~ **RELATES** to an insurance policy or an annuity contract for
3 personal, family, or household purposes if the form fails to obtain
4 the following readability score or meet the other requirements of
5 this subsection, as applicable:

6 (a) The readability score must not be less than 45, as
7 determined by the method provided in subdivisions (b) and (c).

8 (b) The readability score ~~shall be~~ **IS** determined as follows:

9 (i) For a form containing not more than 10,000 words, the
10 entire form ~~shall~~ **MUST** be analyzed. For a form containing more than
11 10,000 words, not ~~less~~ **FEWER** than two 200-word samples per page
12 ~~shall~~ **MUST** be analyzed instead of the entire form. The samples must
13 be separated by at least 20 printed lines.

14 (ii) Count the number of words and sentences in the form or
15 samples and divide the total number of words by the total number of
16 sentences. Multiply this quotient by a factor of 1.015.

17 (iii) Count the total number of syllables in the form or
18 samples and divide the total number of syllables by the total
19 number of words. Multiply this quotient by a factor of 84.6. As
20 used in this subparagraph, "syllable" means a unit of spoken
21 language consisting of 1 or more letters of a word as indicated by
22 an accepted dictionary. If the dictionary shows 2 or more equally
23 acceptable pronunciations of a word, the pronunciation containing
24 fewer syllables may be used.

25 (iv) Add the figures obtained in subparagraphs (ii) and (iii)
26 and subtract this sum from 206.835. The figure obtained equals the
27 readability score for the form.

(c) For the purposes of subdivision (b) (ii) and (iii), the following procedures ~~shall~~**MUST** be used:

(i) A contraction, hyphenated word, or numbers and letters when separated by spaces ~~is~~**ARE** counted as 1 word.

(ii) A unit of words ending with a period, semicolon, or colon, but excluding headings and captions, is counted as 1 sentence.

(d) In determining the readability score, **ALL OF THE FOLLOWING APPLY TO** the method provided in subdivisions (b) and (c):

(i) ~~Shall~~**IT MUST** be applied to an insurance policy form or an annuity contract ~~,~~ together with a rider or indorsement form usually associated with the insurance policy form or annuity contract. **IT MAY BE APPLIED TO A GROUP OF POLICY, CONTRACT, RIDER, OR INDORSEMENT FORMS THAT HAVE SUBSTANTIALLY THE SAME LANGUAGE RESULTING IN A SINGLE READABILITY SCORE FOR THOSE FORMS.**

(ii) ~~Shall~~**IT MUST** not be applied to ~~words or phrases~~**A WORD OR PHRASE** that ~~are~~**IS** defined in an insurance policy form ~~,~~**OR** an annuity contract ~~,~~ or ~~rider, indorsements,~~**A RIDER, INDORSEMENT,** or group ~~certificates under an~~**CERTIFICATE ASSOCIATED WITH THE** insurance policy form or annuity contract.

(iii) ~~Shall~~**IT MUST** not be applied to language specifically agreed upon through collective bargaining or required by a collective bargaining agreement.

(iv) ~~Shall~~**IT MUST** not be applied to language that is prescribed by **OR BASED ON** state or federal statute or ~~by~~**ANY RELATED** rules, ~~or regulations, promulgated under a state or federal statute.~~**OR ORDERS.**

1 (v) IT MUST NOT BE APPLIED TO MEDICAL TERMS THAT ARE INCLUDED
2 IN THE FORM FOR COVERAGE PURPOSES.

3 (e) The form must contain both of the following:

4 (i) Topical captions.

5 (ii) An identification of exclusions.

6 (f) ~~Each~~ **EXCEPT AS OTHERWISE PROVIDED IN THIS SUBDIVISION, AN**
7 insurance policy ~~and~~ **OR** annuity contract that has more than 3,000
8 words printed on not more than 3 pages of text or that has more
9 than 3 pages of text regardless of the number of words must contain
10 a table of contents. This subdivision does not apply to **RIDERS OR**
11 indorsements.

12 (g) Each rider or indorsement form that changes coverage must
13 do all of the following:

14 (i) Contain a properly descriptive title.

15 (ii) Reproduce either the entire paragraph or the provision as
16 changed.

17 (iii) ~~Be~~ **AT THE TIME OF FILING, BE** accompanied by an
18 explanation of the change.

19 (h) If a computer system approved by the director ~~of the~~
20 ~~department of insurance and financial services~~ calculates the
21 readability score of a form as being in compliance with this
22 subsection, the form is considered in compliance with the
23 readability score requirements of this subsection.

24 (i) A variable life product or variable annuity product
25 approved by the United States ~~securities and exchange commission~~
26 **SECURITIES AND EXCHANGE COMMISSION** for sale in this state is
27 ~~compliant~~ **CONSIDERED IN COMPLIANCE** with this section.

1 (4) ~~After January 1, 1992, any~~ **AN INSURER SHALL SUBMIT FOR**
 2 **APPROVAL UNDER SUBSECTION (3) A** change or addition to a policy or
 3 annuity contract form for personal, family, or household purposes,
 4 whether by indorsement, rider, or otherwise, or a change or
 5 addition to a rider or indorsement form ~~to~~ **ASSOCIATED WITH** the
 6 policy **FORM** or annuity contract form, ~~which policy or annuity~~
 7 ~~contract~~ **IF THE** form has not been previously approved under
 8 subsection (3). ~~, shall be submitted for approval under subsection~~
 9 ~~(3).~~

10 (5) Upon written notice to the insurer, the director ~~of the~~
 11 ~~department of insurance and financial services may,~~ **ON A CASE-BY-**
 12 **CASE REVIEW,** disapprove, withdraw approval, or prohibit the
 13 issuance, advertising, or delivery of ~~any~~ **A** form to any person in
 14 this state if the form violates this act, contains inconsistent,
 15 ambiguous, or misleading clauses, or contains exceptions and
 16 conditions that unreasonably or deceptively affect the risk
 17 purported to be assumed in the general coverage of the policy. The
 18 **DIRECTOR SHALL SPECIFY IN THE** notice ~~must specify the objectionable~~
 19 provisions or conditions and state the reasons for the ~~director of~~
 20 ~~the department of insurance and financial services' decision.~~ If
 21 the form is legally in use by the insurer in this state, the ~~notice~~
 22 ~~must~~ **DIRECTOR SHALL** give the effective date of the ~~director of the~~
 23 ~~department of insurance and financial services' disapproval~~ **IN THE**
 24 **NOTICE,** which ~~shall~~ **MUST** not be less than 30 days after the mailing
 25 or delivery of the notice to the insurer. If the form is not
 26 legally in use, **THE** disapproval is effective immediately.

27 (6) If a form is disapproved or approval is withdrawn under

1 this act, the insurer is entitled ~~upon~~ **ON** demand to a hearing
 2 before the director ~~of the department of insurance and financial~~
 3 ~~services~~ or a deputy director ~~of the department of insurance and~~
 4 ~~financial services~~ within 30 days after the notice of disapproval
 5 or of withdrawal of approval. After the hearing, the director ~~of~~
 6 ~~the department of insurance and financial services~~ shall make
 7 findings of fact and law ~~and either~~ affirm, modify, or withdraw
 8 his or her original order or decision. **AN INSURER SHALL NOT ISSUE**
 9 **THE FORM AFTER A FINAL DETERMINATION OF DISAPPROVAL OR WITHDRAWAL**
 10 **OF APPROVAL.**

11 (7) Any issuance, use, or delivery by an insurer of ~~any~~ **A** form
 12 without the prior approval of the director ~~of the department of~~
 13 ~~insurance and financial services~~ as required by **UNDER** subsection
 14 (1) or after withdrawal of approval ~~as provided by~~ **UNDER** subsection
 15 (5) is a separate violation for which the director ~~of the~~
 16 ~~department of insurance and financial services~~ may order the
 17 imposition of a civil penalty of \$25.00 for each offense, ~~but not~~
 18 to exceed ~~the~~ **A** maximum penalty of \$500.00 for any 1 series of
 19 offenses relating to any 1 basic policy form. ~~which~~ **THE ATTORNEY**
 20 **GENERAL MAY ACT TO RECOVER THE** penalty ~~may be recovered by the~~
 21 ~~attorney general~~ **UNDER THIS SUBSECTION** as provided in section 230.

22 (8) The filing requirements of this section do not apply to
 23 any of the following:

24 (a) Insurance against loss of or damage to any of the
 25 following:

26 (i) Imports, exports, or domestic shipments.

27 (ii) Bridges, tunnels, or other instrumentalities of

1 transportation and communication.

2 (iii) Aircraft and attached equipment.

3 (iv) Vessels and watercraft **THAT ARE** under construction, ~~or~~
 4 **ARE** owned by or used in a business, or ~~having~~ **HAVE** a straight-line
 5 hull length of more than 24 feet.

6 (b) Insurance against loss resulting from liability, other
 7 than worker's **DISABILITY** compensation or employers' liability
 8 arising out of the ownership, maintenance, or use of any of the
 9 following:

10 (i) Imports, exports, or domestic shipments.

11 (ii) Aircraft and attached equipment.

12 (iii) Vessels and watercraft **THAT ARE** under construction, ~~or~~
 13 **ARE** owned by or used in a business, or ~~having~~ **HAVE** a straight-line
 14 hull length of more than 24 feet.

15 (c) Surety bonds other than fidelity bonds.

16 (d) Policies, riders, indorsements, or forms of unique
 17 character designed for and used with relation to insurance ~~upon~~ **ON**
 18 a particular subject, or that relate to the manner of distribution
 19 of benefits or to the reservation of rights and benefits under life
 20 or disability insurance policies and are used at the request of the
 21 individual policyholder, contract holder, or certificate holder.

22 ~~Beginning September 1, 1968, the director of the department of~~
 23 ~~insurance and financial services by~~ **BY** order, **THE DIRECTOR** may
 24 exempt from the filing requirements of this section and sections
 25 ~~2242, 3606, 3401A~~ and 4430 for ~~so~~ **AS** long as he or she considers
 26 proper any insurance document or form, except that portion of the
 27 document or form that establishes a relationship between group

1 disability insurance and personal protection insurance benefits
 2 subject to exclusions or deductibles under section 3109a, as
 3 specified in the order to which this section is not practicably
 4 applied, or the filing and approval of which are considered
 5 unnecessary for the protection of the public. Insurance documents
 6 or forms providing medical payments or income replacement benefits,
 7 except that portion of the document or form that establishes a
 8 relationship between group disability insurance and personal
 9 protection insurance benefits subject to exclusions or deductibles
 10 under section 3109a, exempt by order of the director ~~of the~~
 11 ~~department of insurance and financial services~~ from the filing
 12 requirements of this section and ~~sections 2242 and 3606~~ **SECTION**
 13 **3401A** are considered approved by the director ~~of the department of~~
 14 ~~insurance and financial services~~ for purposes of section 3430.

15 (e) ~~Insurance that meets~~ **AN INSURANCE POLICY TO WHICH** both of
 16 the following **APPLY**:

17 (i) ~~Is~~ **THE INSURANCE IS** sold to an exempt commercial
 18 policyholder.

19 (ii) ~~Contains~~ **THE INSURANCE POLICY CONTAINS** a prominent
 20 disclaimer that states "This policy is exempt from the filing
 21 requirements of section 2236 of the insurance code of 1956, 1956 PA
 22 218, MCL 500.2236." or words that are substantially similar.

23 (9) **NOTWITHSTANDING ANY PROVISION OF THIS ACT TO THE CONTRARY,**
 24 **A HEALTH INSURER MAY SATISFY A REQUIREMENT FOR THE DELIVERY OF AN**
 25 **INSURANCE FORM OR NOTICE REQUIRED BY THIS ACT TO A SUBSCRIBER,**
 26 **INSURED, ENROLLEE, OR CONTRACT HOLDER BY DOING ALL OF THE**
 27 **FOLLOWING:**

(A) TAKING APPROPRIATE AND NECESSARY MEASURES REASONABLY
CALCULATED TO ENSURE THAT THE SYSTEM FOR FURNISHING A FORM OR
NOTICE MEETS ALL OF THE FOLLOWING REQUIREMENTS:

(i) IT RESULTS IN THE ACTUAL RECEIPT OF A DELIVERED FORM OR
NOTICE.

(ii) IT PROTECTS THE CONFIDENTIALITY OF A SUBSCRIBER'S,
INSURED'S, ENROLLEE'S, OR CONTRACT HOLDER'S PERSONAL INFORMATION.

(B) ENSURING THAT AN ELECTRONICALLY DELIVERED FORM OR NOTICE
IS PREPARED AND FURNISHED IN A MANNER CONSISTENT WITH THE STYLE,
FORMAT, AND CONTENT REQUIREMENTS APPLICABLE TO THE PARTICULAR FORM
OR NOTICE.

(C) ON REQUEST, DELIVERING TO THE SUBSCRIBER, INSURED,
ENROLLEE, OR CONTRACT HOLDER A PAPER VERSION OF AN ELECTRONICALLY
DELIVERED FORM OR NOTICE.

(10) ~~(9)~~As used in this section and sections 2401 and 2601,
"exempt commercial policyholder" means an insured that purchases
the insurance for other than personal, family, or household
purposes.

(11) AS USED IN THIS SECTION, "INSURER" INCLUDES A NONPROFIT
DENTAL CARE CORPORATION OPERATING UNDER 1963 PA 125, MCL 550.351 TO
550.373.

(12) ~~(10)~~ Every ~~AN~~ order made by the director ~~of the~~
~~department of insurance and financial services under the provisions~~
~~of this~~ section is subject to court review as provided in section
244.

Sec. 2237. ~~No policy of~~ **AN INSURER SHALL NOT DELIVER IN THIS**
STATE AN insurance **POLICY** issued under ~~the provisions of chapters~~

1 ~~CHAPTER 34, and 36 of this act, to take effect after June 30, 1962,~~
 2 ~~shall contain any~~ **OR ISSUE THE POLICY FOR DELIVERY IN THIS STATE,**
 3 **IF THE POLICY CONTAINS A** provision restricting ~~THAT RESTRICTS~~ the
 4 liability of the insurer ~~with respect to~~ **PAY** expenses ~~, for which~~
 5 ~~payment would be legally required in the absence of insurance, on~~
 6 ~~the ground that such~~ **BECAUSE THE** expenses were ~~ARE~~ incurred while
 7 the person insured is in a hospital, institution, or other facility
 8 operated by ~~the~~ **THIS** state or a political subdivision thereof. ~~OF~~
 9 **THIS STATE IF THE INSURED WOULD BE LEGALLY REQUIRED TO PAY THE**
 10 **EXPENSES IN THE ABSENCE OF INSURANCE.**

11 Sec. 3400. (1) ~~The term "policy of disability insurance" as~~ **AS**
 12 used in this chapter, **"DISABILITY INSURANCE POLICY"** includes ~~any~~ **AN**
 13 **INSURANCE** policy or **INSURANCE** contract ~~of insurance~~ **THAT INSURES**
 14 against loss resulting from sickness or from bodily injury or death
 15 by accident, or both, including also the granting of specific
 16 hospital benefits and medical, surgical, and sick-care benefits to
 17 ~~any person,~~ **AN INDIVIDUAL,** family, or group, subject to the
 18 exclusions ~~set forth or referred to in~~ **PROVIDED IN** this section.

19 (2) ~~Nothing in this~~ **THIS** chapter ~~shall~~ **DOES NOT** apply to or
 20 affect **ANY OF THE FOLLOWING:**

21 (a) ~~Any policy of~~ **A** liability or ~~workmen's~~ **WORKER'S DISABILITY**
 22 compensation insurance **POLICY,** ~~with or without~~ **REGARDLESS OF**
 23 **WHETHER** supplementary expense coverage ~~therein,~~ **IS INCLUDED.**

24 (b) ~~Any policy or contract of~~ **A** reinsurance ~~, or~~ **POLICY OR**
 25 **CONTRACT.**

26 (c) Life insurance, endowment, or annuity contracts, or
 27 contracts supplemental ~~thereto which~~ **TO LIFE INSURANCE, ENDOWMENT,**

OR ANNUITY CONTRACTS, THAT ONLY contain ~~only such provisions~~
relating to disability insurance as ~~(i) provide~~ **THAT DO ANY OF THE**
FOLLOWING:

(i) **PROVIDE** additional benefits in case of death or
dismemberment or loss of sight by accident. ~~, or as (ii) operate~~

(ii) **OPERATE** to safeguard ~~such THE~~ contracts against lapse ~~,~~
or to give a special surrender value, ~~or special benefit, or an~~
annuity in the event that the insured or annuitant ~~shall become~~
BECOMES totally and permanently disabled, as defined by the
contract or supplemental contract. ~~, all of which A~~ supplemental
~~contracts shall be issuable~~ **CONTRACT DESCRIBED IN THIS SUBPARAGRAPH**
MUST BE ISSUED under **THE** authority of section 602.

(3) ~~The AN INSURER MAY OMIT THE~~ provisions of ~~this chapter~~
~~contained in REQUIRED UNDER~~ sections 3407, ~~(entire contract,~~
~~changes), 3411, (reinstatement), and 3420 (physical examinations~~
~~and autopsy), may be omitted from~~ ticket policies sold only to
passengers by common carriers.

(4) Section 3475 ~~of this chapter shall apply~~ **APPLIES** to group,
blanket, or family expense disability insurance contracts and the
remaining provisions of this chapter ~~shall apply to such~~ **GROUP,**
BLANKET, OR FAMILY EXPENSE DISABILITY INSURANCE contracts only as
provided in **THIS** chapter. ~~36-~~

SEC. 3401A. (1) AN INSURER AUTHORIZED TO WRITE DISABILITY
INSURANCE IN THIS STATE MAY ISSUE GROUP DISABILITY INSURANCE
POLICIES.

(2) **EXCEPT AS OTHERWISE PROVIDED IN SECTION 2236(8)(D), AN**
INSURER SHALL NOT DELIVER OR ISSUE FOR DELIVERY IN THIS STATE A

1 GROUP DISABILITY INSURANCE POLICY UNLESS A COPY OF THE FORM HAS
2 BEEN FILED WITH AND APPROVED BY THE DIRECTOR.

3 Sec. 3402. ~~No policy of~~ **AN INSURER SHALL NOT DELIVER OR ISSUE**
4 **FOR DELIVERY IN THIS STATE A** disability insurance ~~, as defined in~~
5 ~~section 3400 (1), shall be delivered or issued for delivery to any~~
6 ~~person in this state~~ **POLICY FOR AN INDIVIDUAL OR FAMILY unless ALL**
7 **OF THE FOLLOWING REQUIREMENTS ARE MET:**

8 (A) ~~(1) The entire money and other considerations therefor~~ **FOR**
9 **THE POLICY** are expressed therein; ~~and~~ **IN THE POLICY.**

10 (B) ~~(2) The time at which the insurance takes effect and~~
11 ~~terminates is expressed therein; and~~ **IN THE POLICY.**

12 (C) ~~(3) It purports to insure~~ **EXCEPT AS OTHERWISE PROVIDED IN**
13 **THIS SUBDIVISION, only 1 person, except that a INDIVIDUAL IS**
14 **INSURED UNDER THE POLICY. A DISABILITY INSURANCE** policy may insure,
15 originally or by subsequent amendment, upon the application of an
16 adult member of a family who ~~shall be deemed~~ **IS** the policyholder,
17 any 2 or more eligible members of that family, including husband,
18 wife, dependent children or any children under a specified age,
19 ~~which shall not exceed 19 years and any other person~~ **INDIVIDUAL**
20 **dependent upon the policyholder. + and** **THE AGE SPECIFIED IN A POLICY**
21 **UNDER THIS SUBDIVISION MUST NOT EXCEED 19 YEARS OR, IF THE POLICY**
22 **IS A HEALTH INSURANCE POLICY, 26 YEARS.**

23 ~~— (4) The style, arrangement and over all appearance of the~~
24 ~~policy give no undue prominence to any portion of the text, and~~
25 ~~unless every printed portion of the text of the policy and of any~~
26 ~~endorsements or attached papers is plainly printed in light faced~~
27 ~~type of a style in general use, the size of which shall be uniform~~

~~and not less than 10 point with a lower case unspaced alphabet length, not less than 120 point in length of line (the "text" shall include all printed matter except the name and address of the insurer, name or title of the policy, the brief description, if any, and captions and subcaptions); and~~

~~—— (5) The exceptions and reductions of indemnity are set forth in the policy and, except those which are set forth in sections 3406 through 3454, are printed, at the insurer's option, either included with the benefit provision to which they apply, or under an appropriate caption such as "EXCEPTIONS", or "EXCEPTIONS AND REDUCTIONS": Provided, That if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of such exception or reduction shall be included with the benefit provision to which it applies; and~~

~~—— (6) Each such form, including riders and endorsements, shall be identified by a form number in the lower left hand corner of the first page thereof; and~~

~~—— (7) It contains no provision purporting to make any portion of the charter, rules, constitution or bylaws of the insurer a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates or classification of risks, or short rate table filed with the commissioner.~~

SEC. 3402A. AN INSURER SHALL INCLUDE ALL OF THE FOLLOWING PROVISIONS IN A GROUP DISABILITY INSURANCE POLICY:

(A) THAT THE POLICY, APPLICATION OF THE EMPLOYER OR OF AN EXECUTIVE OFFICER OR TRUSTEE OF AN ASSOCIATION, AND THE INDIVIDUAL

1 APPLICATIONS, IF ANY, OF THE EMPLOYEES OR MEMBERS INSURED,
2 CONSTITUTE THE ENTIRE CONTRACT BETWEEN THE PARTIES. THE INSURER'S
3 IDENTIFICATION OF WHAT CONSTITUTES THE ENTIRE CONTRACT CREATES A
4 REBUTTABLE PRESUMPTION THAT THE IDENTIFIED ITEMS ARE THE ENTIRE
5 CONTRACT.

6 (B) THAT A STATEMENT MADE BY THE EMPLOYER, THE EXECUTIVE
7 OFFICER OR TRUSTEE OF AN ASSOCIATION, OR AN INDIVIDUAL EMPLOYEE OR
8 MEMBER, IN THE ABSENCE OF FRAUD, IS A REPRESENTATION AND NOT A
9 WARRANTY. AN INSURER SHALL NOT USE A STATEMENT MADE BY THE
10 EMPLOYER, THE EXECUTIVE OFFICER OR TRUSTEE OF AN ASSOCIATION, OR AN
11 INDIVIDUAL EMPLOYEE OR MEMBER AS A DEFENSE TO A CLAIM UNDER THE
12 POLICY, UNLESS THE STATEMENT IS CONTAINED IN A WRITTEN APPLICATION.

13 (C) THAT THE INSURER WILL ISSUE TO THE EMPLOYER OR THE
14 EXECUTIVE OFFICER OR TRUSTEE OF AN ASSOCIATION, FOR DELIVERY TO AN
15 EMPLOYEE OR MEMBER WHO IS INSURED UNDER THE POLICY, AN INDIVIDUAL
16 CERTIFICATE THAT STATES THE INSURANCE PROTECTION TO WHICH THE
17 EMPLOYEE OR MEMBER IS ENTITLED AND TO WHOM BENEFITS ARE PAYABLE.

18 (D) THAT NEW EMPLOYEES OR MEMBERS, AS APPLICABLE, WHO ARE
19 ELIGIBLE AND WHO APPLY WILL BE ADDED TO THE GROUP OR CLASS
20 ORIGINALLY INSURED.

21 SEC. 3402B. (1) SUBJECT TO THE COORDINATION OF BENEFITS ACT,
22 1984 PA 64, MCL 550.251 TO 550.255, AN INSURER MAY INCLUDE IN A
23 GROUP OR NONGROUP DISABILITY INSURANCE POLICY A PROVISION FOR THE
24 COORDINATION OF BENEFITS OTHERWISE PAYABLE UNDER THE POLICY WITH
25 BENEFITS PAYABLE FOR THE SAME LOSS UNDER OTHER GROUP OR NONGROUP
26 DISABILITY INSURANCE. AN INSURER THAT DOES NOT INCLUDE IN A GROUP
27 OR NONGROUP DISABILITY INSURANCE POLICY A PROVISION FOR THE

1 COORDINATION OF BENEFITS AS DESCRIBED IN THIS SUBSECTION SHALL
2 COORDINATE BENEFITS UNDER THE POLICY IN THE MANNER PRESCRIBED IN
3 THE COORDINATION OF BENEFITS ACT, 1984 PA 64, MCL 550.251 TO
4 550.255.

5 (2) SUBJECT TO SUBSECTION (1), AN INSURER MAY INCLUDE A
6 PROVISION IN A GROUP OR NONGROUP DISABILITY INSURANCE POLICY THAT
7 BENEFITS PAYABLE BY THE POLICY MAY BE LIMITED IF THERE IS OTHER
8 VALID COVERAGE WITH ANOTHER INSURER THAT PROVIDES BENEFITS FOR THE
9 SAME LOSS ON AN EXPENSE-INCURRED BASIS. THE INSURER MAY PROVIDE
10 THAT IF IT IS NOT GIVEN WRITTEN NOTICE ON THE APPLICATION FOR
11 COVERAGE THAT THE OTHER VALID COVERAGE EXISTS, OR IF OTHER COVERAGE
12 IS ACQUIRED AFTER THE EFFECTIVE DATE OF THE COVERAGE, THE ONLY
13 LIABILITY UNDER ANY EXPENSE-INCURRED COVERAGE OF THE POLICY IS THE
14 AMOUNT OF THE COVERED CLAIM THAT EXCEEDS THE BENEFITS PAYABLE BY
15 THE OTHER COVERAGE. AN INSURER SHALL APPLY BENEFITS PAID OR PAYABLE
16 BY THE PRIMARY INSURER TO SATISFY ANY DEDUCTIBLES, COINSURANCE, AND
17 COPAYMENTS WITH THE POLICY. AN INSURER SHALL NOT APPLY PAYMENTS
18 MADE BY A PRIMARY INSURER TO REDUCE THE POLICY MAXIMUM LIMITS ON
19 THE POLICY. AS USED IN THIS SUBSECTION, "OTHER COVERAGE" INCLUDES A
20 PLAN THAT PROVIDES COVERAGE UNDER A HEALTH INSURANCE POLICY,
21 HOSPITAL OR MEDICAL SERVICE SUBSCRIBER CONTRACT, MEDICAL PRACTICE
22 OR OTHER PREPAYMENT PLAN, OR OTHER EXPENSE-INCURRED PLAN OR
23 PROGRAM. OTHER COVERAGE DOES NOT INCLUDE MEDICAID, HOSPITAL DAILY
24 INDEMNITY PLANS, SPECIFIED DISEASE ONLY POLICIES, OR LIMITED
25 OCCURRENCE POLICIES THAT PROVIDE ONLY FOR INTENSIVE CARE OR
26 CORONARY CARE AT A HOSPITAL, FIRST AID OUTPATIENT MEDICAL EXPENSES
27 RESULTING FROM ACCIDENTS, OR SPECIFIED ACCIDENTS SUCH AS TRAVEL

1 ACCIDENTS.

2 (3) IF THERE ARE MORE THAN 1 GROUP OR NONGROUP DISABILITY
3 INSURANCE POLICIES THAT COVER THE SAME LOSS AND CONTAIN A PROVISION
4 DESCRIBED IN SUBSECTION (2), AND THE INSURERS EACH PAY A SHARE OF
5 THE COVERED EXPENSES FOR THE CLAIM, NEITHER INSURER IS REQUIRED TO
6 PAY MORE THAN IT WOULD HAVE PAID HAD IT BEEN THE PRIMARY INSURER.

7 SEC. 3402C. (1) FOR PURPOSES OF THIS CHAPTER, FAMILY EXPENSE
8 INSURANCE IS ACCIDENT AND HEALTH INSURANCE THAT IS WRITTEN UNDER 1
9 POLICY ISSUED TO THE HEAD OF A FAMILY WHO MAY BE EITHER SPOUSE AND
10 THAT INSURES THE HEAD OF THE FAMILY AND 1 OR MORE DEPENDENTS,
11 INCLUDING A NONDEPENDENT SPOUSE. BENEFITS UNDER A FAMILY EXPENSE
12 INSURANCE POLICY, EXCEPT AS APPLIED TO THE HEAD OF THE FAMILY, DO
13 NOT INCLUDE INDEMNIFICATION FOR LOSS OF TIME FROM ANY CAUSE.

14 (2) AN INSURER AUTHORIZED TO WRITE ACCIDENT AND HEALTH
15 INSURANCE IN THIS STATE MAY ISSUE FAMILY EXPENSE INSURANCE
16 POLICIES.

17 (3) AN INSURER SHALL NOT DELIVER OR ISSUE FOR DELIVERY IN THIS
18 STATE A FAMILY EXPENSE INSURANCE POLICY UNLESS A COPY OF THE FORM
19 OF THE POLICY IS FILED WITH AND APPROVED BY THE DIRECTOR.

20 (4) AN INSURER SHALL INCLUDE IN A FAMILY EXPENSE INSURANCE
21 POLICY THE APPLICABLE PROVISIONS OF SECTIONS 3406 TO 3466 AND ALL
22 OF THE FOLLOWING PROVISIONS:

23 (A) THAT THE POLICY AND THE APPLICATION SIGNED BY THE
24 INDIVIDUAL ACTING AS THE HEAD OF THE FAMILY FOR THE PURPOSE OF
25 FAMILY EXPENSE INSURANCE CONSTITUTE THE ENTIRE CONTRACT BETWEEN THE
26 PARTIES. THE INSURER'S IDENTIFICATION OF WHAT CONSTITUTES THE
27 ENTIRE CONTRACT CREATES A REBUTTABLE PRESUMPTION THAT THE

1 IDENTIFIED ITEMS ARE THE ENTIRE CONTRACT.

2 (B) THAT A STATEMENT MADE BY THE HEAD OF THE FAMILY, IN THE
3 ABSENCE OF FRAUD, IS A REPRESENTATION AND NOT A WARRANTY. AN
4 INSURER SHALL NOT USE A STATEMENT MADE BY THE HEAD OF THE FAMILY AS
5 A DEFENSE TO A CLAIM UNDER THE POLICY, UNLESS THE STATEMENT IS
6 CONTAINED IN A WRITTEN APPLICATION.

7 (C) THAT NEW MEMBERS OF THE FAMILY WHO ARE ELIGIBLE, ON
8 APPLICATION OF THE HEAD OF THE FAMILY, WILL BE ADDED TO THE FAMILY
9 GROUP ORIGINALLY INSURED.

10 (5) A FAMILY EXPENSE INSURANCE POLICY IS SUBJECT TO SECTIONS
11 3474 AND 3474A.

12 SEC. 3402D. (1) FOR PURPOSES OF THIS CHAPTER, BLANKET
13 DISABILITY INSURANCE IS DISABILITY INSURANCE THAT COVERS SPECIAL
14 GROUPS OF INDIVIDUALS, AS FOLLOWS:

15 (A) A POLICY ISSUED TO A COMMON CARRIER AS THE POLICYHOLDER
16 AND THAT COVERS A GROUP DEFINED AS ALL INDIVIDUALS WHO ARE
17 PASSENGERS OF THE COMMON CARRIER.

18 (B) A POLICY ISSUED TO AN EMPLOYER AS THE POLICYHOLDER AND
19 THAT COVERS ALL EMPLOYEES OR ANY GROUP OF EMPLOYEES DEFINED BY
20 REFERENCE TO EXCEPTIONAL HAZARDS INCIDENTAL TO THE EMPLOYMENT.

21 (C) A POLICY ISSUED TO A UNIVERSITY, COLLEGE, SCHOOL, OR OTHER
22 EDUCATIONAL INSTITUTION, OR TO THE HEAD OR PRINCIPAL OF THE
23 UNIVERSITY, COLLEGE, SCHOOL, OR INSTITUTION AS THE POLICYHOLDER,
24 THAT COVERS STUDENTS OR TEACHERS.

25 (D) A POLICY ISSUED TO A VOLUNTEER FIRE DEPARTMENT, FIRST AID
26 GROUP, OR OTHER VOLUNTEER GROUP AS THE POLICYHOLDER THAT COVERS ALL
27 OF THE MEMBERS OF THE DEPARTMENT OR GROUP.

1 (E) A POLICY ISSUED TO A CREDITOR AS THE POLICYHOLDER THAT
2 INSURES DEBTORS OF THE CREDITOR.

3 (F) A POLICY ISSUED TO A SPORTS TEAM OR CAMP AS THE
4 POLICYHOLDER THAT COVERS MEMBERS OR CAMPERS.

5 (2) IN THE DISCRETION OF THE DIRECTOR, BLANKET DISABILITY
6 INSURANCE MAY BE ISSUED TO ANY OTHER SPECIAL GROUP OF INDIVIDUALS
7 THAT IS SUBSTANTIALLY SIMILAR TO A GROUP DESCRIBED IN SUBSECTION
8 (1).

9 SEC. 3402E. (1) AN INSURER AUTHORIZED TO WRITE DISABILITY
10 INSURANCE IN THIS STATE MAY ISSUE BLANKET DISABILITY INSURANCE
11 POLICIES.

12 (2) AN INSURER SHALL NOT DELIVER OR ISSUE FOR DELIVERY IN THIS
13 STATE A BLANKET DISABILITY INSURANCE POLICY UNLESS A COPY OF THE
14 FORM OF THE POLICY IS FILED WITH AND APPROVED BY THE DIRECTOR.

15 (3) A BLANKET DISABILITY INSURANCE POLICY IS SUBJECT TO
16 SECTIONS 3474 AND 3474A.

17 SEC. 3402F. AN INSURER SHALL INCLUDE IN A BLANKET DISABILITY
18 INSURANCE POLICY THE APPLICABLE PROVISIONS OF SECTIONS 3406 TO 3466
19 AND ALL OF THE FOLLOWING PROVISIONS:

20 (A) THAT THE POLICY AND THE APPLICATION SIGNED BY THE
21 POLICYHOLDER CONSTITUTE THE ENTIRE CONTRACT BETWEEN THE PARTIES.
22 THE INSURER'S IDENTIFICATION OF WHAT CONSTITUTES THE ENTIRE
23 CONTRACT CREATES A REBUTTABLE PRESUMPTION THAT THE IDENTIFIED ITEMS
24 ARE THE ENTIRE CONTRACT.

25 (B) THAT A STATEMENT MADE BY THE POLICYHOLDER, IN THE ABSENCE
26 OF FRAUD, IS A REPRESENTATION AND NOT A WARRANTY. AN INSURER SHALL
27 NOT USE A STATEMENT MADE BY THE POLICYHOLDER AS A DEFENSE TO A

1 CLAIM UNDER THE POLICY, UNLESS THE STATEMENT IS CONTAINED IN A
2 WRITTEN APPLICATION.

3 (C) THAT INDIVIDUALS WHO ARE ELIGIBLE FOR COVERAGE, ON
4 APPLICATION OF THE POLICYHOLDER, WILL BE ADDED TO THE GROUP OR
5 CLASS ORIGINALLY INSURED.

6 SEC. 3402G. (1) AN INSURER SHALL NOT REQUIRE AN INDIVIDUAL
7 APPLICATION FROM AN INDIVIDUAL COVERED UNDER A BLANKET DISABILITY
8 INSURANCE POLICY. THE DIRECTOR MAY REQUIRE THE INSURER TO FURNISH A
9 CERTIFICATE TO EACH INDIVIDUAL INSURED UNDER A BLANKET DISABILITY
10 POLICY.

11 (2) EXCEPT AS OTHERWISE PROVIDED IN THIS SUBSECTION, AN
12 INSURER SHALL PAY BENEFITS UNDER A BLANKET DISABILITY INSURANCE
13 POLICY TO THE INSURED OR TO THE INSURED'S DESIGNATED BENEFICIARY OR
14 ESTATE. IF THE INSURED IS A MINOR OR DEVELOPMENTALLY DISABLED, AN
15 INSURER MAY PAY BENEFITS UNDER A BLANKET DISABILITY INSURANCE
16 POLICY TO THE INSURED'S PARENT, GUARDIAN, OR OTHER PERSON TO WHICH
17 THE INSURED IS A DEPENDENT. AN INSURER MAY PROVIDE IN A BLANKET
18 DISABILITY INSURANCE POLICY THAT, WITH THE CONSENT OF THE INSURED,
19 THE BENEFITS MAY BE PAID DIRECTLY TO A PERSON THAT LEGALLY
20 FURNISHES HOSPITAL, MEDICAL, SURGICAL, OR SICK-CARE SERVICES TO THE
21 INSURED, WITHIN THE LIMITS UNDER THE POLICY AND WITHOUT OTHER
22 PREFERENCE AS TO CREDITORS.

23 SEC. 3402H. SECTIONS 3402D TO 3402G DO NOT AFFECT THE LEGAL
24 LIABILITY OF A POLICYHOLDER FOR THE DEATH OF OR INJURY TO AN
25 EMPLOYEE, MEMBER, OR OTHER INDIVIDUAL INSURED UNDER THE BLANKET
26 DISABILITY INSURANCE POLICY.

27 Sec. 3403. (1) ~~Individual disability insurance policies~~

1 ~~providing~~ AN INSURER THAT DELIVERS, ISSUES FOR DELIVERY, OR RENEWS
 2 IN THIS STATE A HEALTH INSURANCE POLICY THAT OFFERS DEPENDENT
 3 coverage ~~on an expense incurred basis which provide coverage for a~~
 4 ~~family member of the insured shall, as to that family member's~~
 5 ~~coverage, also provide that~~ SHALL INCLUDE BOTH OF THE FOLLOWING
 6 PROVISIONS IN THE POLICY:

7 (A) THAT ~~the disability~~ HEALTH insurance benefits applicable
 8 for children ~~shall be~~ ARE payable with respect to a newly born
 9 child of the insured from the moment of birth.

10 (B) ~~(2) The~~ THAT THE coverage for newly born children ~~shall~~
 11 ~~consist~~ CONSISTS of coverage of injury or sickness including the
 12 necessary care and treatment of medically diagnosed congenital
 13 defects and birth abnormalities.

14 (2) ~~(3)~~ If payment of a specific premium is required to
 15 provide coverage for a child UNDER A HEALTH INSURANCE POLICY, AN
 16 INSURER MAY INCLUDE A PROVISION IN the policy ~~may require that~~
 17 ~~notification~~ THAT REQUIRES THE INSURED TO NOTIFY THE INSURER of THE
 18 birth of a newly born child and ~~payment of~~ PAY the required premium
 19 ~~shall be furnished to the insurer within 31 days after the date of~~
 20 birth in order to have the coverage continue beyond the 31-day
 21 period.

22 (3) AN INSURER THAT DELIVERS, ISSUES FOR DELIVERY, OR RENEWS
 23 IN THIS STATE A HEALTH INSURANCE POLICY THAT OFFERS DEPENDENT
 24 COVERAGE SHALL NOT DENY ENROLLMENT TO AN INSURED'S CHILD ON ANY OF
 25 THE FOLLOWING GROUNDS:

26 (A) THE CHILD WAS BORN OUT OF WEDLOCK.

27 (B) THE CHILD IS NOT CLAIMED AS A DEPENDENT ON THE INSURED'S

1 **FEDERAL INCOME TAX RETURN.**

2 (C) **THE CHILD DOES NOT RESIDE WITH THE INSURED OR IN THE**
 3 **INSURER'S SERVICE AREA.**

4 Sec. 3404. ~~If any~~ **THE DIRECTOR MAY REQUIRE THAT A** policy is
 5 issued by an insurer domiciled in this state for delivery to a
 6 person residing in another state ~~, and~~ **MEET THE STANDARDS**
 7 **PRESCRIBED IN SECTIONS 2212A, 3402, AND 3406 TO 3466** if the
 8 official ~~having responsibility~~ **THAT IS RESPONSIBLE** for the
 9 administration of the insurance laws of ~~such~~ **THE** other state ~~shall~~
 10 ~~have advised~~ **ADVISES** the ~~commissioner~~ **DIRECTOR** that any ~~such~~ **THE**
 11 policy is not subject to approval or disapproval by ~~such~~ **THE**
 12 official. ~~, the commissioner may by ruling require that such policy~~
 13 ~~meet the standards set forth in section 3402 and in sections 3406~~
 14 ~~through 3466.~~

15 Sec. 3405. (1) For the purpose of doing business as an
 16 organization under the prudent purchaser act, 1984 PA 233, MCL
 17 550.51 to 550.63, an insurer authorized in this state to write
 18 ~~disability~~ **HEALTH** insurance ~~that provides coverage for hospital,~~
 19 ~~nursing, medical, surgical, or sick care benefits~~ may enter into
 20 prudent purchaser agreements with providers of hospital, nursing,
 21 medical, surgical, or sick-care services pursuant to this section
 22 and the prudent purchaser act, 1984 PA 233, MCL 550.51 to 550.63.

23 (2) An insurer may offer ~~disability~~ **HEALTH** insurance policies
 24 under which the insured persons shall be required, as a condition
 25 of coverage, to obtain ~~hospital, nursing, medical, surgical, or~~
 26 ~~sick care~~ **HEALTH CARE** services exclusively from health care
 27 providers who have entered into prudent purchaser agreements. A

~~person to whom a policy described in this subsection is offered shall also be offered a policy that does not do any of the following:~~

~~—— (a) As a condition of coverage, require insured persons to obtain services exclusively from health care providers who have entered into prudent purchaser agreements.~~

~~—— (b) Give a financial advantage or other advantage to an insured person who elects to obtain services from health care providers who have entered into prudent purchaser agreements.~~

(3) An insurer may offer ~~disability~~ **HEALTH** insurance policies under which insured persons who elect to obtain ~~hospital, nursing, medical, surgical, or sick-care~~ **HEALTH CARE** services from health care providers who have entered into prudent purchaser agreements realize a financial advantage or other advantage by selecting providers who have entered into prudent purchaser agreements. Policies offered under this subsection shall not, as a condition of coverage, require insured persons to obtain hospital, nursing, medical, surgical, or sick-care services exclusively from health care providers who have entered into prudent purchaser agreements. ~~A person to whom a policy described in this subsection is offered shall also be offered a policy that does not do any of the following:~~

~~—— (a) As a condition of coverage, require insured persons to obtain services exclusively from health care providers who have entered into prudent purchaser agreements.~~

~~—— (b) Give a financial advantage or other advantage to an insured person who elects to obtain services from health care~~

~~providers who have entered into prudent purchaser agreements.~~

(4) An insurer shall not charge rates for coverage under policies issued under this section that are unreasonably lower than what is necessary to meet the expenses of the insurer for providing ~~this~~ **THE** coverage ~~and~~ **OR** that have an anticompetitive effect or result in predatory pricing in relation to prudent purchaser agreement coverages offered by other organizations.

(5) An insurer shall not discriminate against a class of health care providers when entering into prudent purchaser agreements with health care providers for its provider panel. This subsection does not do any of the following:

(a) Prohibit the formation of a provider panel consisting of a single class of providers if a service provided for in the specifications of a purchaser may legally be provided only by a single class of providers.

(b) Prohibit the formation of a provider panel that conforms to the specifications of a purchaser of the coverage authorized by this section if the specifications do not exclude any class of health care providers who may legally perform the services included in the coverage.

(c) Require an organization that has uniformly applied the standards filed under section 3(3) of the prudent purchaser act, 1984 PA 233, MCL 550.53, to contract with any individual provider.

~~—— (6) Nothing in 1984 PA 280 applies to any contract that is in existence before December 20, 1984, or the renewal of that contract.~~

~~(6) (7)~~ Notwithstanding any ~~other~~ provision of this act **TO THE**

1 **CONTRARY**, if coverage under a prudent purchaser agreement provides
2 for benefits for services that are within the scope of practice of
3 optometry, an insurer is not required to provide coverage or
4 reimburse for a practice of optometry service unless that service
5 was included in the definition of practice of optometry under
6 section 17401 of the public health code, 1978 PA 368, MCL
7 333.17401, as of May 20, 1992.

8 (7) ~~(8)~~ Notwithstanding any ~~other~~ provision of this act **TO THE**
9 **CONTRARY**, if coverage under a prudent purchaser agreement provides
10 for benefits for services that are within the scope of practice of
11 chiropractic, an insurer is not required to provide coverage or
12 reimburse for a practice of chiropractic service unless that
13 service was included in the definition of practice of chiropractic
14 under section 16401 of the public health code, 1978 PA 368, MCL
15 333.16401, as of January 1, 2009.

16 (8) ~~(9)~~ Notwithstanding any ~~other~~ provision of this act **TO THE**
17 **CONTRARY**, if coverage under a prudent purchaser agreement provides
18 for benefits for services that are provided by a licensed physical
19 therapist or physical therapist assistant under the supervision of
20 a licensed physical therapist, an insurer is not required to
21 provide coverage or reimburse for services provided by a physical
22 therapist or a physical therapist assistant unless that service was
23 provided by a licensed physical therapist or physical therapist
24 assistant under the supervision of a licensed physical therapist
25 pursuant to a prescription from a health care professional who
26 holds a license issued under part 166, 170, 175, or 180 of the
27 public health code, 1978 PA 368, MCL 333.16601 to 333.16648,

1 333.17001 to 333.17084, 333.17501 to 333.17556, and 333.18001 to
2 333.18058, or the equivalent license issued by another state.

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

6 (2) Subject to subsection (3), beginning February 1, 2013, an
7 insurer or a health maintenance organization shall not use a most
8 favored nation clause in any provider contract, including a
9 provider contract in effect on February 1, 2013, unless the most

10 favored nation clause has been filed with and approved by the
11 ~~commissioner.~~ **DIRECTOR.** Subject to subsection (3), beginning
12 February 1, 2013, an insurer or a health maintenance organization
13 shall not enforce a most favored nation clause in any provider
14 contract without the prior approval of the ~~commissioner.~~ **DIRECTOR.**

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

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

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

26 (b) Requires, or grants a contracting insurer or health
27 maintenance organization an option to require, a provider to accept

1 a lower payment or reimbursement rate if the provider agrees to
 2 provide health care services to any other party at a lower rate
 3 than the payment or reimbursement rate specified in the contract
 4 with the insurer or health maintenance organization.

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

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

15 (5) AS USED IN THIS SECTION, AFTER JANUARY 1, 2016, "INSURER"
 16 INCLUDES A NONPROFIT DENTAL CARE CORPORATION OPERATING UNDER 1963
 17 PA 125, MCL 550.351 TO 550.373.

18 Sec. 3406a. ~~A hospital, medical or surgical expense incurred~~
 19 **AN INSURER THAT DELIVERS, ISSUES FOR DELIVERY, OR RENEWS IN THIS**
 20 **STATE A HEALTH INSURANCE** policy shall offer benefits for prosthetic
 21 devices to maintain or replace the body parts of an individual who
 22 has undergone a mastectomy. This coverage ~~shall~~ **MUST** provide that
 23 reasonable charges for medical care and attendance for an
 24 individual who receives reconstructive surgery following a
 25 mastectomy or who is fitted with a prosthetic device ~~shall be~~ **ARE**
 26 covered benefits after the individual's attending physician has
 27 certified the medical necessity or desirability of a proposed

1 course of rehabilitative treatment. The cost and fitting of a
 2 prosthetic device following a mastectomy is included within the
 3 type of coverage ~~intended by~~ **REQUIRED UNDER** this section.

4 Sec. 3406c. (1) An insurer that delivers, issues for delivery,
 5 or renews in this state ~~an expense incurred hospital, medical, or~~
 6 ~~surgical~~ **A HEALTH INSURANCE** policy that provides coverage for
 7 inpatient hospital care shall offer to include coverage for hospice
 8 care. As used in this section, "hospice" means ~~hospice as defined~~
 9 ~~in section 20106 of the public health code, Act No. 368 of the~~
 10 ~~Public Acts of 1978, being section 333.20106 of the Michigan~~
 11 ~~Compiled Laws.~~ **A HEALTH CARE PROGRAM THAT PROVIDES A COORDINATED SET**
 12 **OF SERVICES RENDERED AT HOME OR IN OUTPATIENT OR INSTITUTIONAL**
 13 **SETTINGS FOR INDIVIDUALS SUFFERING FROM A DISEASE OR CONDITION WITH**
 14 **A TERMINAL PROGNOSIS.**

15 (2) If hospice care coverage is provided, **AN INSURER SHALL**
 16 **INCLUDE** a description of the hospice coverage ~~shall be included in~~
 17 communications sent to the insured.

18 Sec. 3406d. (1) Subject to dollar limits, deductibles, and
 19 coinsurance provisions that are not less favorable than those for
 20 physical illness generally, an insurer ~~which~~ **THAT** delivers, issues
 21 for delivery, or renews in this state a ~~hospital, medical, or~~
 22 ~~surgical expense incurred~~ **HEALTH INSURANCE** policy shall offer or
 23 include coverage for breast cancer diagnostic services, breast
 24 cancer outpatient treatment services, and breast cancer
 25 rehabilitative services.

26 (2) Subject to dollar limits, deductibles, and coinsurance
 27 provisions that are not less favorable than those for physical

1 illness generally, an insurer ~~which~~ **THAT** delivers, issues for
2 delivery, or renews in this state a ~~hospital, medical, or surgical~~
3 ~~expense incurred~~ **HEALTH INSURANCE** policy shall offer or include the
4 following coverage for breast cancer screening mammography:

5 (a) If performed on a woman 35 years of age or older and under
6 40 years of age, coverage for 1 screening mammography examination
7 during that 5-year period.

8 (b) If performed on a woman 40 years of age or older, coverage
9 for 1 screening mammography examination every calendar year.

10 (3) As used in this section:

11 (a) "Breast cancer diagnostic services" means a procedure
12 intended to aid in the diagnosis of breast cancer, delivered on an
13 inpatient or outpatient basis, including but not limited to
14 mammography, surgical breast biopsy, and pathologic examination and
15 interpretation.

16 (b) "Breast cancer rehabilitative services" means a procedure
17 intended to improve the result of, or ameliorate the debilitating
18 consequences of, treatment of breast cancer, delivered on an
19 inpatient or outpatient basis, including but not limited to
20 reconstructive plastic surgery, physical therapy, and psychological
21 and social support services.

22 (c) "Breast cancer screening mammography" means a standard 2-
23 view per breast, low-dose radiographic examination of the breasts,
24 using equipment designed and dedicated specifically for
25 mammography, in order to detect unsuspected breast cancer.

26 (d) "Breast cancer outpatient treatment services" means a
27 procedure intended to treat cancer of the human breast, delivered

1 on an outpatient basis, including but not limited to surgery,
 2 radiation therapy, chemotherapy, hormonal therapy, and related
 3 medical follow-up services.

4 ~~—— (4) This section shall take effect November 1, 1989.~~

5 Sec. 3406e. An insurer ~~which~~ **THAT** delivers, issues for
 6 delivery, or renews in this state a ~~hospital, medical, or surgical~~
 7 ~~expense incurred~~ **HEALTH INSURANCE** policy shall provide coverage in
 8 each policy for a drug used in antineoplastic therapy and the
 9 reasonable cost of its administration. Coverage ~~shall~~ **MUST** be
 10 provided for any ~~federal food and drug administration~~ **UNITED STATES**
 11 **FOOD AND DRUG ADMINISTRATION** approved drug regardless of whether
 12 the specific neoplasm for which the drug is being used as treatment
 13 is the specific neoplasm for which the drug has received approval
 14 by the ~~federal food and drug administration~~ **UNITED STATES FOOD AND**
 15 **DRUG ADMINISTRATION** if all of the following conditions are met:

16 (a) The drug is ordered by a physician for the treatment of a
 17 specific type of neoplasm.

18 (b) The drug is approved by the ~~federal food and drug~~
 19 ~~administration~~ **UNITED STATES FOOD AND DRUG ADMINISTRATION** for use
 20 in antineoplastic therapy.

21 (c) The drug is used as part of an antineoplastic drug
 22 regimen.

23 (d) Current medical literature substantiates its efficacy and
 24 recognized oncology organizations generally accept the treatment.

25 (e) The physician has obtained informed consent from the
 26 patient for the treatment regimen ~~which~~ **THAT** includes ~~federal food~~
 27 ~~and drug administration~~ **UNITED STATES FOOD AND DRUG ADMINISTRATION**

1 approved drugs for off-label indications.

2 Sec. 3406j. (1) An insurer that delivers, issues for delivery,
3 or renews in this state ~~an expense incurred hospital, medical, or~~
4 ~~surgical~~ **A HEALTH INSURANCE** policy ~~or certificate~~ shall not rate,
5 cancel coverage on, refuse to provide coverage for, or refuse to
6 issue or renew a **HEALTH INSURANCE** policy ~~or certificate~~ solely
7 because an insured or applicant for insurance is or has been a
8 victim of domestic violence.

9 ~~—— (2) This section does not prohibit an insurer from inquiring~~
10 ~~about, underwriting, or charging a different premium on the basis~~
11 ~~of the individual's physical or mental condition, regardless of the~~
12 ~~cause of the condition.~~

13 (2) ~~(3)~~ An insurer ~~shall~~ **IS** not be held civilly liable for any
14 cause of action that may result from compliance with this section.

15 ~~—— (4) This section applies to policies and certificates issued~~
16 ~~or renewed on or after June 1, 1998.~~

17 (3) ~~(5)~~ As used in this section, "domestic violence" means
18 inflicting bodily injury **ON**, causing serious emotional injury or
19 psychological trauma **TO**, or placing in fear of imminent physical
20 harm by threat or force a person who is a spouse or former spouse
21 of, has or has had a dating relationship with, resides or has
22 resided with, or has a child in common with the person committing
23 the violence.

24 Sec. 3406k. (1) An ~~expense incurred hospital, medical, or~~
25 ~~surgical policy or certificate delivered, issued~~ **INSURER THAT**
26 **DELIVERS, ISSUES** for delivery, or ~~renewed~~ **RENEWS** in this state **A**
27 **HEALTH INSURANCE POLICY** that provides coverage for emergency health

1 ~~services and a health maintenance organization contract shall~~
 2 provide coverage for medically necessary services provided to an
 3 insured for the sudden onset of a medical condition that manifests
 4 itself by signs and symptoms of sufficient severity, including
 5 severe pain, such that **A PRUDENT LAYPERSON WHO POSSESSES AN AVERAGE**
 6 **KNOWLEDGE OF HEALTH AND MEDICINE COULD REASONABLY EXPECT** the
 7 absence of immediate medical attention ~~could reasonably be expected~~
 8 to result in serious jeopardy to the individual's health or to a
 9 pregnancy in the case of a pregnant woman, serious impairment to
 10 bodily functions, or serious dysfunction of any bodily organ or
 11 part. An insurer shall not require a physician to transfer a
 12 patient before the physician determines that the patient has
 13 reached the point of stabilization. An insurer shall not deny
 14 payment for emergency health services up to the point of
 15 stabilization provided to an insured under this subsection because
 16 of either of the following:

17 (a) The final diagnosis.

18 (b) Prior authorization ~~was not~~ **BEING** given by the insurer
 19 before emergency health services were provided.

20 (2) As used in this section, "stabilization" means the point
 21 at which no material deterioration of a condition is likely, within
 22 reasonable medical probability, to result from or occur during
 23 transfer of the patient.

24 Sec. 3406l. (1) Except as otherwise provided in subsections
 25 (2) and (3), an ~~expense incurred hospital, medical, or surgical~~
 26 **INSURER THAT DELIVERS, ISSUES FOR DELIVERY, OR RENEWS IN THIS STATE**
 27 **A HEALTH INSURANCE** policy ~~or certificate that~~ provides benefits for

1 emergency services shall provide for direct reimbursement to any
 2 provider of covered medical transportation services or shall
 3 provide that payment be made jointly to the insured and the
 4 provider, if ~~that~~ **THE** provider has not received payment for those
 5 services from any other source.

6 (2) Subsection (1) does not apply to a transaction between an
 7 insurer and a medical transportation service provider if the
 8 parties have entered into a contract providing for direct payment.

9 (3) An insurer for a policy ~~or certificate~~ issued under
 10 section 3405 ~~or 3631~~ does not have to provide for direct
 11 reimbursement to any nonaffiliated or nonparticipating provider for
 12 medical transportation services that were not emergency health
 13 services as defined **DESCRIBED** in section 3406k.

14 ~~—— (4) Subsection (1) applies to an expense incurred hospital,~~
 15 ~~medical, or surgical policy or certificate that provides benefits~~
 16 ~~for emergency health services if the policy or certificate is~~
 17 ~~delivered, issued for delivery, or renewed in this state on or~~
 18 ~~after September 1, 2004.~~

19 (4) ~~(5)~~ This section does not apply to a health maintenance
 20 organization contract.

21 Sec. 3406m. (1) An insurer that delivers, issues for delivery,
 22 or renews in this state ~~an expense incurred hospital, medical, or~~
 23 ~~surgical~~ **A HEALTH INSURANCE** policy ~~or certificate~~ that requires an
 24 insured to designate a participating primary care provider and
 25 provides for annual well-woman examinations and routine obstetrical
 26 and gynecologic services shall permit a female insured to access an
 27 obstetrician-gynecologist for annual well-woman examinations and

1 routine obstetrical and gynecologic services.

2 (2) An insurer shall not require prior authorization or
3 referral for access under subsection (1) to an obstetrician-
4 gynecologist who is participating with the insurer. An insurer may
5 require prior authorization or referral for access to a
6 nonparticipating obstetrician-gynecologist.

7 (3) ~~A-AN INSURER SHALL INCLUDE A~~ description of the coverage
8 ~~provided by REQUIRED UNDER~~ this section ~~shall be included by the~~
9 ~~insurer~~ in a communication sent to the insured or group purchaser
10 of coverage.

11 Sec. 3406n. (1) An insurer that delivers, issues for delivery,
12 or renews in this state ~~an expense incurred hospital, medical, or~~
13 ~~surgical~~ **A HEALTH INSURANCE** policy ~~or certificate~~ that requires an
14 insured to designate a participating primary care provider and
15 provides for dependent care coverage shall permit a dependent minor
16 insured to select and access a pediatrician for general pediatric
17 care services.

18 (2) An insurer shall not require prior authorization or
19 referral for access under subsection (1) to a pediatrician who
20 participates with the insurer. An insurer may require prior
21 authorization or referral for access to a nonparticipating
22 pediatrician.

23 Sec. 3406o. (1) An insurer that delivers, issues for delivery,
24 or renews in this state ~~an expense incurred hospital, medical, or~~
25 ~~surgical~~ **A HEALTH INSURANCE** policy ~~or certificate~~ that provides
26 coverage for prescription drugs and limits those benefits to drugs
27 included in a formulary shall do all of the following:

1 (a) Provide for participation of participating physicians,
2 dentists, and pharmacists in the development of the formulary.

3 (b) Disclose to health care providers and upon request to
4 insureds the nature of the formulary restrictions.

5 (c) Provide for exceptions from the formulary limitation when
6 a nonformulary alternative is a medically necessary and appropriate
7 alternative. This subdivision does not prevent an insurer from
8 establishing prior authorization requirements or another process
9 for consideration of coverage or higher cost-sharing for
10 nonformulary alternatives. ~~Notice as to whether or not an exception~~
11 ~~under this subdivision has been granted shall be given by the~~
12 ~~insurer within 24 hours after receiving all information necessary~~
13 ~~to determine whether the exception should be granted.~~

14 (2) ON A REQUEST FOR AN EXPEDITED REVIEW OF COVERAGE FOR A
15 NONFORMULARY ALTERNATIVE BASED ON EXIGENT CIRCUMSTANCES, AN INSURER
16 SHALL MAKE A DETERMINATION AND NOTIFY THE ENROLLEE OR THE
17 ENROLLEE'S DESIGNEE AND THE PRESCRIBING PHYSICIAN, OR OTHER
18 PRESCRIBER, AS APPROPRIATE, OF THE DETERMINATION WITHIN 24 HOURS
19 AFTER THE INSURER RECEIVES THE REQUEST. FOR PURPOSES OF THIS
20 SUBSECTION, EXIGENT CIRCUMSTANCES EXIST WHEN AN ENROLLEE IS
21 SUFFERING FROM A HEALTH CONDITION THAT MAY SERIOUSLY JEOPARDIZE THE
22 ENROLLEE'S LIFE, HEALTH, OR ABILITY TO REGAIN MAXIMUM FUNCTION OR
23 WHEN AN ENROLLEE IS UNDERGOING A CURRENT COURSE OF TREATMENT USING
24 A NONFORMULARY DRUG.

25 (3) IF SUBSECTION (2) DOES NOT APPLY, AN INSURER SHALL MAKE A
26 DETERMINATION ON COVERAGE FOR A NONFORMULARY ALTERNATIVE AND NOTIFY
27 THE ENROLLEE OR THE ENROLLEE'S DESIGNEE AND THE PRESCRIBING

1 PHYSICIAN, OR OTHER PRESCRIBER, AS APPROPRIATE, OF THE
2 DETERMINATION WITHIN 72 HOURS AFTER THE INSURER RECEIVES THE
3 REQUEST.

4 Sec. 3406p. (1) An insurer ~~providing an expense incurred~~
5 ~~hospital, medical, or surgical policy or certificate delivered or~~
6 ~~issued~~ **THAT DELIVERS, ISSUES** for delivery, **OR RENEWS** in this state
7 ~~and a health maintenance organization~~ **A HEALTH INSURANCE POLICY**
8 shall establish and provide to insureds, enrollees, and
9 ~~participating~~ **AFFILIATED** providers a program to prevent the onset
10 of clinical diabetes. This program for ~~participating~~ **AFFILIATED**
11 providers ~~shall~~ **MUST** emphasize best practice guidelines to prevent
12 the onset of clinical diabetes and to treat diabetes, including,
13 but not limited to, diet, lifestyle, physical exercise and fitness,
14 and early diagnosis and treatment.

15 (2) An insurer ~~and a health maintenance organization providing~~
16 **THAT PROVIDES** a program ~~pursuant to~~ **UNDER** subsection (1) shall
17 regularly measure the effectiveness of the program by regularly
18 surveying individuals covered by the **HEALTH INSURANCE** policy. ~~7~~
19 ~~certificate, or contract. Not later than 2 years after the~~
20 ~~effective date of the amendatory act that added this section, each~~
21 ~~insurer and health maintenance organization providing a program~~
22 ~~pursuant to subsection (1) shall prepare a report containing the~~
23 ~~results of the survey and shall provide a copy of the report to the~~
24 ~~department of community health.~~

25 (3) An ~~expense incurred hospital, medical, or surgical policy~~
26 ~~or certificate delivered or issued~~ **INSURER THAT DELIVERS, ISSUES**
27 for delivery, **OR RENEWS** in this state ~~and a health maintenance~~

~~organization contract~~ **A HEALTH INSURANCE POLICY** shall include coverage for the following equipment, supplies, and educational training for the treatment of diabetes, if determined to be medically necessary and prescribed by an allopathic or osteopathic physician:

(a) Blood glucose monitors and blood glucose monitors for the legally blind.

(b) Test strips for glucose monitors, visual reading and urine testing strips, lancets, and spring-powered lancet devices.

(c) Syringes.

(d) Insulin pumps and medical supplies required for the use of an insulin pump.

(e) Diabetes self-management training to ensure that persons with diabetes are trained as to the proper self-management and treatment of their diabetic condition.

~~(4) An expense incurred hospital, medical, or surgical policy or certificate delivered or issued~~ **INSURER THAT DELIVERS, ISSUES** for delivery, **OR RENEWS** in this state and ~~a health maintenance organization contract~~ **A HEALTH INSURANCE POLICY** that provides outpatient pharmaceutical coverage directly or by rider shall include the following coverage for the treatment of diabetes, if determined to be medically necessary:

(a) Insulin, if prescribed by an allopathic or osteopathic physician.

(b) Nonexperimental medication for controlling blood sugar, if prescribed by an allopathic or osteopathic physician.

(c) Medications used in the treatment of foot ailments,

1 infections, and other medical conditions of the foot, ankle, or
 2 nails associated with diabetes, if prescribed by an allopathic,
 3 osteopathic, or podiatric physician.

4 (5) Coverage under subsection (3) for diabetes self-management
 5 training is subject to all of the following:

6 (a) ~~Is~~ **THE TRAINING IS** limited to completion of a certified
 7 diabetes education program ~~upon occurrence of~~ **IF** either of the
 8 following **APPLIES**:

9 (i) ~~If~~ **THE TRAINING IS** considered medically necessary upon the
 10 diagnosis of diabetes by an allopathic or osteopathic physician who
 11 is managing the patient's diabetic condition and ~~if the services~~
 12 ~~are~~ **IS** needed under a comprehensive plan of care to ensure therapy
 13 compliance or to provide necessary skills and knowledge.

14 (ii) ~~If an~~ **AN** allopathic or osteopathic physician ~~diagnoses~~
 15 **HAS DIAGNOSED** a significant change with long-term implications in
 16 the patient's symptoms or conditions that necessitates changes in a
 17 **THE** patient's self-management or a significant change in medical
 18 protocol or treatment modalities.

19 (b) ~~Shall~~ **THE TRAINING MUST** be provided by a diabetes
 20 outpatient training program certified to receive ~~medicaid or~~
 21 ~~medicare~~ **MEDICAID OR MEDICARE** reimbursement or certified by the
 22 department of community health. Training provided under this
 23 subdivision ~~shall~~ **MUST** be conducted in group settings whenever
 24 practicable.

25 (6) Coverage under this section is not subject to dollar
 26 limits, deductibles, or copayment provisions that are greater than
 27 those for physical illness generally.

(7) As used in this section, "diabetes" includes all of the following:

(a) Gestational diabetes.

(b) Insulin-dependent diabetes.

(c) Non-insulin-dependent diabetes.

Sec. 3406q. (1) An ~~expense incurred hospital, medical, or surgical policy or certificate delivered, issued~~ **INSURER THAT DELIVERS, ISSUES** for delivery, or ~~renewed~~ **RENEWS** in this state **A HEALTH INSURANCE POLICY** that provides pharmaceutical coverage ~~and a health maintenance organization contract that provides pharmaceutical coverage~~ shall provide coverage for an off-label use of a ~~federal food and drug administration~~ **UNITED STATES FOOD AND DRUG ADMINISTRATION** approved drug and the reasonable cost of supplies medically necessary to administer the drug.

(2) Coverage for a drug under subsection (1) applies if all of the following conditions are met:

(a) The drug is approved by the ~~federal food and drug administration~~ **UNITED STATES FOOD AND DRUG ADMINISTRATION**.

(b) The drug is prescribed by an allopathic or osteopathic physician for the treatment of either of the following:

(i) A life-threatening condition ~~so long as~~ **IF** the drug is medically necessary to treat ~~that~~ **THE** condition and the drug is on the plan formulary or accessible through the ~~health plan's~~ **INSURER'S** formulary procedures.

(ii) A chronic and seriously debilitating condition ~~so long as~~ **IF** the drug is medically necessary to treat ~~that~~ **THE** condition and the drug is on the plan formulary or accessible through the ~~health~~

1 ~~plan's~~ **INSURER'S** formulary procedures.

2 (c) The drug has been recognized for treatment for the
3 condition for which it is prescribed by 1 of the following:

4 (i) The American ~~medical association~~ **MEDICAL ASSOCIATION** drug
5 evaluations.

6 (ii) The American ~~hospital formulary service~~ **HOSPITAL**
7 **FORMULARY SERVICE** drug information.

8 (iii) The United States ~~pharmacopoeia dispensing information,~~
9 ~~volume 1, "drug information for the health care~~
10 ~~professional".~~ **PHARMACOPOEIA DISPENSING INFORMATION, VOLUME 1, "DRUG**
11 **INFORMATION FOR THE HEALTH CARE PROFESSIONAL".**

12 (iv) Two articles from major peer-reviewed medical journals
13 that present data supporting the proposed off-label use or uses as
14 generally safe and effective unless there is clear and convincing
15 contradictory evidence presented in a major peer-reviewed medical
16 journal.

17 (3) Upon request, the prescribing allopathic or osteopathic
18 physician shall supply to the insurer ~~or health maintenance~~
19 ~~organization~~ documentation supporting compliance with subsection
20 (2).

21 (4) This section does not prohibit the use of a copayment,
22 deductible, sanction, or ~~a~~ mechanism for appropriately controlling
23 the utilization of a drug that is prescribed for a use different
24 from the use for which the drug has been approved by the ~~food and~~
25 ~~drug administration.~~ **UNITED STATES FOOD AND DRUG ADMINISTRATION.**
26 This may include prior approval or a drug utilization review
27 program. Any copayment, deductible, sanction, prior approval, drug

1 utilization review program, or mechanism described in this
 2 subsection ~~shall~~ **MUST** not be more restrictive than for prescription
 3 coverage generally.

4 (5) As used in this section:

5 (a) "Chronic and seriously debilitating" means a disease or
 6 condition that requires ongoing treatment to maintain remission or
 7 prevent deterioration and that causes significant long-term
 8 morbidity.

9 (b) "Life-threatening" means a disease or condition ~~where~~ **AS**
 10 **TO WHICH** the likelihood of death is high unless the course of the
 11 disease is interrupted or that has a potentially fatal outcome
 12 ~~where~~ **AND AS TO WHICH** the end point of clinical intervention is
 13 survival.

14 (c) "Off-label" means the use of a drug for clinical
 15 indications other than those stated in the labeling approved by the
 16 ~~federal food and drug administration~~ **UNITED STATES FOOD AND DRUG**
 17 **ADMINISTRATION.**

18 Sec. 3406r. (1) As used in this section, "nurse midwife" means
 19 an individual licensed as a registered professional nurse under
 20 article 15 of the public health code, 1978 PA 368, MCL 333.16101 to
 21 333.18838, who has been issued a specialty certification in the
 22 practice of nurse midwifery by the Michigan board of nursing under
 23 section 17210 of the public health code, 1978 PA 368, MCL
 24 333.17210.

25 (2) ~~Effective March 1, 2005, a health maintenance organization~~
 26 ~~contract and an expense incurred hospital, medical, or surgical~~
 27 ~~policy or certificate~~ **AN INSURER THAT DELIVERS, ISSUES FOR**

1 **DELIVERY, OR RENEWS IN THIS STATE A POLICY OF HEALTH INSURANCE** that
2 provides coverage for obstetrical and gynecological services shall
3 include coverage for obstetrical and gynecological services whether
4 performed by a physician or a nurse midwife acting within the scope
5 of his or her license or specialty certification or shall do 1 or
6 both of the following:

7 (a) Offer to provide coverage for obstetrical and
8 gynecological services whether performed by a physician or a nurse
9 midwife acting within the scope of his or her license or specialty
10 certification.

11 (b) Offer to provide coverage for maternity services and
12 gynecological services rendered during pre- and post-natal care
13 whether performed by a physician or a nurse midwife acting within
14 the scope of his or her license or specialty certification.

15 Sec. 3406s. (1) Except as otherwise provided in this section,
16 ~~an expense incurred hospital, medical, or surgical group or~~
17 ~~individual policy or certificate delivered, issued~~ **INSURER THAT**
18 **DELIVERS, ISSUES** for delivery, or ~~renewed~~ **RENEWS** in this state and
19 ~~a health maintenance organization group or individual contract~~ **A**
20 **HEALTH INSURANCE POLICY** shall provide coverage for the diagnosis of
21 autism spectrum disorders and treatment of autism spectrum
22 disorders. An insurer ~~and a health maintenance organization~~ shall
23 not do any of the following:

24 (a) Terminate coverage or refuse to deliver, execute, issue,
25 amend, adjust, or renew coverage solely because an individual is
26 diagnosed with, or has received treatment for, an autism spectrum
27 disorder.

1 (b) Limit the number of visits an insured or enrollee may use
 2 for treatment of autism spectrum disorders covered under this
 3 section.

4 (c) Deny or limit coverage under this section on the basis
 5 that treatment is educational or habilitative in nature.

6 (d) Except as otherwise provided in this subdivision, subject
 7 coverage under this section to dollar limits, copays, deductibles,
 8 or coinsurance provisions that do not apply to physical illness
 9 generally. ~~Coverage~~ **AN INSURER MAY LIMIT COVERAGE** under this
 10 section for treatment of autism spectrum disorders ~~may be limited~~
 11 to an insured or enrollee through 18 years of age and may ~~be~~
 12 subject **THE COVERAGE** to a maximum annual benefit as follows:

13 (i) For a covered insured or enrollee through 6 years of age,
 14 \$50,000.00.

15 (ii) For a covered insured or enrollee from 7 years of age
 16 through 12 years of age, \$40,000.00.

17 (iii) For a covered insured or enrollee from 13 years of age
 18 through 18 years of age, \$30,000.00.

19 (2) This section does not limit benefits that are otherwise
 20 available to an insured or enrollee under a policy, contract, or
 21 certificate. An insurer ~~or health maintenance organization~~ shall
 22 utilize evidence-based care and managed care cost-containment
 23 practices pursuant to the insurer's ~~or health maintenance~~
 24 ~~organization's~~ procedures ~~so long as that~~ **IF THE** care and those
 25 practices are consistent with this section. ~~The~~ **AN INSURER MAY**
 26 **SUBJECT** coverage under this section ~~may be subject to~~ other general
 27 exclusions and limitations of the policy, contract, or certificate,

1 including, but not limited to, coordination of benefits,
 2 ~~participating~~ **AFFILIATED** provider requirements, restrictions on
 3 services provided by family or household members, utilization
 4 review of health care services including review of medical
 5 necessity, case management, and other managed care provisions.

6 (3) If an insured or enrollee is receiving treatment for an
 7 autism spectrum disorder, an insurer ~~or health maintenance~~
 8 ~~organization~~ may, as a condition to providing the coverage under
 9 this section, do all of the following:

10 (a) Require a review of ~~that~~ **THE** treatment consistent with
 11 current protocols and may require a treatment plan. If requested by
 12 the insurer, ~~or health maintenance organization~~, the cost of
 13 treatment review ~~shall~~ **MUST** be borne by the insurer. ~~or health~~
 14 ~~maintenance organization.~~

15 (b) Request the results of the autism diagnostic observation
 16 schedule that has been used in the diagnosis of an autism spectrum
 17 disorder for ~~that~~ **THE** insured or enrollee.

18 (c) Request that the autism diagnostic observation schedule be
 19 performed on ~~that~~ **THE** insured or enrollee not more frequently than
 20 once every 3 years.

21 (d) Request that an annual development evaluation be conducted
 22 and the results of ~~that~~ **THE** annual development evaluation be
 23 submitted to the insurer. ~~or health maintenance organization.~~

24 (4) ~~Beginning January 1, 2014, a~~ **A** qualified health plan
 25 offered through an American health benefit exchange established in
 26 this state pursuant to the federal act is not required to provide
 27 coverage under this section to the extent that it exceeds coverage

1 that is included in the essential health benefits as required
2 pursuant to the federal act. As used in this subsection, "federal
3 act" means the ~~federal~~-patient protection and affordable care act,
4 Public Law 111-148, as amended by the ~~federal~~-health care and
5 education reconciliation act of 2010, Public Law 111-152, and any
6 regulations promulgated under those acts.

7 (5) This section does not apply to a short-term or 1-time
8 limited duration policy or certificate of no longer than 6 months
9 as described in section 2213b.

10 (6) This section does not require the coverage of prescription
11 drugs and related services unless the insured or enrollee is
12 covered by a prescription drug plan. This section does not require
13 an insurer ~~or health maintenance organization~~ to provide coverage
14 for autism spectrum disorders to an insured or enrollee under more
15 than 1 of its **HEALTH INSURANCE** policies. ~~, certificates, or~~
16 ~~contracts.~~ If an insured or enrollee has more than 1 **HEALTH**
17 **INSURANCE** policy ~~, certificate, or contract~~ that covers autism
18 spectrum disorders, the benefits provided are subject to the limits
19 of this section when coordinating benefits.

20 (7) As used in this section:

21 (a) "Applied behavior analysis" means the design,
22 implementation, and evaluation of environmental modifications,
23 using behavioral stimuli and consequences, to produce significant
24 improvement in human behavior, including the use of direct
25 observation, measurement, and functional analysis of the
26 relationship between environment and behavior.

27 (b) "Autism diagnostic observation schedule" means the

1 protocol available through ~~western psychological services~~ **WESTERN**
 2 **PSYCHOLOGICAL SERVICES** for diagnosing and assessing autism spectrum
 3 disorders or any other standardized diagnostic measure for autism
 4 spectrum disorders that is approved by the ~~commissioner~~, **DIRECTOR**,
 5 if the ~~commissioner~~ **DIRECTOR** determines that the diagnostic measure
 6 is recognized by the health care industry and is an evidence-based
 7 diagnostic tool.

8 (c) "Autism spectrum disorders" means any of the following
 9 pervasive developmental disorders as defined by the ~~diagnostic and~~
 10 ~~statistical manual~~: **DIAGNOSTIC AND STATISTICAL MANUAL:**

11 (i) Autistic disorder.

12 (ii) Asperger's disorder.

13 (iii) Pervasive developmental disorder not otherwise
 14 specified.

15 (d) "Behavioral health treatment" means evidence-based
 16 counseling and treatment programs, including applied behavior
 17 analysis, that meet both of the following requirements:

18 (i) Are necessary to develop, maintain, or restore, to the
 19 maximum extent practicable, the functioning of an individual.

20 (ii) Are provided or supervised by a board certified behavior
 21 analyst or a licensed psychologist ~~so long as~~ **IF** the services
 22 performed are commensurate with the psychologist's formal
 23 university training and supervised experience.

24 (e) "Diagnosis of autism spectrum disorders" means
 25 assessments, evaluations, or tests, including the autism diagnostic
 26 observation schedule, performed by a licensed physician or a
 27 licensed psychologist to diagnose whether an individual has 1 of

1 the autism spectrum disorders.

2 (f) "~~Diagnostic and statistical manual~~" or "~~DSM~~" **STATISTICAL**
 3 **MANUAL**" means the ~~diagnostic and statistical manual of mental~~
 4 ~~disorders~~ **DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS**
 5 published by the American ~~psychiatric association~~ **PSYCHIATRIC**
 6 **ASSOCIATION** or ~~other~~ **ANOTHER** manual that contains common language
 7 and standard criteria for the classification of mental disorders
 8 and that is approved by the ~~commissioner~~, **DIRECTOR**, if the
 9 ~~commissioner~~ **DIRECTOR** determines that the manual is recognized by
 10 the health care industry and the classification of mental disorders
 11 is at least as comprehensive as the manual published by the
 12 American ~~psychiatric association~~ **PSYCHIATRIC ASSOCIATION** on the
 13 ~~effective date of this section~~ **APRIL 18, 2012.**

14 (g) "Pharmacy care" means medications prescribed by a licensed
 15 physician and related services performed by a licensed pharmacist
 16 and any health-related services considered medically necessary to
 17 determine the need or effectiveness of the medications.

18 (h) "Psychiatric care" means evidence-based direct or
 19 consultative services provided by a psychiatrist licensed in the
 20 state in which the psychiatrist practices.

21 (i) "Psychological care" means evidence-based direct or
 22 consultative services provided by a psychologist licensed in the
 23 state in which the psychologist practices.

24 (j) "Therapeutic care" means evidence-based services provided
 25 by a licensed or certified speech therapist, occupational
 26 therapist, physical therapist, or social worker.

27 (k) "Treatment of autism spectrum disorders" means evidence-

1 based treatment that includes the following care prescribed or
 2 ordered for an individual diagnosed with 1 of the autism spectrum
 3 disorders by a licensed physician or a licensed psychologist who
 4 determines the care to be medically necessary:

5 (i) Behavioral health treatment.

6 (ii) Pharmacy care.

7 (iii) Psychiatric care.

8 (iv) Psychological care.

9 (v) Therapeutic care.

10 (l) "Treatment plan" means a written, comprehensive, and
 11 individualized intervention plan that incorporates specific
 12 treatment goals and objectives and that is developed by a board
 13 certified or licensed provider who has the appropriate credentials
 14 and who is operating within his or her scope of practice, when the
 15 treatment of an autism spectrum disorder is first prescribed or
 16 ordered by a licensed physician or licensed psychologist as
 17 described in subdivision (k).

18 Sec. 3407. ~~There~~ **EXCEPT AS OTHERWISE PROVIDED IN THIS ACT, AN**
 19 **INSURER shall be a provision as follows: INCLUDE THE FOLLOWING**
 20 **PROVISION IN A DISABILITY INSURANCE POLICY:**

21 **ENTIRE CONTRACT; CHANGES:** This policy, including the
 22 **APPLICABLE RIDERS AND** endorsements; **THE APPLICATION FOR COVERAGE IF**
 23 **SPECIFIED BY THE INSURER; THE IDENTIFICATION CARD IF SPECIFIED BY**
 24 **THE INSURER;** and the attached papers, if any, constitutes the
 25 entire contract of insurance. No change in this policy ~~shall be~~ **IS**
 26 valid until approved by an executive officer of the insurer and
 27 unless ~~such~~ **THE** approval ~~be~~ **IS** endorsed ~~hereon~~ **ON THIS POLICY** or

1 attached hereto. ~~No agent has~~ **TO THIS POLICY. AN INSURANCE PRODUCER**
 2 **DOES NOT HAVE** authority to change this policy or to waive any of
 3 its provisions.

4 Sec. 3407b. (1) An ~~expense incurred hospital, medical, or~~
 5 ~~surgical~~ **INSURER THAT DELIVERS, ISSUES FOR DELIVERY, OR RENEWS IN**
 6 **THIS STATE A HEALTH INSURANCE** policy ~~or certificate delivered,~~
 7 ~~issued for delivery, or renewed in this state~~ shall not require an
 8 insured or his or her dependent or an asymptomatic applicant for
 9 insurance or his or her asymptomatic dependent to do either of the
 10 following:

11 (a) Undergo genetic testing before issuing, renewing, or
 12 continuing the policy ~~or certificate~~ in this state.

13 (b) Disclose whether genetic testing has been conducted or the
 14 results of genetic testing or genetic information.

15 ~~—— (2) This section does not prohibit an insurer from requiring~~
 16 ~~an applicant for an expense incurred hospital, medical, or surgical~~
 17 ~~policy or certificate to answer questions concerning family~~
 18 ~~history.~~

19 (2) ~~(3)~~ As used in this section:

20 (a) "Clinical purposes" includes all of the following:

21 (i) ~~Predicted~~ **PREDICTING** risk of diseases.

22 (ii) Identifying carriers for single-gene disorders.

23 (iii) Establishing prenatal and clinical diagnosis or
 24 prognosis.

25 (iv) Prenatal, newborn, and other carrier screening, as well
 26 as testing in high-risk families.

27 (v) ~~Tests~~ **TESTING** for metabolites if undertaken with high

1 probability that an excess or deficiency of the metabolite
 2 indicates or suggests the presence of heritable mutations in single
 3 genes.

4 (vi) Other ~~tests~~ **TESTING** if ~~their~~ **THE** intended purpose is
 5 diagnosis of a presymptomatic genetic condition.

6 (b) "Genetic information" means information about a gene, gene
 7 product, or inherited characteristic derived from a genetic test.

8 (c) "Genetic test" means the analysis of human DNA, RNA,
 9 chromosomes, and those proteins and metabolites used to detect
 10 heritable or somatic disease-related genotypes or karyotypes for
 11 clinical purposes. A genetic test must be generally accepted in the
 12 scientific and medical communities as being specifically
 13 determinative for the presence, absence, or mutation of a gene or
 14 chromosome ~~in order~~ to qualify under this definition. Genetic test
 15 does not include a routine physical examination or a routine
 16 analysis, including, but not limited to, a chemical analysis, of
 17 body fluids, unless conducted specifically to determine the
 18 presence, absence, or mutation of a gene or chromosome.

19 Sec. 3408. (1) ~~There~~ **AN INSURER** shall ~~be~~ **INCLUDE IN A**
 20 **DISABILITY INSURANCE POLICY, OTHER THAN A HEALTH INSURANCE POLICY,**
 21 a provision ~~as follows:~~ **THAT CONSISTS OF BOTH OF THE FOLLOWING:**

22 (A) **ONE OF THE FOLLOWING, AS APPLICABLE:**

23 (i) **TIME LIMIT ON CERTAIN DEFENSES:** ~~(a)~~ After 3 years from the
 24 date of issue of this policy, ~~no misstatements,~~ **THE INSURER WILL**
 25 **NOT USE A MISSTATEMENT,** except ~~A fraudulent misstatements,~~
 26 **MISSTATEMENT,** made by the applicant in the application for ~~such~~ **THE**
 27 policy ~~shall be used~~ to void the policy or to deny a claim for loss

1 incurred or disability, ~~(as AS defined in the policy) commencing~~
 2 **POLICY, BEGINNING** after the expiration of ~~such THE~~ 3-year period.
 3 ~~— (The foregoing THIS policy provisions shall~~ **PROVISION DOES** not
 4 ~~be so construed as to affect any A~~ legal requirement for avoidance
 5 of a policy or denial of a claim during ~~such THE~~ initial 3-year
 6 period, ~~nor to AND DOES NOT~~ limit the application of sections 3432,
 7 ~~(change of occupation), 3434, (misstatement of age), 3436, (other~~
 8 ~~insurance same insurer), 3438, (insurance with other~~
 9 ~~insurers provision of service or expense incurred basis), and 3440~~
 10 ~~(insurance with other insurers) in the event of IF A~~ misstatement
 11 with respect to age or occupation or other ~~insurance.~~ **INSURANCE IS**
 12 **MADE.**

13 (ii) ~~(A INSTEAD OF THE PROVISION REQUIRED UNDER SUBPARAGRAPH~~
 14 ~~(i), FOR A~~ policy ~~which THAT~~ the insured has the right to continue
 15 in force subject to its terms by the timely payment of premium ~~(1)~~
 16 until at least age 50 or, ~~(2) in the case of FOR~~ a policy issued
 17 after age 44, for at least 5 years ~~from AFTER~~ its date of issue, **AN**
 18 **INSURER** may ~~contain in lieu of the foregoing the following~~
 19 ~~provision (from which the clause in parentheses may be omitted at~~
 20 ~~the insurer's option) INCLUDE THE FOLLOWING IN THE POLICY,~~ under
 21 the caption **"INCONTESTABLE": "INCONTESTABLE":**

22 After this policy has been in force for a period of 3 years
 23 during the lifetime of the insured (excluding any period during
 24 which the insured is disabled), it ~~shall become BECOMES~~
 25 incontestable as to the statements contained in the application.

26 (b) ~~No A~~ claim for **A** loss incurred or disability, ~~(as AS~~
 27 defined in the policy, ~~) commencing BEGINNING~~ after 3 years from

1 the date of issue of this policy ~~shall~~ **WILL NOT** be reduced or
 2 denied on the ground that a disease or physical condition not
 3 excluded from coverage by name or specific description effective on
 4 the date of loss ~~had existed prior to~~ **BEFORE** the effective date of
 5 coverage of this policy.

6 (2) ~~(For~~ **FOR** the purpose of permitting insurers to use a
 7 uniform policy in several states, the insurer ~~is permitted to~~ **MAY**
 8 print in the policy form in ~~required~~ **THE** provisions ~~(a)~~ **REQUIRED**
 9 **UNDER SUBSECTION (1) (A) and (b) above** the term of "3 years".
 10 ~~Nevertheless, the provisions~~ **NOTWITHSTANDING ANY PROVISION** of the
 11 contract ~~and text of the statute~~ **OR LAW** to the contrary,
 12 ~~notwithstanding, the time limits for said~~ **THE** defenses ~~under any~~
 13 ~~contract~~ **DESCRIBED IN THIS SECTION AND INCLUDED IN A DISABILITY**
 14 **INSURANCE POLICY, NOT INCLUDING A HEALTH INSURANCE POLICY, THAT IS**
 15 delivered or issued for delivery ~~to any person in this state shall~~
 16 **MUST** not exceed 2 years.) **YEARS.**

17 Sec. 3409. (1) Except as **OTHERWISE** provided in ~~subsection (2),~~
 18 **THIS SECTION, AN INSURER THAT DELIVERS, ISSUES FOR DELIVERY, OR**
 19 **RENEWS IN THIS STATE** a disability insurance **POLICY**, other than **A**
 20 **POLICY THAT PROVIDES** group ~~and~~ **OR** blanket insurance, ~~delivered or~~
 21 ~~issued for delivery to a person in this state shall contain~~ **INCLUDE**
 22 the following notice, in substance printed or stamped on the front
 23 page and made a permanent part of the policy:

24 Cancellation during first 10 days: During a period of 10 days
 25 after the date the policyholder receives ~~the~~ **THIS** policy, the
 26 policyholder may cancel the policy and receive from the insurer a
 27 prompt refund of any premium paid for the policy, including a

1 policy fee or other charge, by mailing or otherwise surrendering
2 the policy to the insurer together with a written request for
3 cancellation. If a policyholder or purchaser pursuant to ~~such~~**THIS**
4 notice returns the policy or contract to the company or association
5 at its home or branch office or to the agent through whom it was
6 purchased, it ~~shall be~~**IS** void from the beginning and the parties
7 ~~shall be~~**ARE** in the same position as if no policy or contract had
8 been issued.

9 Cancellation after 10 days: A policyholder may cancel ~~the~~**THIS**
10 policy after the first 10 days ~~following~~**AFTER** receipt of the
11 policy by giving written notice to the insurer effective upon
12 receipt or on a later date as may be specified in the notice. ~~In~~
13 ~~the event of cancellation,~~**IF THIS POLICY IS CANCELED UNDER THIS**
14 **PARAGRAPH**, the insurer ~~shall~~**WILL** promptly refund to the
15 policyholder the excess of paid premium above the pro rata premium
16 for the expired time. Cancellation **UNDER THIS PARAGRAPH** is without
17 prejudice to any claim originating ~~prior to~~**BEFORE** the effective
18 date of cancellation.

19 (2) ~~A policy of~~**AN INSURER THAT SELLS A** disability insurance
20 ~~which is sold~~**POLICY** through solicitation to a person who is
21 eligible for ~~medicare~~**MEDICARE** shall ~~contain~~**INCLUDE** the following
22 notice, in substance printed or stamped on the front page and made
23 a permanent part of the policy:

24 Cancellation during the first 30 days: During a period of 30
25 days after the date the policyholder receives ~~the~~**THIS** policy, the
26 policyholder may cancel the policy and receive from the insurer a
27 prompt refund of any premium paid for the policy, including a

1 policy fee or other charge, by mailing or otherwise surrendering
 2 the policy to the insurer together with a written request for
 3 cancellation. If a policyholder or purchaser pursuant to ~~such~~**THIS**
 4 notice returns the policy or contract to the company or association
 5 at its home or branch office or to the agent through whom it was
 6 purchased, it ~~shall be~~**IS** void from the beginning and the parties
 7 ~~shall be~~**ARE** in the same position as if no policy or contract had
 8 been issued.

9 Cancellation after 30 days: A policyholder may cancel ~~the~~**THIS**
 10 policy after the first 30 days ~~following~~**AFTER** receipt of the
 11 policy by giving written notice to the insurer effective upon
 12 receipt or on a later date as may be specified in the notice. ~~In~~
 13 ~~the event of cancellation,~~**IF THIS POLICY IS CANCELED UNDER THIS**
 14 **PARAGRAPH,** the insurer ~~shall~~**WILL** promptly refund to the
 15 policyholder the excess of paid premium above the pro rata premium
 16 for the expired time. Cancellation **UNDER THIS PARAGRAPH** is without
 17 prejudice to any claim originating ~~prior to~~**BEFORE** the effective
 18 date of cancellation.

19 **(3) IF A POLICYHOLDER CANCELS A DISABILITY INSURANCE POLICY**
 20 **DURING THE FIRST 30 DAYS AFTER RECEIPT OF THE POLICY, THE**
 21 **POLICYHOLDER IS RESPONSIBLE FOR CLAIMS PAID BY THE INSURER THAT**
 22 **WERE INCURRED BEFORE THE EFFECTIVE DATE OF CANCELLATION.**

23 Sec. 3411. (1) ~~There~~**SUBJECT TO SUBSECTION (2), AN INSURER**
 24 ~~shall be a~~**INCLUDE THE FOLLOWING** provision ~~as follows:~~**IN A**
 25 **DISABILITY INSURANCE POLICY OTHER THAN A HEALTH INSURANCE POLICY:**

26 **REINSTATEMENT:** If any renewal premium ~~be~~**IS** not paid within
 27 the time granted the insured for payment, a subsequent acceptance

1 of premium by the insurer or by ~~any~~**AN** agent duly authorized by the
 2 insurer to accept ~~such~~**THE** premium, without requiring in connection
 3 ~~therewith~~**WITH THE ACCEPTANCE OF THE PREMIUM** an application for
 4 reinstatement, ~~shall reinstate~~**IS A REINSTATEMENT OF** the policy.
 5 ~~Provided, however, That~~**POLICY. HOWEVER,** if the insurer or ~~such~~**ITS**
 6 agent requires an application for reinstatement and issues a
 7 conditional receipt for the premium tendered, the policy ~~will be~~**IS**
 8 reinstated upon approval of ~~such~~**THE** application by the insurer or,
 9 ~~lacking such approval, upon~~**IF NOT APPROVED BY THE INSURER, ON** the
 10 forty-fifth day ~~following~~**AFTER** the date of ~~such~~**THE** conditional
 11 receipt unless the insurer has previously notified the insured in
 12 writing of its disapproval of ~~such~~**THE** application. ~~The~~**UNDER THE**
 13 reinstated policy, ~~shall~~**THE INSURER WILL** cover only loss resulting
 14 from ~~such~~ accidental injury ~~as may be~~**THAT IS** sustained after the
 15 date of reinstatement and loss due to ~~such~~ sickness ~~as may begin~~
 16 **THAT BEGINS** more than 10 days after ~~such~~**THAT** date. In all other
 17 respects, the insured and insurer ~~shall~~ have the same rights
 18 ~~thereunder~~**UNDER THE POLICY** as they had under the policy
 19 immediately before the due date of the defaulted premium, subject
 20 to any provisions endorsed ~~hereon~~**ON THE POLICY** or attached ~~hereto~~
 21 **TO THE POLICY** in connection with the reinstatement. ~~Any~~**THE INSURER**
 22 **WILL APPLY ANY** premium accepted in connection with a reinstatement
 23 ~~shall be applied~~ to a period for which premium has not been
 24 previously paid, but not to any period more than 60 days ~~prior to~~
 25 **BEFORE** the date of reinstatement.

26 (2) ~~(The~~**AN INSURER MAY OMIT THE** last sentence of the ~~above~~
 27 ~~provision may be omitted~~**REQUIRED UNDER SUBSECTION (1)** from ~~any~~**A**

1 policy ~~which~~ **THAT** the insured has the right to continue in force
 2 subject to its terms by the timely payment of premium ~~(1)~~ until at
 3 least age 50 or, ~~(2) in the case of~~ **FOR** a policy issued after age
 4 44, for at least 5 years ~~from~~ **AFTER** its date of ~~issue~~ **ISSUE**.

5 Sec. 3412. (1) ~~There~~ **EXCEPT AS OTHERWISE PROVIDED IN**
 6 **SUBSECTION (2), AN INSURER** shall ~~be~~ **INCLUDE IN A DISABILITY**
 7 **INSURANCE POLICY, OTHER THAN A HEALTH INSURANCE POLICY,** a provision
 8 as follows:

9 **NOTICE OF CLAIM:** Written notice of claim must be given to the
 10 insurer within 20 days after the occurrence or commencement of ~~any~~
 11 **A** loss covered by the policy, or as soon ~~thereafter~~ **AFTER THE LOSS**
 12 as is reasonably possible. Notice given by or on behalf of the
 13 insured or the beneficiary to the insurer at
 14 (insert the location of ~~such~~ **THE** office ~~as~~ the insurer ~~may~~
 15 ~~designate~~ **DESIGNATES** for the ~~the~~ **THIS** purpose), or to any authorized
 16 agent of the insurer, with information sufficient to identify the
 17 insured, ~~shall be deemed~~ **IS CONSIDERED** notice to the insurer.

18 (2) ~~(In~~ **FOR** a policy ~~providing~~ **THAT PROVIDES** a loss-of-time
 19 benefit ~~which may be~~ payable for at least 2 years, an insurer may
 20 at its option insert the following between the first and second
 21 sentences of the ~~above~~ provision **REQUIRED UNDER SUBSECTION (1):**

22 Subject to the qualifications set forth below, if the insured
 23 suffers loss of time on account of disability for which indemnity
 24 ~~may be~~ **IS** payable for at least 2 years, ~~he shall,~~ **THE INSURED WILL,**
 25 at least once in every 6 months after having given notice of claim,
 26 give to the insurer notice of continuance of ~~said~~ **THE** disability,
 27 ~~except in the event of legal incapacity.~~ **UNLESS THE INSURED IS**

1 **LEGALLY INCAPACITATED.** The period of 6 months following any filing
 2 of proof by the insured or any payment by the insurer on account of
 3 ~~such-**THE**~~ claim or any denial of liability in whole or in part by
 4 the insurer ~~shall be-**IS**~~ excluded in applying this provision. Delay
 5 in ~~the giving of such-**THE**~~ notice ~~shall-**REQUIRED UNDER THIS**~~
 6 **PROVISION DOES** not impair the insured's right to any indemnity
 7 ~~which-**THAT**~~ would otherwise have accrued during the ~~period of-6~~
 8 months preceding the date on which ~~such-**THE**~~ notice is actually
 9 ~~given-**GIVEN.**~~

10 Sec. 3413. ~~There-**AN INSURER**~~ shall ~~be-**INCLUDE IN A DISABILITY**~~
 11 **INSURANCE POLICY, OTHER THAN A HEALTH INSURANCE POLICY,** a provision
 12 as follows:

13 **CLAIM FORMS:** The insurer, upon receipt of a notice of claim,
 14 will furnish to the claimant ~~such-**THE**~~ forms ~~as-**THAT**~~ are usually
 15 furnished ~~by it-**for**~~ filing proofs of loss. If ~~such-**THE**~~ forms are
 16 not furnished within 15 days after the giving of ~~such-**THE**~~ notice,
 17 the claimant ~~shall be-**deemed**~~ **IS CONSIDERED** to have complied with
 18 the requirements of this policy as to proof of loss upon
 19 submitting, within the time fixed in the policy for filing proofs
 20 of loss, written proof covering the occurrence, the character, and
 21 the extent of the loss for which claim is made.

22 Sec. 3414. ~~There-**AN INSURER**~~ shall ~~be-**INCLUDE IN A DISABILITY**~~
 23 **INSURANCE POLICY, OTHER THAN A HEALTH INSURANCE POLICY,** a provision
 24 as follows:

25 **PROOFS OF LOSS:** Written proof of loss must be furnished to the
 26 insurer at its ~~said-**DESIGNATED**~~ office. ~~in case of-**PROOF OF LOSS FOR**~~
 27 **A** claim for loss for which this policy provides any periodic

1 payment **THAT IS** contingent upon continuing loss **MUST BE FURNISHED**
 2 within 90 days after the termination of the period for which the
 3 insurer is liable. ~~and in case of~~ **PROOF OF LOSS FOR A** claim for any
 4 other loss **MUST BE FURNISHED** within 90 days after the date of ~~such~~
 5 **THE** loss. Failure to furnish ~~such~~ **THE** proof within the time
 6 required ~~shall~~ **UNDER THIS PROVISION DOES** not invalidate ~~nor~~ **OR**
 7 reduce ~~any~~ **THE** claim if it was not reasonably possible to give
 8 proof within ~~such~~ **THE** time, ~~provided such~~ **REQUIRED IF THE** proof is
 9 furnished as soon as reasonably possible and, ~~in no event, except~~
 10 ~~in the absence of legal capacity,~~ **UNLESS THE CLAIMANT IS LEGALLY**
 11 **INCAPACITATED, NOT** later than 1 year ~~from~~ **AFTER** the time proof is
 12 otherwise required.

13 Sec. 3416. ~~There~~ **AN INSURER** shall ~~be~~ **INCLUDE IN A DISABILITY**
 14 **INSURANCE POLICY, OTHER THAN A HEALTH INSURANCE POLICY,** a provision
 15 as follows:

16 **TIME OF PAYMENT OF CLAIMS:** Indemnities payable under this
 17 policy for ~~any~~ **A** loss other than loss for which this policy
 18 provides ~~any~~ **A** periodic payment will be paid immediately upon
 19 receipt of due written proof of ~~such~~ **THE** loss. Subject to due
 20 written proof of loss, all accrued indemnities for loss for which
 21 this policy provides periodic payment will be paid
 22 (insert period for payment ~~which~~ **THAT** must
 23 not be less frequently than monthly) and any balance remaining
 24 unpaid ~~upon~~ **ON** the termination of liability will be paid
 25 immediately upon receipt of due written proof.

26 Sec. 3418. (1) ~~There~~ **EXCEPT AS OTHERWISE PROVIDED IN**
 27 **SUBSECTION (2), AN INSURER** shall ~~be~~ **INCLUDE IN A DISABILITY**

1 **INSURANCE POLICY, OTHER THAN A HEALTH INSURANCE POLICY,** a provision
 2 as follows:

3 **PAYMENT OF CLAIMS:** Indemnity for loss of life will be payable
 4 in accordance with the beneficiary designation and the provisions
 5 respecting ~~such~~**THE** payment, which may be prescribed ~~herein~~**IN THIS**
 6 **POLICY,** and effective at the time of payment. If ~~no such~~**A**
 7 designation or provision is ~~then effective, such~~**NOT IN EFFECT, THE**
 8 indemnity ~~shall be~~**IS** payable to the estate of the insured. ~~Any~~
 9 ~~other~~**OTHER** accrued indemnities unpaid at the insured's death may,
 10 at the option of the insurer, be paid either to ~~such~~**THE**
 11 beneficiary or to ~~such~~**THE** estate. All other indemnities ~~will be~~
 12 **ARE** payable to the insured.

13 (2) ~~The~~**ONE OR MORE OF THE** following provisions ~~, or either~~
 14 ~~of them,~~ may be included with the ~~foregoing~~ provision **REQUIRED**
 15 **UNDER SUBSECTION (1)** at the option of the insurer:

16 (A) If ~~any~~ indemnity ~~of~~**UNDER** this policy ~~shall be~~**IS** payable
 17 to the estate of the insured, or to an insured or beneficiary who
 18 is a minor or otherwise not competent to give a valid release, the
 19 insurer may pay ~~such~~**THE** indemnity, up to an amount **THAT DOES** not
 20 ~~exceeding~~**EXCEED** \$..... (insert an amount ~~which shall~~**THAT DOES**
 21 not exceed \$1,000.00), to any relative by blood or connection by
 22 marriage of the insured or beneficiary who is ~~deemed~~**DETERMINED** by
 23 the insurer to be equitably entitled ~~thereto. Any payment~~**TO THE**
 24 **INDEMNITY. PAYMENT** made by the insurer in good faith pursuant to
 25 this provision ~~shall fully discharge~~**DISCHARGES** the insurer to the
 26 extent of ~~such~~**THE** payment.

27 (B) Subject to any written direction of the insured in the

1 application or otherwise, all or a portion of any indemnities
 2 provided by this policy on account of ~~hospital, nursing, medical,~~
 3 ~~or surgical~~ **HEALTH CARE** services may, at the insurer's option and
 4 unless the insured requests otherwise in writing not later than the
 5 time of filing proofs of ~~such~~ **THE** loss, be paid directly to the
 6 hospital or person rendering ~~such services.~~ **THE HEALTH CARE**
 7 **SERVICES.**

8 Sec. 3420. ~~There~~ **AN INSURER** shall ~~be~~ **INCLUDE IN A DISABILITY**
 9 **INSURANCE POLICY, OTHER THAN A HEALTH INSURANCE POLICY,** a provision
 10 as follows:

11 **PHYSICAL EXAMINATIONS AND AUTOPSY:** The insurer at its own
 12 expense ~~shall have~~ **HAS** the right and **MUST BE GIVEN THE** opportunity
 13 to examine the ~~person of the insured when~~ **AT REASONABLE TIMES** and
 14 ~~as often~~ **AS FREQUENTLY** as it may reasonably ~~require~~ **REQUIRED** during
 15 the pendency of a claim ~~hereunder~~ **UNDER THIS POLICY** and to make an
 16 autopsy in case of death ~~where it is~~ **IF** not forbidden by law.

17 Sec. 3422. ~~There~~ **AN INSURER** shall ~~be~~ **INCLUDE IN A DISABILITY**
 18 **INSURANCE POLICY, OTHER THAN A HEALTH INSURANCE POLICY,** a provision
 19 as follows:

20 **LEGAL ACTIONS:** ~~No~~ **AN INSURED MUST NOT BRING AN** action at law
 21 or in equity ~~shall be brought to recover on this policy prior to~~
 22 **BEFORE** the expiration of 60 days after written proof of loss has
 23 been furnished in accordance with the requirements of this policy.
 24 ~~No such~~ **AN INSURED MUST NOT BRING AN** action ~~shall be brought~~ **AT LAW**
 25 **OR IN EQUITY** after the expiration of 3 years after the time written
 26 proof of loss is required to be furnished.

27 Sec. 3424. (1) ~~There~~ **EXCEPT AS OTHERWISE PROVIDED IN**

1 SUBSECTION (2), AN INSURER shall ~~be~~ **INCLUDE IN A DISABILITY**
 2 **INSURANCE POLICY, OTHER THAN A HEALTH INSURANCE POLICY,** a provision
 3 as follows:

4 **CHANGE OF BENEFICIARY:** Unless the insured makes an irrevocable
 5 designation of beneficiary, the **INSURED HAS THE** right to change of
 6 ~~THE~~ beneficiary is ~~reserved to the insured and the consent~~ **UNDER**
 7 **THIS POLICY. CONSENT** of the ~~A~~ beneficiary or beneficiaries shall **IS**
 8 not ~~be requisite~~ **REQUIRED** to surrender ~~or~~ **THIS POLICY, FOR THE**
 9 assignment of ~~this~~ **THE** policy, ~~or to any change of~~ **A** beneficiary,
 10 ~~or beneficiaries,~~ or to **MAKE** any other changes in ~~this~~ **THE** policy.

11 (2) ~~(The~~ **THE** first clause of ~~this~~ **THE** provision **REQUIRED UNDER**
 12 **SUBSECTION (1),** relating to the irrevocable designation of
 13 beneficiary, may be omitted at the insurer's ~~option.~~ **OPTION.**

14 Sec. 3425. (1) ~~Each~~ **EXCEPT AS OTHERWISE PROVIDED IN THIS**
 15 **SUBSECTION, AN** insurer ~~offering~~ **THAT DELIVERS, ISSUES FOR DELIVERY,**
 16 **OR RENEWS IN THIS STATE A** health insurance ~~policies in this state~~
 17 **POLICY** shall provide coverage for intermediate and outpatient care
 18 for substance abuse, ~~upon issuance or renewal, in all contracts~~
 19 ~~for, group and individual hospital, medical, surgical expense~~
 20 ~~incurred health insurance policies other than~~ **USE DISORDER. THIS**
 21 **SECTION DOES NOT APPLY TO** limited classification policies.

22 ~~—— (2) In the case of group health insurance policies, if the~~
 23 ~~premium for a group health insurance policy would be increased by~~
 24 ~~3% or more because of the provision of the coverage required under~~
 25 ~~subsection (1), the master policyholder shall have the option to~~
 26 ~~decline the coverage required to be provided under subsection (1).~~
 27 ~~In the case of individual health insurance policies, if the total~~

~~premium for all individual health insurance policies of an insurer would be increased by 3% or more because of the provision of the coverage required under subsection (1) in all of those policies, the named insured of each such policy shall have the option to decline the coverage required to be provided under subsection (1).~~

(2) ~~(3)~~ Charges, terms, and conditions for the coverage required to be provided under subsection (1) ~~shall~~ **MUST** not be less favorable than the maximum prescribed for any other comparable service.

(3) ~~(4)~~ The **INSURER SHALL NOT REDUCE THE** coverage required to be provided under subsection (1) ~~shall not be reduced by~~ terms or conditions ~~which~~ **THAT** apply to other items of coverage in a health insurance policy, group or individual. This subsection ~~shall~~ **DOES** not ~~be construed to prohibit~~ **AN INSURER FROM PROVIDING IN A** health insurance policies that provide for **POLICY** deductibles and copayment provisions for coverage for intermediate and outpatient care for substance abuse. **USE DISORDER.**

~~— (5) The coverage required to be provided under subsection (1) shall, at a minimum, provide for up to \$1,500.00 in benefits 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.~~

(4) ~~(6)~~ As used in this section:

~~— (a) "Health insurance policy" means a hospital, medical, or surgical expense incurred policy.~~

1 (A) ~~(b)~~—"Intermediate care" means the use, in a full 24-hour
 2 residential therapy setting, or in a partial, less than 24-hour,
 3 residential therapy setting, of any or all of the following
 4 therapeutic techniques, as identified in a treatment plan for
 5 individuals physiologically or psychologically dependent ~~upon~~**ON** or
 6 abusing alcohol or drugs:

7 (i) Chemotherapy.

8 (ii) Counseling.

9 (iii) Detoxification services.

10 (iv) Other ancillary services, such as medical testing,
 11 diagnostic evaluation, and referral to other services identified in
 12 a ~~THE~~ treatment plan.

13 (B) ~~(c)~~—"Limited classification policy" means an accident only
 14 policy, a limited accident policy, a travel accident policy, or a
 15 specified disease policy.

16 (C) ~~(d)~~—"Outpatient care" means the use, on both a scheduled
 17 and a nonscheduled basis, of any or all of the following
 18 therapeutic techniques, as identified in a treatment plan for
 19 individuals physiologically or psychologically dependent ~~upon~~**ON** or
 20 abusing alcohol or drugs:

21 (i) Chemotherapy.

22 (ii) Counseling.

23 (iii) Detoxification services.

24 (iv) Other ancillary services, such as medical testing,
 25 diagnostic evaluation, and referral to other services identified in
 26 a ~~THE~~ treatment plan.

27 (D) ~~(e)~~—"Substance abuse"**USE DISORDER** means that term as

defined in section 6107 of Act No. 368 of the Public Acts of 1978,
 being section 333.6107 of the Michigan Compiled Laws. **100D OF THE**
MENTAL HEALTH CODE, 1974 PA 258, MCL 330.1100D.

~~———— (7) This section shall take effect January 1, 1982.~~

Sec. 3426. (1) ~~Each~~ **AN** 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~~ **THAT DELIVERS, ISSUES FOR DELIVERY, OR**
RENEWS IN THIS STATE A GROUP HEALTH INSURANCE POLICY may offer
 group wellness coverage. ~~Wellness coverage~~ **AN INSURER** 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~~ **MUST** not
 exceed **50% OF PAID PREMIUMS FOR TOBACCO CESSATION PROGRAMS OR 30%**
 of paid premiums **FOR OTHER WELLNESS PROGRAMS**, unless otherwise
 approved by the commissioner. ~~Each~~ **DIRECTOR. AN** 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.

1 (2) ~~Each~~ **AN** insurer ~~providing~~ **THAT DELIVERS, ISSUES FOR**
 2 **DELIVERY, OR RENEWS IN THIS STATE** an individual or family ~~expense~~
 3 ~~incurred hospital, medical, or surgical policy delivered, issued~~
 4 ~~for delivery, or renewed in this state and each health maintenance~~
 5 ~~organization~~ **HEALTH INSURANCE POLICY** may offer individual and
 6 family wellness coverage. ~~Wellness coverage~~ **AN INSURER** may provide
 7 for an appropriate rebate or reduction in premiums or for reduced
 8 copayments, coinsurance, or deductibles, or a combination of these
 9 incentives, for participation in any health behavior wellness,
 10 maintenance, or improvement program approved by the insurer. ~~or~~
 11 ~~health maintenance organization.~~ The insured or enrollee shall
 12 provide evidence of demonstrative maintenance or improvement of the
 13 individual's or family's health behaviors as determined by
 14 assessments of agreed-upon health status indicators between the
 15 insured ~~or enrollee~~ and the insurer. ~~or health maintenance~~
 16 ~~organization.~~ Any rebate of premium provided by the insurer ~~or~~
 17 ~~health maintenance organization~~ is presumed to be appropriate
 18 unless credible data demonstrate otherwise, but ~~shall~~ **MUST** not
 19 exceed ~~30%~~ **50%** of paid premiums, unless otherwise approved by the
 20 ~~commissioner.~~ **Each DIRECTOR. AN** insurer and ~~each health maintenance~~
 21 ~~organization~~ shall make available to individuals and families all
 22 wellness coverage plans that the insurer ~~or health maintenance~~
 23 ~~organization~~ markets to individuals and families in this state.
 24 (3) An insurer ~~and a health maintenance organization are~~ **IS**
 25 not required to continue any health behavior wellness, maintenance,
 26 or improvement program or to continue any incentive associated with
 27 a health behavior wellness, maintenance, or improvement program.

(4) A HEALTH BEHAVIOR WELLNESS, MAINTENANCE, OR IMPROVEMENT PROGRAM UNDER THIS SECTION MAY INCLUDE OTHER REQUIREMENTS IN ADDITION TO THOSE THAT ARE SPECIFIC TO HEALTH BEHAVIOR WELLNESS, MAINTENANCE, OR IMPROVEMENT, IF THE PROGRAM, TAKEN AS A WHOLE, MEETS THE INTENT OF THIS SECTION.

Sec. 3428. ~~Beginning January 1, 2014, an~~ **AN** insurer **THAT** **DELIVERS, ISSUES FOR DELIVERY, OR RENEWS IN THIS STATE A HEALTH INSURANCE POLICY** shall establish and maintain a provider network that, at a minimum, satisfies any network adequacy requirements imposed by the ~~commissioner pursuant to~~ **DIRECTOR UNDER** federal law.

Sec. 3432. ~~There~~ **AN INSURER** may ~~be~~ **INCLUDE IN A DISABILITY INSURANCE POLICY, OTHER THAN A HEALTH INSURANCE POLICY,** a provision as follows:

CHANGE OF OCCUPATION: If the insured ~~be~~ **IS** injured or ~~contract~~ **CONTRACTS AN ILLNESS** after ~~having changed~~ **CHANGING** his **OR HER** occupation to ~~one~~ **1** classified by the insurer as more hazardous than ~~that~~ **THE OCCUPATION** stated in this policy or while doing for compensation anything pertaining to ~~any~~ **AN** occupation ~~so~~ classified **AS MORE HAZARDOUS**, the insurer will pay only ~~such~~ **THE** portion of the indemnities provided in this policy ~~as~~ **THAT** the premium paid would have purchased at the rates and within the limits fixed by the insurer for ~~such~~ **THE** more hazardous occupation. If the insured changes his **OR HER** occupation to ~~one~~ **1** classified by the insurer as less hazardous than that stated in this policy, the insurer, upon receipt of proof of ~~such~~ **THE** change of occupation, will reduce the premium rate accordingly, and will return the excess pro rata unearned premium from the date of change of occupation or from the

1 policy anniversary date immediately preceding receipt of ~~such~~ **THE**
 2 proof, whichever is the more recent. In applying this provision,
 3 the classification of occupational risk and the premium rates ~~shall~~
 4 ~~be such as have been~~ **MUST BE THOSE THAT WERE** last filed by the
 5 insurer ~~prior to~~ **BEFORE** the occurrence of the loss for which the
 6 insurer is liable or ~~prior to~~ **BEFORE THE** date of proof of change in
 7 **THE** occupation with the state official ~~having supervision of~~ **THAT**
 8 **SUPERVISES** insurance in the state where the insured resided at the
 9 time this policy was issued. ~~+~~ ~~but~~ **HOWEVER**, if ~~such~~ **THAT** filing was
 10 not required ~~, then~~ **IN THAT STATE**, the classification of
 11 occupational risk and the premium rates ~~shall~~ **MUST** be those last
 12 made effective by the insurer in ~~such~~ **THAT** state ~~prior to~~ **BEFORE**
 13 the occurrence of the loss or ~~prior to~~ **BEFORE** the date of proof of
 14 change in **THE** occupation.

15 Sec. 3438. (1) ~~There~~ **AN INSURER** may ~~be~~ **INCLUDE IN AN**
 16 **INDIVIDUAL DISABILITY INSURANCE POLICY** a provision as follows:
 17 **INSURANCE WITH OTHER INSURERS:** If ~~there be~~ **THIS INSURER HAS**
 18 **NOT BEEN GIVEN WRITTEN NOTICE BEFORE THE OCCURRENCE OR COMMENCEMENT**
 19 **OF LOSS THAT THE INSURED UNDER THIS POLICY HAS** other valid
 20 coverage, not with this insurer, ~~providing~~ **AND THAT OTHER VALID**
 21 **COVERAGE PROVIDES** benefits for the same loss on a provision of
 22 service basis or on an expense incurred basis, ~~and of which this~~
 23 ~~insurer has not been given written notice prior to the occurrence~~
 24 ~~or commencement of loss,~~ the only liability under any expense
 25 incurred coverage of this policy ~~shall be~~ **IS** for ~~such~~ **THE**
 26 proportion of the loss as the amount ~~which~~ **THAT** would otherwise
 27 have been payable ~~hereunder~~ **UNDER THIS POLICY** plus the total of the

1 like amounts under all ~~such~~ other valid coverages for the ~~same~~ loss
 2 of which this insurer had notice bears to the total like amounts
 3 under all valid coverages for ~~such~~ **THE** loss, and for the return of
 4 ~~such~~ **THE** portion of the ~~premiums~~ **PREMIUM** paid as ~~shall exceed~~ **THAT**
 5 **EXCEEDS** the pro rata portion for the amount so determined. For the
 6 purpose of applying this provision when other coverage is on a
 7 provision of service basis, the **TERM** "like amount" ~~of such~~ **MEANS**
 8 **WITH RESPECT TO THE** other coverage ~~shall be taken as~~ the amount
 9 ~~which~~ **THAT** the services rendered would have cost in the absence of
 10 ~~such~~ **THE** coverage.

11 (2) ~~(If~~ **IF** the ~~foregoing~~ policy provision **DESCRIBED IN**
 12 **SUBSECTION (1)** is included in a ~~an~~ **AN INDIVIDUAL** policy ~~which~~ **OF**
 13 **DISABILITY INSURANCE THAT** also contains the policy provision ~~set~~
 14 ~~out~~ **DESCRIBED** in section 3440, ~~there~~ **THE INSURER** shall ~~be added~~ **ADD**
 15 to the caption of the ~~foregoing~~ **POLICY** provision the phrase
 16 **"-EXPENSE INCURRED BENEFITS"**. The insurer may, at its option,
 17 include in this provision a definition of "other valid coverage",
 18 approved as to form by the ~~commissioner~~, **DIRECTOR**, which definition
 19 ~~shall~~ **MUST** be limited in subject matter to coverage provided by
 20 organizations subject to regulation by insurance law or by
 21 insurance authorities of this or any other state of the United
 22 States or any province of Canada, ~~and~~ **TO COVERAGE PROVIDED** by
 23 hospital or medical service organizations, and to any other
 24 coverage the inclusion of which may be approved by the
 25 ~~commissioner~~. **DIRECTOR**. In the absence of ~~such~~ **A** definition, ~~such~~
 26 **THE** term ~~shall~~ **MUST** not include group insurance, automobile medical
 27 payments insurance, or coverage provided by hospital or medical

1 service organizations, ~~or~~ by union welfare plans, or **BY** employer or
 2 employee benefit organizations.

3 (3) For the purpose of applying the ~~foregoing~~ policy provision
 4 ~~with respect~~ **UNDER THIS SECTION** to any insured, any amount of
 5 benefit provided for ~~such~~ **THE** insured ~~pursuant to any~~ **UNDER A**
 6 compulsory benefit statute, ~~(including any workmen's~~ **INCLUDING A**
 7 **WORKER'S DISABILITY** compensation or employer's liability ~~statute)~~
 8 **STATUTE**, whether provided by a governmental agency or ~~otherwise~~
 9 ~~shall~~ **OTHER ENTITY, MUST** in all cases be ~~deemed~~ **CONSIDERED** to be
 10 ~~"other~~ **OTHER** valid ~~coverage"~~ **COVERAGE** of which the insurer has had
 11 notice. In applying the ~~foregoing~~ policy provision ~~no~~ **UNDER THIS**
 12 **SECTION, AN INSURER SHALL NOT INCLUDE** third party liability
 13 coverage ~~shall be included as "other~~ **OTHER** valid ~~coverage".)~~
 14 **COVERAGE.**

15 Sec. 3440. (1) ~~There~~ **AN INSURER** may ~~be~~ **INCLUDE IN AN**
 16 **INDIVIDUAL DISABILITY INSURANCE POLICY** a provision as follows:

17 **INSURANCE WITH OTHER INSURERS:** If ~~there be~~ **THIS INSURER HAS**
 18 **NOT BEEN GIVEN WRITTEN NOTICE BEFORE THE OCCURRENCE OR COMMENCEMENT**
 19 **OF LOSS THAT THE INSURED UNDER THIS POLICY HAS** other valid
 20 coverage, not with this insurer, ~~providing~~ **AND THAT OTHER VALID**
 21 **COVERAGE PROVIDES** benefits for the same loss on other than an
 22 expense incurred basis, ~~and of which this insurer has not been~~
 23 ~~given written notice prior to the occurrence or commencement of~~
 24 ~~loss,~~ the only liability for ~~such~~ **THE** benefits under this policy
 25 ~~shall be~~ **IS** for ~~such~~ **THE** proportion of the indemnities otherwise
 26 provided ~~hereunder~~ **UNDER THIS POLICY** for ~~such~~ **THE** loss as the like
 27 indemnities of which the insurer had notice, including the

1 indemnities under this policy, bear to the total amount of all like
 2 indemnities for ~~such~~**THE** loss, and for the return of ~~such~~**THE**
 3 portion of the premium paid ~~as shall exceed~~**THAT EXCEEDS** the pro
 4 rata portion for the indemnities ~~thus~~ determined **UNDER THIS**
 5 **PROVISION.**

6 (2) If the ~~foregoing~~ policy provision **DESCRIBED IN SUBSECTION**
 7 **(1)** is included in a ~~an~~**AN INDIVIDUAL** policy ~~which~~**OF DISABILITY**
 8 **INSURANCE THAT** also contains the policy provision ~~set out~~**DESCRIBED**
 9 in section 3438, ~~there~~**THE INSURER** shall ~~be added~~**ADD** to the
 10 caption of the ~~foregoing~~**POLICY** provision the phrase ~~"~~**OTHER**
 11 **BENEFITS"**. The insurer may, at its option, include in this
 12 provision a definition of "other valid coverage", approved as to
 13 form by the ~~commissioner~~**DIRECTOR**, which definition shall ~~shall~~**MUST** be
 14 limited in subject matter to coverage provided by organizations
 15 subject to regulation by insurance law or by insurance authorities
 16 of this or any other state of the United States or any province of
 17 Canada, and to any other coverage the inclusion of which ~~may be~~**IS**
 18 approved by the ~~commissioner~~**DIRECTOR**. In the absence of ~~such~~**A**
 19 definition, ~~such~~**THE** term shall ~~shall~~**MUST** not include group insurance ,
 20 or benefits provided by union welfare plans or by employer or
 21 employee benefit organizations. For the purpose of applying the
 22 ~~foregoing~~ policy provision with respect to any insured, any amount
 23 of benefit provided for ~~such~~**THE** insured ~~pursuant to~~**UNDER** any
 24 compulsory benefit statute, including ~~any~~ worker's **DISABILITY**
 25 compensation or employer's liability statute, whether provided by a
 26 governmental agency or ~~otherwise shall~~**OTHER ENTITY, MUST** in all
 27 cases be ~~deemed~~**CONSIDERED** to be "other valid coverage" of which

1 the insurer has had notice, unless the policy contains provisions
 2 for the reduction of benefits otherwise payable under the policy by
 3 the amount of income from other sources that the insured or the
 4 insured's dependents are qualified to receive ~~due to~~ **BECAUSE OF** the
 5 insured's age or disability from worker's **DISABILITY** compensation
 6 or federal social security, if at the time the policy was issued,
 7 the premium had been appropriately reduced to reflect ~~such~~ **THE**
 8 anticipated reduction in benefits. In applying the ~~foregoing~~ policy
 9 provision, ~~no~~ **AN INSURER SHALL NOT INCLUDE** third party liability
 10 coverage ~~shall be included as "other~~ **OTHER** valid
 11 ~~coverage".~~ **COVERAGE.**

12 Sec. 3452. (1) ~~There~~ **AN INSURER** may ~~be~~ **INCLUDE IN A DISABILITY**
 13 **INSURANCE POLICY** a provision as follows:

14 **ILLEGAL OCCUPATION OR ILLEGAL ACTIVITY:** The insurer ~~shall~~ **IS**
 15 not ~~be~~ liable for any loss to which a contributing cause was the
 16 insured's commission of or attempt to commit a felony or to which a
 17 contributing cause was the insured's being engaged in an illegal
 18 occupation **OR ILLEGAL ACTIVITY.**

19 (2) **AS USED IN THIS SECTION, "ILLEGAL ACTIVITY" INCLUDES, BUT**
 20 **IS NOT LIMITED TO, ANY OF THE FOLLOWING:**

21 (A) **OPERATING A VEHICLE WHILE INTOXICATED IN VIOLATION OF**
 22 **SECTION 625 OF THE MICHIGAN VEHICLE CODE, 1949 PA 300, MCL 257.625,**
 23 **OR SIMILAR LAW IN A JURISDICTION OUTSIDE OF THIS STATE.**

24 (B) **OPERATING A METHAMPHETAMINE LABORATORY. AS USED IN THIS**
 25 **SUBDIVISION, "METHAMPHETAMINE LABORATORY" MEANS THAT TERM AS**
 26 **DEFINED IN SECTION 1 OF 2006 PA 255, MCL 333.26371.**

27 Sec. 3472. (1) ~~Beginning January 1, 2014, during~~ **DURING** an

1 applicable open enrollment period, an insurer **THAT OFFERS,**
2 **DELIVERS, ISSUES FOR DELIVERY, OR RENEWS IN THIS STATE A HEALTH**
3 **INSURANCE POLICY** shall not deny or condition the issuance or
4 effectiveness of ~~a~~**THE** policy and shall not discriminate in the
5 pricing of ~~a~~**THE** policy on the basis of health status, claims
6 experience, receipt of health care, or medical condition.

7 (2) Subject to prior approval of the ~~commissioner~~**DIRECTOR**,
8 an insurer shall establish reasonable open enrollment periods for
9 all ~~disability~~**HEALTH INSURANCE** policies offered, delivered, issued
10 for delivery, or renewed in this state. ~~on or after January 1,~~
11 ~~2014.~~

12 (3) The ~~commissioner~~**DIRECTOR** shall establish minimum
13 standards for the frequency and duration of open enrollment periods
14 established under subsection (2). The ~~commissioner~~**DIRECTOR** shall
15 uniformly apply the minimum standards for the frequency and
16 duration of open enrollment periods established under this
17 subsection to all insurers.

18 (4) **SUBJECT TO APPROVAL BY THE DIRECTOR, AN INSURER MAY DENY**
19 **HEALTH INSURANCE COVERAGE IN THE GROUP OR INDIVIDUAL MARKET IF THE**
20 **INSURER DOES NOT HAVE THE NETWORK CAPACITY OR FINANCIAL RESERVES**
21 **NECESSARY TO OFFER ADDITIONAL COVERAGE. AN INSURER DESCRIBED IN**
22 **THIS SUBSECTION SHALL ACT UNIFORMLY WITH REGARD TO ALL EMPLOYERS OR**
23 **INDIVIDUALS IN THE GROUP OR INDIVIDUAL MARKET. AN INSURER DESCRIBED**
24 **IN THIS SUBSECTION SHALL ACT WITHOUT REGARD TO THE CLAIMS**
25 **EXPERIENCE OF AN INDIVIDUAL OR EMPLOYER AND ITS EMPLOYEES AND THE**
26 **EMPLOYEE'S DEPENDENTS AND WITHOUT REGARD TO ANY HEALTH-STATUS-**
27 **RELATED FACTOR RELATING TO THE INDIVIDUAL OR EMPLOYER AND ITS**

1 EMPLOYEES AND THE EMPLOYEE'S DEPENDENTS.

2 (5) SUBJECT TO APPROVAL BY THE DIRECTOR, AN INSURER THAT
 3 DENIES HEALTH INSURANCE COVERAGE TO AN EMPLOYER OR INDIVIDUAL UNDER
 4 SUBSECTION (4) SHALL NOT OFFER COVERAGE IN THE GROUP OR INDIVIDUAL
 5 MARKET, AS APPLICABLE, BEFORE THE LATER OF THE ONE HUNDRED EIGHTY-
 6 FIRST DAY AFTER THE DATE THE INSURER DENIES THE COVERAGE OR THE
 7 DATE THE INSURER DEMONSTRATES TO THE DIRECTOR THAT THE INSURER HAS
 8 SUFFICIENT NETWORK CAPACITY OR FINANCIAL RESERVES, AS APPLICABLE,
 9 TO UNDERWRITE ADDITIONAL COVERAGE.

10 (6) SUBJECT TO APPROVAL BY THE DIRECTOR, SUBSECTION (4) DOES
 11 NOT LIMIT THE INSURER'S ABILITY TO RENEW COVERAGE ALREADY IN FORCE
 12 OR RELIEVE THE INSURER OF THE RESPONSIBILITY TO RENEW THE COVERAGE.

13 (7) THE DIRECTOR MAY PROVIDE FOR THE APPLICATION OF SUBSECTION
 14 (4) ON A SERVICE-AREA-SPECIFIC BASIS FOR HEALTH MAINTENANCE
 15 ORGANIZATIONS.

16 Sec. 3474. (1) ~~No~~ EXCEPT AS OTHERWISE PROVIDED IN SECTION
 17 2236(8)(D), AN INSURER SHALL NOT DELIVER, ISSUE FOR DELIVERY, OR
 18 RENEW IN THIS STATE A DISABILITY INSURANCE policy, ~~of insurance~~
 19 ~~against loss or expense from the sickness, or from the bodily~~
 20 ~~injury or death from accident of the insured, nor any INCLUDING A~~
 21 HEALTH INSURANCE POLICY, AND SHALL NOT USE AN application, rider,
 22 or endorsement ~~to be used in connection therewith, shall be~~
 23 ~~delivered or issued for delivery to any person in this state, WITH~~
 24 THE POLICY until A COPY OF THE POLICY FORM, THE RATE, AND the
 25 classification of risks ~~and any premium rates pertaining thereto~~
 26 have been filed with AND APPROVED BY the ~~department of~~
 27 ~~insurance.~~ DIRECTOR.

1 (2) THE DIRECTOR MAY, WITHIN 60 DAYS AFTER THE FILING OF A
2 DISABILITY INSURANCE POLICY FORM OR RATE, DISAPPROVE THE FORM OR
3 RATE FOR ANY OF THE FOLLOWING REASONS, SUBJECT TO THE REQUIREMENTS
4 AS TO NOTICE, HEARING, AND APPEAL IN SECTIONS 244 AND 2236:

5 (A) THE PREMIUM IS UNREASONABLE IN RELATION TO THE BENEFITS
6 PROVIDED.

7 (B) THE POLICY CONTAINS A PROVISION THAT IS UNJUST, UNFAIR,
8 INEQUITABLE, MISLEADING, OR DECEPTIVE OR THAT ENCOURAGES
9 MISREPRESENTATION OF THE POLICY.

10 (C) THE POLICY OR RATE DOES NOT COMPLY WITH OTHER PROVISIONS
11 OF LAW.

12 (D) WITH RESPECT TO A HEALTH INSURANCE POLICY, THE RATE IS
13 UNREASONABLY LOWER THAN WHAT IS NECESSARY TO MEET THE EXPENSES OF
14 THE INSURER FOR PROVIDING THE COVERAGE AND WOULD HAVE AN
15 ANTICOMPETITIVE EFFECT OR RESULT IN PREDATORY PRICING IN RELATION
16 TO COVERAGES OFFERED BY OTHER INSURERS.

17 (3) THE DIRECTOR MAY AT ANY TIME WITHDRAW HIS OR HER APPROVAL
18 OF A POLICY FORM OR RATE ON ANY OF THE GROUNDS LISTED IN SUBSECTION
19 (2), SUBJECT TO THE REQUIREMENTS AS TO NOTICE, HEARING, AND APPEAL
20 IN SECTIONS 244 AND 2236. AN INSURER SHALL NOT ISSUE THE FORM OR
21 RATE AFTER THE EFFECTIVE DATE OF THE WITHDRAWAL OF APPROVAL.

22 (4) SUBSECTION (2) DOES NOT APPLY TO A RATE FOR A POLICY OF
23 HEALTH INSURANCE THAT IS THE RESULT OF COLLECTIVE BARGAINING AND
24 THAT AFFECTS ONLY THE ENROLLEES OR INSURED WHO ARE MEMBERS OF THE
25 GROUP ENGAGED IN THE COLLECTIVE BARGAINING. HOWEVER, AN INSURER
26 SHALL FILE A RATE DESCRIBED IN THIS SUBSECTION WITH THE DIRECTOR
27 WITHIN 60 DAYS AFTER THE EFFECTIVE DATE OF THE POLICY.

1 (5) AS USED IN THIS SECTION, AFTER JANUARY 1, 2016, "INSURER"
2 INCLUDES A NONPROFIT DENTAL CARE CORPORATION OPERATING UNDER 1963
3 PA 125, MCL 550.351 TO 550.373.

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

10 ~~—— (a) Whether the policy or certificate covers an individual or~~
11 ~~family.~~

12 ~~—— (b) The rating area.~~

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

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

17 (1) A HEALTH INSURANCE POLICY AND THE RATES FOR THE POLICY,
18 INCLUDING ANY DEDUCTIBLES, COPAYMENTS, AND COINSURANCES, MUST BE
19 FAIR, SOUND, AND REASONABLE IN RELATION TO THE SERVICES PROVIDED,
20 AND THE PROCEDURES FOR OFFERING AND TERMINATING HEALTH INSURANCE
21 POLICIES MUST NOT BE UNFAIRLY DISCRIMINATORY.

22 (2) A HEALTH INSURANCE POLICY AND THE RATES FOR THE POLICY
23 MUST NOT DISCRIMINATE ON THE BASIS OF RACE, COLOR, CREED, NATIONAL
24 ORIGIN, RESIDENCE WITHIN THE APPROVED SERVICE AREA, IF APPLICABLE,
25 LAWFUL OCCUPATION, SEX, HANDICAP, OR MARITAL STATUS, EXCEPT THAT
26 MARITAL STATUS MAY BE USED TO CLASSIFY INDIVIDUALS OR RISKS FOR THE
27 PURPOSE OF INSURING FAMILY UNITS. THE DIRECTOR MAY APPROVE A RATE

1 DIFFERENTIAL BASED ON SEX, AGE, RESIDENCE, DISABILITY, MARITAL
 2 STATUS, OR LAWFUL OCCUPATION, IF THE DIFFERENTIAL IS SUPPORTED BY
 3 SOUND ACTUARIAL PRINCIPLES AND A REASONABLE CLASSIFICATION SYSTEM
 4 AND IS RELATED TO THE ACTUAL AND CREDIBLE LOSS STATISTICS OR
 5 REASONABLY ANTICIPATED EXPERIENCE FOR NEW COVERAGES.

6 (3) A HEALTHY LIFESTYLE PROGRAM AS DEFINED IN SECTION 3517 IS
 7 NOT SUBJECT TO THE DIRECTOR'S APPROVAL UNDER THIS SECTION AND IS
 8 NOT REQUIRED TO BE SUPPORTED BY SOUND ACTUARIAL PRINCIPLES OR A
 9 REASONABLE CLASSIFICATION SYSTEM OR TO BE RELATED TO ACTUAL AND
 10 CREDIBLE LOSS STATISTICS OR REASONABLY ANTICIPATED EXPERIENCE FOR
 11 THE COVERAGE.

12 Sec. 3475. (1) Notwithstanding any provision of ~~any~~ **A**
 13 **DISABILITY INSURANCE** policy, ~~of insurance or certificate, if an~~
 14 ~~insurance~~ **THE DISABILITY INSURANCE** policy ~~or certificate provides~~
 15 for reimbursement for any service that is legally performed by a
 16 person fully licensed as a psychologist under part 182 of the
 17 public health code, 1978 PA 368, MCL 333.18201 to 333.18237; by a
 18 podiatrist licensed under part 180 of the public health code, 1978
 19 PA 368, MCL 333.18001 to 333.18058; or by a chiropractor licensed
 20 under part 164 of the public health code, 1978 PA 368, MCL
 21 333.16401 to 333.16431, ~~+~~ **THE INSURER SHALL NOT DENY** reimbursement
 22 under the insurance policy ~~or certificate shall not be denied if~~
 23 the service is rendered by a person fully licensed as a
 24 psychologist under part 182 of the public health code, 1978 PA 368,
 25 MCL 333.18201 to 333.18237; by a podiatrist licensed under part 180
 26 of the public health code, 1978 PA 368, MCL 333.18001 to 333.18058;
 27 or by a chiropractor licensed under part 164 of the public health

code, 1978 PA 368, MCL 333.16401 to 333.16431, ~~within the~~
 statutory provisions provided in his or her individual practice
 act.

(2) This section does not require coverage for a psychologist
 in ~~any~~**AN** insurance policy. This section does not require coverage
 or reimbursement for any of the following:

(a) A practice of chiropractic service unless ~~that~~**THE** service
 was included in the definition of practice of chiropractic under
 section 16401 of the public health code, 1978 PA 368, MCL
 333.16401, as of January 1, 2009.

(b) A service provided by a physical therapist or physical
 therapist assistant unless ~~that~~**THE** service was provided by a
 licensed physical therapist or physical therapist assistant under
 the supervision of a licensed physical therapist pursuant to a
 prescription from a health care professional who holds a license
 issued under part 166, 170, 175, or 180 of the public health code,
 1978 PA 368, MCL 333.16601 to 333.16648, 333.17001 to 333.17084,
 333.17501 to 333.17556, and 333.18001 to 333.18058, or the
 equivalent license issued by another state.

(3) This section does not apply to a policy ~~or certificate~~
 written under section 3405 ~~or 3631~~ that involves a prudent
 purchaser agreement.

Sec. 3476. (1) An ~~expense incurred hospital, medical, or~~
~~surgical group or individual~~**INSURER THAT DELIVERS, ISSUES FOR**
DELIVERY, OR RENEWS IN THIS STATE A HEALTH INSURANCE policy ~~or~~
~~certificate delivered, issued for delivery, or renewed in this~~
~~state and a health maintenance organization group or individual~~

~~contract shall not require face-to-face contact between a health~~
~~care professional and a patient for services appropriately provided~~
~~through telemedicine, as determined by the insurer. or health~~
~~maintenance organization. Telemedicine services shall~~ **MUST** ~~be~~
 provided by a health care professional who is licensed, registered,
 or otherwise authorized to engage in his or her health care
 profession in the state where the patient is located. Telemedicine
 services are subject to all terms and conditions of the **HEALTH**
INSURANCE policy, ~~certificate, or contract~~ agreed upon between the
 policy, ~~certificate, or contract~~ holder and the insurer, ~~or health~~
~~maintenance organization, including, but not limited to, required~~
 copayments, coinsurances, deductibles, and approved amounts.

(2) As used in this section, "telemedicine" means the use of
 an electronic media to link patients with health care professionals
 in different locations. To be considered telemedicine under this
 section, the health care professional must be able to examine the
 patient via a real-time, interactive audio or video, or both,
 telecommunications system and the patient must be able to interact
 with the off-site health care professional at the time the services
 are provided.

~~—— (3) This section applies to a policy, certificate, or contract~~
~~issued or renewed on or after January 1, 2013.~~

SEC. 3477. (1) AN INSURER SHALL NOT USE ANY FINANCIAL
INCENTIVE OR MAKE ANY PAYMENT TO A HEALTH PROFESSIONAL THAT ACTS
DIRECTLY OR INDIRECTLY AS AN INDUCEMENT TO DENY, REDUCE, LIMIT, OR
DELAY SPECIFIC MEDICALLY NECESSARY AND APPROPRIATE SERVICES.

(2) SUBSECTION (1) DOES NOT PROHIBIT PAYMENT ARRANGEMENTS THAT

1 ARE NOT TIED TO SPECIFIC MEDICAL DECISIONS OR PROHIBIT THE USE OF
2 RISK SHARING AS OTHERWISE AUTHORIZED IN THIS CHAPTER.

3 Sec. 3501. As used in this chapter:

4 (a) "Affiliated provider" means a health professional,
5 licensed hospital, licensed pharmacy, or any other institution,
6 organization, or person ~~having a~~ **THAT HAS ENTERED INTO A**
7 **PARTICIPATING PROVIDER** contract, **DIRECTLY OR INDIRECTLY**, with a
8 health maintenance organization to render 1 or more health
9 ~~maintenance services to an enrollee.~~ **AFFILIATED PROVIDER INCLUDES A**
10 **PERSON DESCRIBED IN THIS SUBDIVISION THAT HAS ENTERED INTO A**
11 **WRITTEN ARRANGEMENT WITH ANOTHER PERSON, INCLUDING, BUT NOT LIMITED**
12 **TO, A PHYSICIAN HOSPITAL ORGANIZATION OR PHYSICIAN ORGANIZATION,**
13 **THAT CONTRACTS DIRECTLY WITH A HEALTH MAINTENANCE ORGANIZATION.**

14 (b) "Basic health services" means **MEDICALLY NECESSARY HEALTH**
15 **SERVICES THAT HEALTH MAINTENANCE ORGANIZATIONS MUST OFFER TO LARGE**
16 **EMPLOYERS IN AT LEAST 1 HEALTH MAINTENANCE CONTRACT. BASIC HEALTH**
17 **SERVICES INCLUDE ALL OF THE FOLLOWING:**

18 (i) Physician services including ~~consultant and referral~~
19 ~~services by a physician, but not including psychiatric services.~~
20 **PRIMARY CARE AND SPECIALTY CARE.**

21 (ii) Ambulatory services.

22 (iii) Inpatient hospital services. ~~, other than those for the~~
23 ~~treatment of mental illness.~~

24 (iv) Emergency health services.

25 (v) ~~Outpatient mental~~ **MENTAL health AND SUBSTANCE USE DISORDER**
26 **services. , not fewer than 20 visits per year.**

27 ~~—— (vi) Intermediate and outpatient care for substance abuse as~~

1 follows:

2 ~~—— (A) For group contracts, if the fees for a group contract~~
3 ~~would be increased by 3% or more because of the provision of~~
4 ~~services under this subparagraph, the group subscriber may decline~~
5 ~~the services. For individual contracts, if the total fees for all~~
6 ~~individual contracts would be increased by 3% or more because of~~
7 ~~the provision of the services required under this subparagraph in~~
8 ~~all of those contracts, the named subscriber of each contract may~~
9 ~~decline the services.~~

10 ~~—— (B) Charges, terms, and conditions for the services required~~
11 ~~to be provided under this subparagraph shall not be less favorable~~
12 ~~than the maximum prescribed for any other comparable service.~~

13 ~~—— (C) The services required to be provided under this~~
14 ~~subparagraph shall not be reduced by terms or conditions that apply~~
15 ~~to other services in a group or individual contract. This sub-~~
16 ~~subparagraph shall not be construed to prohibit contracts that~~
17 ~~provide for deductibles and copayment provisions for services for~~
18 ~~intermediate and outpatient care for substance abuse.~~

19 ~~—— (D) The services required to be provided under this~~
20 ~~subparagraph shall, at a minimum, provide for up to \$2,968.00 in~~
21 ~~services for intermediate and outpatient care for substance abuse~~
22 ~~per individual per year. This minimum shall be adjusted annually by~~
23 ~~March 31 each year in accordance with the annual average percentage~~
24 ~~increase or decrease in the United States consumer price index for~~
25 ~~the 12 month period ending the preceding December 31.~~

26 ~~—— (E) As used in this subparagraph, "intermediate care",~~
27 ~~"outpatient care", and "substance abuse" have those meanings~~

1 ascribed to them in section 3425.

2 (vi) ~~(vii)~~ Diagnostic laboratory and diagnostic and
3 therapeutic radiological services.

4 (vii) ~~(viii)~~ Home health services.

5 (viii) ~~(ix)~~ Preventive health services.

6 (c) "Credentialing verification" means the process of
7 obtaining and verifying information about a health professional and
8 evaluating ~~that~~ **THE** health professional when ~~that~~ **THE** health
9 professional applies to become a participating provider with a
10 health maintenance organization.

11 ~~—— (d) "Enrollee" means an individual who is entitled to receive~~
12 ~~health maintenance services under a health maintenance contract.~~

13 (D) ~~(e)~~ "Health maintenance contract" means a contract between
14 a health maintenance organization and a subscriber or group of
15 subscribers, ~~to provide, when medically indicated, designated OR~~
16 **ARRANGE FOR THE PROVISION OF** health maintenance services, ~~as~~
17 ~~described in and pursuant to the terms of the contract, including,~~
18 ~~at a minimum, basic health maintenance services. WITHIN THE HEALTH~~
19 **MAINTENANCE ORGANIZATION'S SERVICE AREA.** Health maintenance
20 contract includes a prudent purchaser ~~contract.~~ **AGREEMENT UNDER**
21 **SECTION 3405.**

22 (E) ~~(f)~~ "Health maintenance organization" means ~~an entity~~ **A**
23 **PERSON** that, **AMONG OTHER THINGS**, does the following:

24 (i) Delivers health maintenance services that are medically
25 ~~indicated~~ **NECESSARY** to enrollees under the terms of its health
26 maintenance contract, directly or through contracts with affiliated
27 providers, in exchange for a fixed prepaid sum or per capita

1 prepayment, without regard to the frequency, extent, or kind of
2 health services.

3 (ii) Is responsible for the availability, accessibility, and
4 quality of the health ~~maintenance~~ services provided.

5 ~~—— (g) "Health maintenance services" means services provided to~~
6 ~~enrollees of a health maintenance organization under their health~~
7 ~~maintenance contract.~~

8 (F) ~~(h)~~ "Health professional" means an individual licensed,
9 certified, or authorized in accordance with state law to practice a
10 health profession in his or her respective state.

11 ~~—— (i) "Primary verification" means verification by the health~~
12 ~~maintenance organization of a health professional's credentials~~
13 ~~based upon evidence obtained from the issuing source of the~~
14 ~~credential.~~

15 ~~—— (j) "Prudent purchaser contract" means a contract offered by a~~
16 ~~health maintenance organization to groups or to individuals under~~
17 ~~which enrollees who select to obtain health care services directly~~
18 ~~from the organization or through its affiliated providers receive a~~
19 ~~financial advantage or other advantage by selecting those~~
20 ~~providers.~~

21 ~~—— (k) "Secondary verification" means verification by the health~~
22 ~~maintenance organization of a health professional's credentials~~
23 ~~based upon evidence obtained by means other than direct contact~~
24 ~~with the issuing source of the credential.~~

25 (G) "HEALTH SERVICES" MEANS SERVICES PROVIDED TO ENROLLEES OF
26 A HEALTH MAINTENANCE ORGANIZATION UNDER THEIR HEALTH MAINTENANCE
27 CONTRACT.

1 **(H)** ~~(I)~~ "Service area" means a defined geographical area in
 2 which **COVERED** health ~~maintenance~~ services are generally available
 3 and readily accessible to enrollees and where health maintenance
 4 organizations may market their contracts.

5 ~~—— (m) "Subscriber" means an individual who enters into a health~~
 6 ~~maintenance contract, or on whose behalf a health maintenance~~
 7 ~~contract is entered into, with a health maintenance organization~~
 8 ~~that has received a certificate of authority under this chapter and~~
 9 ~~to whom a health maintenance contract is issued.~~

10 Sec. 3503. (1) ~~All~~ **UNLESS SPECIFICALLY EXCLUDED, OR OTHERWISE**
 11 **SPECIFICALLY PROVIDED FOR IN THIS CHAPTER, ALL** of the provisions of
 12 this act that apply to a domestic insurer authorized to issue ~~an~~
 13 ~~expense incurred hospital, medical, or surgical policy or~~
 14 ~~certificate, including, but not limited to, sections 223 and 7925~~
 15 ~~and chapters 34 and 36, A HEALTH INSURANCE POLICY~~ apply to a health
 16 maintenance organization. ~~under this chapter unless specifically~~
 17 ~~excluded, or otherwise specifically provided for in this chapter.~~

18 (2) Sections 408, 410, 411, **AND** 901, and ~~5208, chapter~~
 19 **CHAPTERS 77** ~~, and , except as otherwise provided in subsection (1),~~
 20 ~~chapter 79~~ do not apply to a health maintenance organization.

21 Sec. 3505. (1) A health maintenance organization shall ~~receive~~
 22 **NOT ISSUE A HEALTH MAINTENANCE CONTRACT BEFORE IT RECEIVES** a
 23 certificate of authority under this ~~chapter before issuing health~~
 24 ~~maintenance contracts. A health maintenance organization license~~
 25 ~~issued under former part 210 of the public health code, 1978 PA~~
 26 ~~368, automatically becomes a certificate of authority under this~~
 27 ~~chapter on the effective date of this chapter.~~**ACT.**

1 (2) ~~"Health~~ **A PERSON SHALL NOT USE THE TERM HEALTH** maintenance
 2 ~~organization"~~ shall not be used **ORGANIZATION** to describe or refer
 3 to ~~any entity or~~ **A** person, and ~~an entity or~~ **A** person shall not use
 4 any other descriptive words that may mislead, deceive, or imply
 5 that it is a health maintenance organization, unless the ~~entity or~~
 6 person **DESCRIBED OR REFERRED TO** has a certificate of authority as a
 7 health maintenance organization under this ~~chapter~~ **ACT**.

8 (3) ~~A~~ **EXCEPT AS OTHERWISE PROVIDED IN THIS SUBSECTION, A**
 9 health maintenance organization shall not use in its name,
 10 contracts, or literature the words "insurance", "casualty",
 11 "surety", **OR** "mutual" ~~—~~ or any other words descriptive of an
 12 insurance, casualty, or surety business or deceptively similar to
 13 the name or description of an insurance or surety corporation doing
 14 business in this state. **A HEALTH MAINTENANCE ORGANIZATION MAY USE A**
 15 **NAME OR DESCRIPTION THAT IS SIMILAR TO ITS AFFILIATE.**

16 Sec. 3507. The ~~commissioner~~ **DIRECTOR** shall establish a system
 17 of authorizing and regulating health maintenance organizations in
 18 this state to protect and promote the public health through the
 19 assurance that the organizations provide **ALL OF THE FOLLOWING**:

20 (a) An acceptable quality of health care by qualified
 21 personnel.

22 (b) Health care facilities, equipment, and personnel that may
 23 reasonably be required to economically provide health ~~maintenance~~
 24 services.

25 (c) Operational arrangements that integrate the delivery of
 26 various services.

27 (d) ~~A financially~~ **FINANCIALLY** sound prepayment ~~plan~~ **PLANS** for

1 meeting health care costs.

2 Sec. 3508. (1) A health maintenance organization shall develop
3 and maintain a quality assessment program ~~to assess the quality of~~
4 ~~health care provided to enrollees~~ that includes, at a minimum,
5 systematic collection, analysis, and reporting of relevant data in
6 accordance with statutory and regulatory requirements. ~~A health~~
7 ~~maintenance organization shall make available its quality~~
8 ~~assessment program as prescribed by the commissioner.~~

9 (2) A health maintenance organization shall establish and
10 maintain a quality improvement program to design, measure, assess,
11 and improve the processes and outcomes of health care as identified
12 in the program. A health maintenance organization shall ~~make~~
13 ~~available its quality improvement program as prescribed by the~~
14 ~~commissioner. The~~ **PLACE THE** quality improvement program ~~shall be~~
15 under the direction of ~~the health maintenance organization's~~ **ITS**
16 medical director and ~~shall include~~ **ALL OF THE FOLLOWING IN THE**
17 **PROGRAM:**

18 (a) A written statement of the program's objectives, lines of
19 authority and accountability, evaluation tools, including data
20 collection responsibilities, and performance improvement
21 activities.

22 (b) An annual effectiveness review of the program.

23 (c) A written quality improvement plan that, at a minimum,
24 describes how the health maintenance organization analyzes both the
25 processes and outcomes of care, identifies the targeted diagnoses
26 and treatments to be reviewed each year, uses a range of
27 appropriate methods to analyze quality, compares program findings

1 with past performance and internal goals and external standards,
2 measures the performance of affiliated providers, and conducts peer
3 review activities.

4 Sec. 3509. (1) An application to the ~~commissioner~~**DIRECTOR** for
5 a certificate of authority ~~shall~~**MUST** be on a form prescribed and
6 provided by the ~~commissioner~~**DIRECTOR**.

7 (2) A certificate of authority issued **TO A HEALTH MAINTENANCE**
8 **ORGANIZATION** under this ~~chapter~~**ACT** is limited to the service area
9 described in the application ~~upon~~**ON** which the certificate of
10 authority was issued. **APPROVED PARTS OF A HEALTH MAINTENANCE**
11 **ORGANIZATION'S SERVICE AREA ARE NOT REQUIRED TO BE CONTIGUOUS.**

12 (3) A health maintenance organization seeking to change the
13 approved service area shall submit an application to change service
14 area to the ~~commissioner~~**DIRECTOR** and shall not change the service
15 area until approval is received. The ~~commissioner~~**DIRECTOR** shall
16 specify the information required to be in the application under
17 this subsection.

18 Sec. 3511. (1) ~~By the end of the first 12 months of operation,~~
19 **a-A HEALTH MAINTENANCE ORGANIZATION'S GOVERNING BODY MUST INCLUDE**
20 **NO LESS THAN 1 INDIVIDUAL WHO REPRESENTS THE HEALTH MAINTENANCE**
21 **ORGANIZATION'S MEMBERSHIP.**

22 (2) ~~A health maintenance organization's governing body~~
23 **ORGANIZATION THAT IS UNDER A CONTRACT WITH THIS STATE TO PROVIDE**
24 **MEDICAL SERVICES AUTHORIZED UNDER SUBCHAPTER XIX OR XXI OF THE**
25 **SOCIAL SECURITY ACT, 42 USC 1396 TO 1396W-5 AND 1397AA TO 1397MM,**
26 ~~shall have a~~**COMPLY WITH EITHER OF THE FOLLOWING REQUIREMENTS:**

27 **(A) A minimum of 1/3 of its GOVERNING BODY MUST BE**

1 **REPRESENTATIVES OF ITS** membership consisting of ~~adult~~ enrollees of
 2 the organization who are not compensated officers, employees,
 3 ~~stockholders who own more than 5% of the organization's shares, or~~
 4 other individuals responsible for the conduct of, or financially
 5 interested in, the organization's affairs. ~~The enrollee board~~
 6 ~~members shall be elected by a simple plurality of the voting~~
 7 ~~subscribers. Each subscriber shall have 1 vote. The enrollee board~~
 8 ~~members shall hold office for 3 years after their election, except~~
 9 ~~that the terms of office following the first enrollee election may~~
 10 ~~be adjusted to allow the terms of enrollee board members to expire~~
 11 ~~on a staggered basis. A vacancy among enrollee board members shall~~
 12 ~~be filled by appointment by a simple majority of the remaining~~
 13 ~~enrollee members of the board from individuals meeting the~~
 14 ~~qualifications of this section. A vacancy shall be filled only for~~
 15 ~~the unexpired portion of the original term, at which time the~~
 16 ~~enrollee member shall be elected in the manner prescribed by this~~
 17 ~~chapter.~~

18 **(B) THE HEALTH MAINTENANCE ORGANIZATION MUST ESTABLISH A**
 19 **CONSUMER ADVISORY COUNCIL THAT REPORTS TO THE GOVERNING BODY. THE**
 20 **CONSUMER ADVISORY COUNCIL MUST INCLUDE AT LEAST 1 ENROLLEE, 1**
 21 **FAMILY MEMBER OR LEGAL GUARDIAN OF AN ENROLLEE, AND 1 CONSUMER**
 22 **ADVOCATE.**

23 **(3) ~~(2)~~** A health maintenance organization's governing body
 24 shall meet at least quarterly unless specifically exempted from
 25 this requirement by the ~~commissioner~~ **DIRECTOR**.

26 Sec. 3513. (1) The ~~commissioner~~ **DIRECTOR** shall regulate health
 27 delivery aspects of health maintenance organization operations ~~for~~

1 ~~the purpose of assuring~~ **TO ENSURE** that health maintenance
 2 organizations are capable of providing care and services promptly,
 3 appropriately, and in a manner that ~~assures~~ **ENSURES** continuity and
 4 acceptable quality of health care. The ~~commissioner~~ **DIRECTOR** shall
 5 encourage health maintenance organizations to ~~utilize~~ **USE** a wide
 6 variety of health-related disciplines and facilities and to develop
 7 services that contribute to the prevention of disease and
 8 disability and ~~to the~~ restoration of health.

9 (2) The ~~commissioner~~ **DIRECTOR** shall ~~regulate the business and~~
 10 ~~financial aspects of health maintenance organization operations for~~
 11 ~~the purpose of assuring that the organizations are financially~~
 12 ~~sound and follow acceptable business practices. The commissioner~~
 13 ~~shall assure~~ **ENSURE** that the **HEALTH MAINTENANCE** organizations
 14 operate in the interest of enrollees consistent with overall health
 15 care cost containment while delivering acceptable quality of care
 16 and services that are available and accessible to enrollees with
 17 appropriate administrative costs and health care provider
 18 incentives. A health maintenance organization shall do all of the
 19 following:

20 (a) Provide, as promptly as appropriate, health ~~maintenance~~
 21 services in a manner that ~~assures~~ **ENSURES** continuity and imparts
 22 quality health care under conditions the ~~commissioner~~ **DIRECTOR**
 23 considers to be in the public interest.

24 (b) Provide ~~, within the geographic area served by the health~~
 25 ~~maintenance organization, health maintenance services~~ **WITHIN ITS**
 26 **SERVICE AREA** that are ~~available, accessible, and provided as~~
 27 ~~promptly as appropriate to each of its enrollees in a manner that~~

~~assures continuity, and are available and accessible to enrollees 24 hours a day and 7 days a week for the treatment of emergency episodes of illness or injury.~~

~~— (c) Provide adequate arrangements for a continuous evaluation of the quality of health care.~~

(C) ~~(d)~~ Provide that reasonable provisions exist for an enrollee to obtain emergency health services both within and outside of the geographic **ITS SERVICE** area. ~~served by the health maintenance organization.~~

~~— (e) Provide that reasonable procedures exist for resolving enrollee grievances as required by this chapter or as otherwise provided by law.~~

(3) ~~(f)~~ **Be A HEALTH MAINTENANCE ORGANIZATION MUST BE** incorporated as a distinct legal entity under the business corporation act, 1972 PA 284, MCL 450.1101 to 450.2098, the nonprofit corporation act, 1982 PA 162, MCL 450.2101 to 450.3192, or the Michigan limited liability company act, 1993 PA 23, MCL 450.4101 to 450.5200.

~~— (g) Have a governing body that meets the requirements of this chapter.~~

Sec. 3515. (1) A health maintenance organization may provide additional health ~~maintenance~~ services or any other related health care service or treatment not required under this ~~chapter~~. **ACT.**

(2) A health maintenance organization may have health maintenance contracts with deductibles. A health maintenance organization may have health maintenance contracts that include copayments, stated as dollar amounts for the cost of covered

1 services, and coinsurance, stated as percentages for the cost of
2 covered services. ~~Coinurance for basic health services, excluding~~
3 ~~deductibles, shall not exceed 50% of a health maintenance~~
4 ~~organization's reimbursement to an affiliated provider for~~
5 ~~providing the service to an enrollee and shall not be based on the~~
6 ~~provider's standard charge for the service.~~ This subsection does
7 not limit the ~~commissioner's~~ **DIRECTOR'S** authority to regulate and
8 establish fair, sound, and reasonable copayment and coinsurance
9 limits including out of pocket maximums.

10 ~~—— (3) By May 15, 2008, and by each May 15 after 2008, the~~
11 ~~commissioner shall make a determination as to whether the greater~~
12 ~~copayment and coinsurance levels allowed by the amendatory act that~~
13 ~~added this subsection have increased the number of employers who~~
14 ~~have contracted for health maintenance organization services and~~
15 ~~whether these levels have increased the number of enrollees~~
16 ~~receiving health maintenance organization services. In making this~~
17 ~~determination, the commissioner shall hold a public hearing by~~
18 ~~February 1, 2008, and may hold a public hearing thereafter, shall~~
19 ~~seek the advice and input from appropriate independent sources,~~
20 ~~including, but not limited to, all health maintenance organizations~~
21 ~~operating in this state and with enrollees in this state, and shall~~
22 ~~issue a report delineating specific examples of copayment and~~
23 ~~coinsurance levels in force and suggestions to increase the number~~
24 ~~of persons enrolled in health maintenance organizations.~~

25 ~~—— (4) If the results of the report issued under subsection (3)~~
26 ~~are disputed or if the commissioner determines that the~~
27 ~~circumstances that the report was based on have changed, the~~

~~commissioner shall issue a supplemental report to the report under subsection (3) that includes copies of the written objections disputing the commissioner's report determinations or that specifies the change of circumstances. The supplemental report shall be issued not later than December 15 immediately following the release of the report under subsection (3) that this report supplements and shall be supported by substantial evidence.~~

~~—— (5) All of the following shall be considered by the commissioner for purposes of subsections (3) and (4):~~

~~—— (a) Information and data gathered from health maintenance organizations regarding the effects of greater copayment and coinsurance levels allowed by the amendatory act that added this subsection.~~

~~—— (b) Information and data provided by employers who employ residents of this state.~~

~~—— (c) Any other information and data the commissioner considers relevant.~~

~~—— (6) The reports and certifications required under subsections (3) and (4) shall be forwarded to the governor, the clerk of the house of representatives, the secretary of the senate, and all members of the senate and house of representatives standing committees on insurance and health issues.~~

~~(3) (7)~~ A health maintenance organization shall not require **THAT** contributions be made to a deductible for preventive health care services. As used in this subsection, "preventive health care services" means services designated to maintain an individual in optimum health and to prevent unnecessary injury, illness, or

1 disability.

2 (4) ~~(8)~~—A health maintenance organization may accept from
3 governmental agencies and from private persons payments covering
4 any part of the cost of health maintenance contracts.

5 Sec. 3517. (1) A health maintenance contract shall not provide
6 for payment of cash or other material benefit to an enrollee ~~7~~
7 ~~except OTHER THAN as stated in this chapter.~~ **PERMITTED UNDER THE LAW**
8 **OF THIS STATE OR AS APPROVED BY THE DIRECTOR UNDER SECTION 2236.**

9 (2) Subsection (1) does not prohibit a health maintenance
10 organization from promoting optimum health by offering to all
11 currently enrolled subscribers or to all currently covered
12 enrollees 1 or more healthy lifestyle programs. ~~A~~ **AS USED IN THIS**
13 **SUBSECTION, "healthy lifestyle program" means a program recognized**
14 **by a health maintenance organization that enhances health, EDUCATES**
15 **ENROLLEES ON HEALTH-RELATED MATTERS, or reduces risk of disease,**
16 **including, but not limited to, promoting nutrition and physical**
17 **exercise and compliance with disease management programs and**
18 **preventive service guidelines that are supported by evidence-based**
19 **medical practice. A HEALTHY LIFESTYLE PROGRAM MAY INCLUDE OTHER**
20 **REQUIREMENTS IN ADDITION TO THOSE THAT ENHANCE HEALTH, EDUCATE**
21 **ENROLLEES ON HEALTH-RELATED MATTERS, OR REDUCE RISK OF DISEASE IF**
22 **THE HEALTHY LIFESTYLE PROGRAM, TAKEN AS A WHOLE, MEETS THE INTENT**
23 **OF THIS SUBSECTION.** Subsection (1) does not prohibit a health
24 maintenance organization from offering a currently enrolled
25 subscriber or currently covered enrollee goods, vouchers, or
26 equipment that supports achieving optimal health goals. An offering
27 of goods, vouchers, or equipment under this subsection is not a

1 violation of subsection (1) and ~~shall~~ **IS** not be considered valuable
2 consideration, a material benefit, a gift, a rebate, or an
3 inducement under this act.

4 (3) For an emergency episode of illness or injury that
5 requires immediate treatment before it can be secured through the
6 health maintenance organization, or for an out-of-area service
7 specifically authorized by the health maintenance organization, an
8 enrollee may ~~utilize~~ **USE** a provider ~~within~~ **IN** or ~~without~~ **OUTSIDE OF**
9 this state not normally engaged by the health maintenance
10 organization to render service to its enrollees. The **HEALTH**
11 **MAINTENANCE** organization shall pay reasonable expenses or fees to
12 the provider or enrollee as appropriate in an individual case.
13 These transactions are not ~~considered~~ acts of insurance and, except
14 as provided in this chapter and section 3406k, are not otherwise
15 subject to this act.

16 Sec. 3519. ~~(1) A health maintenance organization contract and~~
17 ~~the contract's rates, including any deductibles, copayments, and~~
18 ~~coinsurances, between the organization and its subscribers shall be~~
19 ~~fair, sound, and reasonable in relation to the services provided,~~
20 ~~and the procedures for offering and terminating contracts shall not~~
21 ~~be unfairly discriminatory.~~

22 ~~—— (2) A health maintenance organization contract and the~~
23 ~~contract's rates shall not discriminate on the basis of race,~~
24 ~~color, creed, national origin, residence within the approved~~
25 ~~service area of the health maintenance organization, lawful~~
26 ~~occupation, sex, handicap, or marital status, except that marital~~
27 ~~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 shall include, at a minimum, OFFER basic health services TO LARGE EMPLOYERS IN AT LEAST 1 HEALTH MAINTENANCE CONTRACT.~~

Sec. 3528. (1) A health maintenance organization shall ~~do all of the following:~~

~~—— (a) Establish~~ **ESTABLISH** written policies and procedures for credentialing verification of all health professionals with whom the health maintenance organization contracts. ~~and~~ **A HEALTH MAINTENANCE ORGANIZATION** shall apply these standards consistently. **THIS ACT DOES NOT REQUIRE A HEALTH MAINTENANCE ORGANIZATION TO SELECT A PROVIDER AS AN AFFILIATED PROVIDER SOLELY BECAUSE THE PROVIDER MEETS THE HEALTH MAINTENANCE ORGANIZATION'S CREDENTIALING VERIFICATION STANDARDS. THIS ACT DOES NOT PREVENT A HEALTH MAINTENANCE ORGANIZATION FROM USING SEPARATE OR ADDITIONAL CRITERIA IN SELECTING THE HEALTH PROFESSIONALS WITH WHOM IT CONTRACTS.**

~~—— (b) Verify the credentials of a health professional before~~

~~entering into a contract with that health professional. The health maintenance organization's medical director or other designated health professional shall have responsibility for, and shall participate in, health professional credentialing verification.~~

~~—— (c) Establish a credentialing verification committee consisting of licensed physicians and other health professionals to review credentialing verification information and supporting documents and make decisions regarding credentialing verification.~~

~~—— (d) Make available for review by the applying health professional upon written request all application and credentialing verification policies and procedures.~~

~~—— (e) Retain all records and documents relating to a health professional's credentialing verification process for at least 2 years.~~

~~—— (f) Keep confidential all information obtained in the credentialing verification process, except as otherwise provided by law.~~

~~—— (2) A health maintenance organization shall obtain primary verification of at least all of the following information about an applicant to become a health professional with the health maintenance organization:~~

~~—— (a) Current license to practice in this state and history of licensure.~~

~~—— (b) Current level of professional liability coverage, if applicable.~~

~~—— (c) Status of hospital privileges, if applicable.~~

~~—— (3) A health maintenance organization shall obtain, subject to~~

~~either primary or secondary verification at the health maintenance organization's discretion, all of the following information about an applicant to become an affiliated provider with the health maintenance organization:~~

~~—— (a) The health professional's license history in this and all other states.~~

~~—— (b) The health professional's malpractice history.~~

~~—— (c) The health professional's practice history.~~

~~—— (d) Specialty board certification status, if applicable.~~

~~—— (e) Current drug enforcement agency (DEA) registration certificate, if applicable.~~

~~—— (f) Graduation from medical or other appropriate school.~~

~~—— (g) Completion of postgraduate training, if applicable.~~

~~(4) A health maintenance organization shall obtain at least every 3 years primary verification of all of the following for a participating health professional:~~

~~—— (a) Current license to practice in this state.~~

~~—— (b) Current level of professional liability coverage, if applicable.~~

~~—— (c) Status of hospital privileges, if applicable.~~

~~(5) A health maintenance organization shall require all participating providers to notify the health maintenance organization of changes in the status of any of the items listed in this section at any time and identify for providers the individual at the health maintenance organization to whom they should report changes in the status of an item listed in this section.~~

~~(6) A health maintenance organization shall provide a health~~

~~professional with the opportunity to review and correct information submitted in support of that health professional's credentialing verification application as follows:~~

~~—— (a) Each health professional who is subject to the credentialing verification process has the right to review all information, including the source of that information, obtained by the health maintenance organization to satisfy the requirements of this section during the health maintenance organization's credentialing process.~~

~~—— (b) A health maintenance organization shall notify a health professional of any information obtained during the health maintenance organization's credentialing verification process that does not meet the health maintenance organization's credentialing verification standards or that varies substantially from the information provided to the health maintenance organization by the health professional, except that the health maintenance organization is not required to reveal the source of information if the information is not obtained to meet the requirements of this section or if disclosure is prohibited by law.~~

~~—— (c) A health professional has the right to correct any erroneous information. A health maintenance organization shall have a formal process by which a health professional may submit supplemental or corrected information to the health maintenance organization's credentialing verification committee and request a reconsideration of the health professional's credentialing verification application if the health professional feels that the health carrier's credentialing verification committee has received~~

~~information that is incorrect or misleading. Supplemental information is subject to confirmation by the health maintenance organization.~~

~~—— (7) If a health maintenance organization contracts to have another entity perform the credentialing functions required by this section, the commissioner shall hold the health maintenance organization responsible for monitoring the activities of the entity with which it contracts and for ensuring that the requirements of this section are met.~~

~~—— (8) Nothing in this act shall be construed to require a health maintenance organization to select a provider as a participating provider solely because the provider meets the health maintenance organization's credentialing verification standards, or to prevent a health maintenance organization from utilizing separate or additional criteria in selecting the health professionals with whom it contracts.~~

(2) A HEALTH MAINTENANCE ORGANIZATION IS CONSIDERED TO MEET THE REQUIREMENTS OF THIS SECTION IF THE HEALTH MAINTENANCE ORGANIZATION IS ACCREDITED BY A NATIONALLY RECOGNIZED ACCREDITED BODY APPROVED BY THE DIRECTOR. AS USED IN THIS SUBSECTION, "NATIONALLY RECOGNIZED ACCREDITED BODY" INCLUDES THE NATIONAL COMMITTEE FOR QUALITY ASSURANCE.

Sec. 3533. ~~(1) A~~ **SUBJECT TO SECTION 3405, A** health maintenance organization may offer prudent purchaser contracts to groups or individuals and in conjunction with those contracts a health maintenance organization may pay or may reimburse enrollees, or may contract with another entity **PERSON** to pay or reimburse enrollees,

1 for unauthorized services or for services by nonaffiliated
2 providers in accordance with the terms of the contract and subject
3 to copayments, coinsurances, deductibles, or other financial
4 penalties designed to encourage enrollees to obtain services from
5 ~~the organization's~~ **AFFILIATED** providers.

6 ~~—— (2) Prudent purchaser contracts and the rates charged for them~~
7 ~~are subject to the same regulatory requirements as health~~
8 ~~maintenance contracts. The rates charged by an organization for~~
9 ~~coverage under contracts issued under this section shall not be~~
10 ~~unreasonably lower than what is necessary to meet the expenses of~~
11 ~~the organization for providing this coverage and shall not have an~~
12 ~~anticompetitive effect or result in predatory pricing in relation~~
13 ~~to prudent purchaser agreement coverages offered by other~~
14 ~~organizations.~~

15 ~~—— (3) A health maintenance organization shall not issue prudent~~
16 ~~purchaser contracts unless it is in full compliance with the~~
17 ~~requirements for adequate working capital, statutory deposits, and~~
18 ~~reserves as provided in this chapter and it is not operating under~~
19 ~~any limitation to its authorization to do business in this state.~~

20 ~~—— (4) A health maintenance organization shall maintain financial~~
21 ~~records for its prudent purchaser contracts and activities in a~~
22 ~~form separate or separable from the financial records of other~~
23 ~~operations and activities carried on by the organization.~~

24 Sec. 3535. Solicitation of enrollees or advertising of the
25 services, charges, or other nonprofessional aspects of the health
26 maintenance organization's operation under this section ~~shall~~ **IS**
27 ~~not be construed to be in violation of laws relating to~~

1 solicitation or advertising by health professionals. ~~but~~ **A HEALTH**
 2 **MAINTENANCE ORGANIZATION** shall not, **IN ITS SOLICITATION OR**
 3 **ADVERTISING ALLOWED UNDER THIS SECTION**, include advertising that
 4 makes ~~any~~ **A** qualitative judgment as to a health professional who
 5 provides services for ~~a~~ **THE** health maintenance organization. A
 6 **HEALTH MAINTENANCE ORGANIZATION SHALL NOT, IN ITS** solicitation or
 7 advertising ~~shall not~~ **ALLOWED UNDER THIS SECTION**, offer a material
 8 benefit or other thing of value as an inducement to prospective
 9 subscribers other than the services of the **HEALTH MAINTENANCE**
 10 organization.

11 **SEC. 3544. (1) A HEALTH MAINTENANCE ORGANIZATION MAY PROCESS**
 12 **AND PAY CLAIMS ON BEHALF OF A NONINSURED BENEFIT PLAN ONLY AFTER**
 13 **THE HEALTH MAINTENANCE ORGANIZATION HAS RECEIVED ADEQUATE MONEY**
 14 **FROM THE NONINSURED BENEFIT PLAN SPONSOR TO FULLY COVER THE CLAIM**
 15 **PAYMENTS.**

16 **(2) AS USED IN THIS SECTION, "NONINSURED BENEFIT PLAN" MEANS**
 17 **THAT TERM AS DEFINED IN SECTION 5208.**

18 Sec. 3545. With the ~~commissioner's~~ **DIRECTOR'S** prior approval,
 19 a health maintenance organization may acquire obligations from
 20 another managed care entity. The ~~commissioner~~ **DIRECTOR** shall not
 21 grant prior approval unless the ~~commissioner~~ **DIRECTOR** determines
 22 that the transaction will not jeopardize the health maintenance
 23 organization's financial security.

24 Sec. 3547. (1) The ~~commissioner~~ **DIRECTOR** at any time may visit
 25 or examine the health care service operations of a health
 26 maintenance organization and consult with enrollees to the extent
 27 necessary to carry out the intent of this ~~chapter~~ **ACT**.

1 (2) ~~In addition to~~ **THE DIRECTOR HAS** the authority granted
 2 under chapter 2 ~~, the commissioner.~~ **WITH REGARD TO A HEALTH**
 3 **MAINTENANCE ORGANIZATION UNDER THIS CHAPTER.**

4 (3) ~~(a) Shall have~~ **A HEALTH MAINTENANCE ORGANIZATION SHALL**
 5 **GIVE THE DIRECTOR** access to all information of the health
 6 maintenance organization relating to the delivery of health
 7 services, including, but not limited to books, papers, computer
 8 databases, and documents, in a manner that preserves the
 9 confidentiality of the health records of individual enrollees.

10 (4) ~~(b) May require the submission of~~ **AT THE REQUEST OF THE**
 11 **DIRECTOR, A HEALTH MAINTENANCE ORGANIZATION SHALL SUBMIT**
 12 information regarding a proposed contract between a ~~THE~~ health
 13 maintenance organization and an affiliated provider ~~as THAT~~ the
 14 ~~commissioner~~ **DIRECTOR** considers necessary to ~~assure~~ **ENSURE** that the
 15 contract is in compliance with this ~~chapter.~~ **ACT.**

16 Sec. 3548. (1) A health maintenance organization shall keep
 17 all of its books, records, and files at or under the control of its
 18 principal place of doing business in this state, and shall keep a
 19 record of all of its securities, notes, mortgages, or other
 20 evidences of indebtedness, representing investment of funds at its
 21 principal place of doing business in this state in the same manner
 22 as provided for in section 5256.

23 (2) A health maintenance organization shall maintain financial
 24 records for its health maintenance activities separate from the
 25 financial records of any other operation or activity. ~~carried on by~~
 26 ~~the person licensed under this chapter to operate the health~~
 27 ~~maintenance organization.~~

1 (3) A health maintenance organization shall hold and maintain
 2 legal title to all assets, including cash and investments. ~~Health-A~~
 3 **HEALTH** maintenance organization **SHALL NOT COMMINGLE** funds and ~~OR~~
 4 assets ~~shall not be commingled with affiliates or other entities in~~
 5 pooling or cash management type arrangements **WITH AFFILIATES OR**
 6 **OTHER PERSONS**. All ~~A~~ health maintenance organization **SHALL HOLD ALL**
 7 **OF ITS** assets ~~shall be held separate from all other activities of~~
 8 other members in a holding company system.

9 Sec. 3551. (1) A health maintenance organization's
 10 **ORGANIZATION SHALL DETERMINE ITS** minimum net worth ~~shall be~~
 11 ~~determined using accounting procedures approved by the commissioner~~
 12 ~~that~~ **DIRECTOR. THE ACCOUNTING PROCEDURES MUST** ensure that a health
 13 maintenance organization is financially and actuarially sound.

14 ~~—— (2) A health maintenance organization licensed under former~~
 15 ~~part 210 of the public health code, 1978 PA 368, on the effective~~
 16 ~~date of this chapter that automatically received a certificate of~~
 17 ~~authority under section 3505(1) shall possess and maintain~~
 18 ~~unimpaired net worth as required under former section 21034 of the~~
 19 ~~public health code, 1978 PA 368, until the earlier of the~~
 20 ~~following:~~

21 ~~—— (a) The health maintenance organization attains a level of net~~
 22 ~~worth as provided in subsection (3) at which time the health~~
 23 ~~maintenance organization shall continue to maintain that level of~~
 24 ~~net worth.~~

25 ~~—— (b) December 31, 2003.~~

26 (2) ~~(3) A health maintenance organization applying for TO~~
 27 **OBTAIN OR MAINTAIN** a certificate of authority ~~on or after the~~

~~effective date of this chapter and~~ **IN THIS STATE**, a health maintenance organization ~~wishing to maintain a certificate of authority in this state after December 31, 2003~~ shall possess and maintain unimpaired net worth in an amount determined adequate by the ~~commissioner~~ **DIRECTOR** to continue to comply with section 403 but not **IN AN AMOUNT** less than the following, **AS APPLICABLE**:

(a) For a health maintenance organization that contracts **WITH** or employs providers in numbers sufficient to provide 90% of the health maintenance organization's benefit payout, minimum net worth is the greatest of the following:

(i) \$1,500,000.00.

(ii) Four percent of the health maintenance organization's subscription revenue.

(iii) Three months' uncovered expenditures.

(b) For a health maintenance organization that does not contract **WITH** or employ providers in numbers sufficient to provide 90% of the health maintenance organization's benefit payout, minimum net worth is the greatest of the following:

(i) \$3,000,000.00.

(ii) Ten percent of the health maintenance organization's subscription revenue.

(iii) Three months' uncovered expenditures.

(3) ~~(4)~~ The ~~commissioner~~ **DIRECTOR** shall take into account the risk-based capital requirements as developed by the ~~national association of insurance commissioners~~ **NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS** in order to determine adequate compliance with section 403 under this section.

1 Sec. 3553. ~~(1) Minimum deposit requirements for a health~~
 2 ~~maintenance organization shall be determined as provided under this~~
 3 ~~section and using accounting procedures approved by the~~
 4 ~~commissioner that ensure that a health maintenance organization is~~
 5 ~~financially and actuarially sound.~~

6 ~~—— (2) A health maintenance organization licensed under former~~
 7 ~~part 210 of the public health code, 1978 PA 368, on the effective~~
 8 ~~date of this chapter that automatically received a certificate of~~
 9 ~~authority under section 3505(1) shall possess and maintain a~~
 10 ~~deposit as required under former section 21034 of the public health~~
 11 ~~code, 1978 PA 368, until the earlier of the following:~~

12 ~~—— (a) The health maintenance organization attains the level of~~
 13 ~~deposit as provided in subsection (3) at which time the health~~
 14 ~~maintenance organization shall continue to maintain that level of~~
 15 ~~deposit.~~

16 ~~—— (b) December 31, 2001.~~

17 (1) ~~(3) A TO OBTAIN OR MAINTAIN A CERTIFICATE OF AUTHORITY IN~~
 18 **THIS STATE, A** ~~health maintenance organization applying for a~~
 19 ~~certificate of authority on or after the effective date of this~~
 20 ~~chapter and a health maintenance organization wishing to maintain a~~
 21 ~~certificate of authority in this state after December 31, 2001~~
 22 shall possess and maintain a deposit in an amount determined
 23 adequate by the ~~commissioner~~**DIRECTOR** to continue to comply with
 24 section 403 but not less than \$100,000.00 plus 5% of annual
 25 subscription revenue up to a \$1,000,000.00 maximum deposit.

26 (2) ~~(4) The A HEALTH MAINTENANCE ORGANIZATION SHALL MAKE THE~~
 27 deposit required under this section shall be made **SUBSECTION (1)**

1 with the state treasurer or with a federal or state chartered
2 financial institution under a trust indenture acceptable to the
3 ~~commissioner~~**DIRECTOR** for the sole benefit of the subscribers and
4 enrollees in case of insolvency.

5 Sec. 3555. A health maintenance organization shall maintain a
6 financial plan evaluating, at a minimum, cash flow needs and
7 adequacy of working capital. The plan ~~shall~~**UNDER THIS SUBSECTION**
8 **MUST** do all of the following:

9 (a) Demonstrate compliance with all health maintenance
10 organization financial requirements provided for in this
11 ~~chapter~~**ACT**.

12 (b) Provide for adequate working capital, which ~~shall~~**MUST** not
13 be negative at any time. The ~~commissioner~~**DIRECTOR** may establish a
14 minimum working capital requirement for a health maintenance
15 organization to ensure the prompt payment of liabilities.

16 (c) Identify the means of achieving and maintaining a positive
17 cash flow, including provisions for retirement of existing or
18 proposed indebtedness.

19 Sec. 3557. A health maintenance organization shall file notice
20 with the ~~commissioner~~**DIRECTOR** of any substantive changes in
21 operations ~~no later than~~**WITHIN** 30 days after the substantive
22 change in operations **OCCURS**. A substantive change in operations
23 includes, but is not limited to, any of the following:

24 (a) A change in the health maintenance organization's officers
25 or directors. In addition to the notification, the health
26 maintenance organization shall file a disclosure statement on a
27 form prescribed by the ~~commissioner~~**DIRECTOR** for each newly

1 appointed or elected officer or director.

2 (b) A change in the location of corporate offices.

3 (c) A change in the organization's articles of incorporation
4 or bylaws. A **HEALTH MAINTENANCE ORGANIZATION SHALL INCLUDE A** copy
5 of the revised articles of incorporation or bylaws ~~shall be~~
6 ~~included~~ with the notice.

7 (d) A change in contractual arrangements under which the
8 health maintenance organization is managed.

9 (e) Any other significant change in operations.

10 Sec. 3559. (1) Subject to subsection (2), a health maintenance
11 organization shall obtain a reinsurance contract or establish a
12 plan of self-insurance as ~~may be~~ necessary to ensure solvency or to
13 protect subscribers in the event of insolvency. A reinsurance
14 contract ~~shall~~ **MUST** be with an insurer that is authorized or
15 eligible to transact insurance in ~~Michigan~~ **THIS STATE**.

16 (2) A **HEALTH MAINTENANCE ORGANIZATION SHALL FILE A** reinsurance
17 contract or plan under subsection (1) ~~shall be filed~~ for approval
18 with the ~~commissioner not later than~~ **DIRECTOR WITHIN** 30 days after
19 the finalization of the contract or plan. A reinsurance contract or
20 plan ~~shall~~ **MUST** clearly state all services to be received by the
21 health maintenance organization. A reinsurance contract or plan
22 ~~shall be~~ **IS** considered approved 30 days after it is filed with the
23 ~~commissioner~~ **DIRECTOR** unless disapproved in writing by the
24 ~~commissioner~~ **DIRECTOR** before the expiration of ~~those~~ **THE** 30 days.

25 (3) A health maintenance organization shall maintain insurance
26 coverage to protect the health maintenance organization that
27 includes, at a minimum, fire, theft, fidelity, general liability,

1 errors and omissions, director's and officer's liability coverage,
2 and malpractice insurance. A health maintenance organization shall
3 obtain the ~~commissioner's~~**DIRECTOR'S** prior approval before self-
4 insuring for these coverages.

5 Sec. 3561. A health maintenance organization shall have a plan
6 for handling insolvency that allows for continuation of benefits
7 for the duration of the **HEALTH MAINTENANCE** contract period for
8 which premiums have been paid and continuation of benefits to any
9 ~~member~~**ENROLLEE** who is confined on the date of insolvency in an
10 inpatient facility until his or her discharge from ~~that~~**THE**
11 facility. Continuation of benefits in the event of insolvency is
12 satisfied if the health maintenance organization has at least 1 of
13 the following, as approved by the ~~commissioner~~**DIRECTOR**:

14 (a) A financial guarantee contract insured by a surety bond
15 issued by an independent insurer with a secure rating from a rating
16 agency that meets the requirements of section 436a(1)(p).

17 (b) A reinsurance contract issued by an authorized or eligible
18 insurer to cover the expenses to be paid for continued benefits
19 after an insolvency.

20 (c) A contract between the health maintenance organization and
21 its affiliated providers that provides for the continuation of
22 provider services in the event of the health maintenance
23 organization's insolvency. A **HEALTH MAINTENANCE ORGANIZATION SHALL**
24 **INCLUDE IN A** contract under this subdivision ~~shall provide a~~
25 mechanism for appropriate sharing by the health maintenance
26 organization of the continuation of provider services as approved
27 by the ~~commissioner~~**DIRECTOR** and shall not ~~provide~~**INCLUDE A**

1 **PROVISION** that continuation of provider services is solely the
2 responsibility of the affiliated providers.

3 (d) An irrevocable letter of credit.

4 (e) An insolvency reserve account established with a federal
5 or state chartered financial institution under a trust indenture
6 acceptable to the ~~commissioner~~**DIRECTOR** for the sole benefit of
7 subscribers and enrollees, equal to 3 months' premium income.

8 Sec. 3563. (1) If a health maintenance organization becomes
9 insolvent, upon the ~~commissioner's~~**DIRECTOR'S** order all other
10 health ~~maintenance organizations and health insurers~~ that
11 participated in the enrollment process with the insolvent health
12 maintenance organization at a group's last regular enrollment
13 period shall offer the insolvent health maintenance organization's
14 ~~and health insurer's~~ group enrollees a 30-day enrollment period
15 beginning on the date of the ~~commissioner's~~**DIRECTOR'S** order. Each
16 health ~~maintenance organization and health insurer~~ shall offer the
17 insolvent health maintenance organization's enrollees the same
18 coverages and rates that it had offered to the enrollees of the
19 group at its last regular enrollment period.

20 (2) If no other health ~~maintenance organization or health~~
21 insurer ~~had been~~**WAS** offered to some groups enrolled in the ~~AN~~
22 insolvent health maintenance organization, or if the ~~commissioner~~
23 **DIRECTOR** determines that the other health ~~maintenance organizations~~
24 ~~or health insurers~~ lack sufficient health care delivery resources
25 to ~~assure~~**ENSURE** that health care services will be available and
26 accessible to all of the group enrollees of the insolvent health
27 maintenance organization, ~~then the commissioner~~**DIRECTOR** shall

1 allocate equitably the insolvent health maintenance organization's
2 group contracts for these groups among all health maintenance
3 organizations that operate within a portion of the insolvent health
4 maintenance organization's service area, taking into consideration
5 the health care delivery resources of each health maintenance
6 organization. Each health maintenance organization to which a group
7 or groups are ~~so~~-allocated **UNDER THIS SUBSECTION** shall offer the
8 group or groups the health maintenance organization's existing
9 coverage that is most similar to each group's coverage with the
10 insolvent health maintenance organization at rates determined in
11 accordance with the successor health maintenance organization's
12 existing rating methodology.

13 (3) The ~~commissioner~~-**DIRECTOR** shall allocate equitably the
14 insolvent health maintenance organization's nongroup enrollees who
15 are unable to obtain other coverage among all health maintenance
16 organizations that operate within a portion of the insolvent health
17 maintenance organization's service area, taking into consideration
18 the health care delivery resources of each health maintenance
19 organization. Each health maintenance organization to which
20 nongroup enrollees are allocated **UNDER THIS SUBSECTION** shall offer
21 the nongroup enrollees ~~the health maintenance organization's~~
22 ~~existing~~ coverage without a preexisting condition limitation for
23 individual ~~or conversion~~ coverage as determined by the enrollee's
24 type of coverage in the insolvent health maintenance organization
25 at rates ~~determined in accordance with~~ **UNDER** the successor health
26 maintenance organization's existing rating methodology. Successor
27 health maintenance organizations that do not offer direct nongroup

1 enrollment may aggregate all of the allocated nongroup enrollees
2 into 1 group for rating and coverage purposes.

3 (4) If a health maintenance organization that contracts with a
4 state funded health care program becomes insolvent, the
5 ~~commissioner~~**DIRECTOR** shall inform the state agency responsible for
6 the program of the insolvency. Notwithstanding any other provision
7 of this section **TO THE CONTRARY**, enrollees of an insolvent health
8 maintenance organization covered by a state funded health care
9 program may be reassigned ~~in accordance with~~**UNDER** state and
10 federal statutes governing the ~~particular~~ program.

11 (5) **NOTWITHSTANDING ANY PROVISION OF THIS SECTION TO THE**
12 **CONTRARY, AN ENROLLEE OF AN INSOLVENT HEALTH MAINTENANCE**
13 **ORGANIZATION WHO IS ELIGIBLE TO OBTAIN COVERAGE AS EITHER AN**
14 **INDIVIDUAL OR A MEMBER OF A SMALL GROUP UNDER AN AMERICAN HEALTH**
15 **BENEFIT EXCHANGE ESTABLISHED OR OPERATING IN THIS STATE PURSUANT TO**
16 **THE PATIENT PROTECTION AND AFFORDABLE CARE ACT, PUBLIC LAW 111-148,**
17 **AS AMENDED BY THE HEALTH CARE AND EDUCATION RECONCILIATION ACT OF**
18 **2010, PUBLIC LAW 111-152, MAY OBTAIN SUBSTITUTE COVERAGE THROUGH**
19 **THE EXCHANGE.**

20 Sec. 3569. (1) Except as provided in section 3515(2), a health
21 maintenance organization shall assume full financial risk on a
22 prospective basis for the provision of health ~~maintenance~~ services
23 **UNDER A HEALTH MAINTENANCE ORGANIZATION CONTRACT. However, the A**
24 **HEALTH MAINTENANCE** organization may do any of the following:

25 (a) Require an affiliated provider to assume financial risk
26 under the terms of its contract.

27 (b) Obtain insurance.

1 (c) Make other arrangements for the cost of providing to an
2 enrollee health ~~maintenance~~ services the aggregate value of which
3 is more than \$5,000.00 in a year for that enrollee.

4 (2) If the health maintenance organization requires an
5 affiliated provider to assume financial risk under the terms of its
6 contract, the contract ~~shall~~ **MUST** require both of the following:

7 (a) The health maintenance organization to pay the affiliated
8 provider, including a subcontracted provider, directly or through a
9 licensed third party administrator for health ~~maintenance~~ services
10 provided to its enrollees.

11 (b) The health maintenance organization to keep all pooled
12 funds and withhold amounts and account for them on its financial
13 books and records and reconcile them at year end ~~in accordance with~~
14 ~~the written agreement between the affiliated provider and the~~
15 ~~health maintenance organization.~~ **PURSUANT TO THE CONTRACT.**

16 (3) ~~As used in~~ **FOR PURPOSES OF** this section, ~~"requiring a~~
17 **HEALTH MAINTENANCE ORGANIZATION REQUIRES** an affiliated provider to
18 assume financial risk" ~~means a transaction whereby~~ **RISK IF IT**
19 **SHARES WITH THE AFFILIATED PROVIDER, IN RETURN FOR CONSIDERATION,** a
20 portion of the chance of loss, including expenses incurred, related
21 to the delivery of health ~~maintenance~~ services ~~is shared with an~~
22 ~~affiliated provider in return for a consideration.~~ **TO ENROLLEES.**
23 ~~These~~ **THE TYPE OF** transactions **UNDER WHICH A HEALTH MAINTENANCE**
24 **ORGANIZATION MAY REQUIRE AN AFFILIATED PROVIDER TO ASSUME FINANCIAL**
25 **RISK UNDER THIS SECTION** include, but are not limited to, full or
26 partial capitation agreements, withholds, risk corridors, and
27 indemnity agreements.

1 Sec. 3571. ~~A health maintenance organization is not precluded~~
 2 ~~from meeting the requirements of, receiving money from, and~~
 3 ~~enrolling beneficiaries or recipients of state and federal health~~
 4 ~~programs.~~ A health maintenance organization that participates in a
 5 state or federal health program shall meet the solvency and
 6 financial requirements of this act, unless the health maintenance
 7 organization is in receivership or under supervision. ~~but~~
 8 **NOTWITHSTANDING ANY PROVISION OF THIS ACT TO THE CONTRARY, A HEALTH**
 9 **MAINTENANCE ORGANIZATION THAT PARTICIPATES IN A STATE OR FEDERAL**
 10 **HEALTH PROGRAM** is not required to offer benefits or services that
 11 exceed the requirements of the ~~state or federal health~~ **APPLICABLE**
 12 program. This section does not apply to state employee or federal
 13 employee health programs.

14 Sec. 3573. (1) A person ~~proposing~~ **THAT PROPOSES** to operate a
 15 system of health care delivery and financing ~~that is to be offered~~
 16 to individuals, whether or not as members of groups, in exchange
 17 for a fixed payment and **TO BE** organized so that providers and the
 18 organization are in some part at risk for the cost of services in a
 19 manner similar to a health maintenance organization, but **THAT** fails
 20 to meet the requirements ~~set forth in this chapter,~~ **OF THIS ACT FOR**
 21 **A HEALTH MAINTENANCE ORGANIZATION,** may operate ~~such a~~ **THE** system **OF**
 22 **HEALTH CARE DELIVERY AND FINANCING** if the ~~commissioner~~ **DIRECTOR**
 23 finds that the proposed operation will benefit persons who will be
 24 served by it. The **DIRECTOR SHALL AUTHORIZE AND REGULATE THE**
 25 operation ~~shall be authorized and regulated~~ **OF THE SYSTEM** in the
 26 same manner as a health maintenance organization under this ~~chapter~~
 27 **ACT,** including the filing of periodic reports, except to the extent

1 that the ~~commissioner~~**DIRECTOR** finds that the regulation is
 2 inappropriate to the system of health care delivery and financing.

3 (2) A person operating a system of health care delivery and
 4 financing under this section shall not advertise or solicit or in
 5 any way identify itself in a manner implying to the public that it
 6 is a health maintenance organization authorized under this
 7 ~~chapter~~**ACT**.

8 Sec. 3701. As used in this chapter:

9 (a) "Actuarial certification" means a written statement by a
 10 member of the American ~~academy of actuaries~~**ACADEMY OF ACTUARIES** or
 11 another individual acceptable to the ~~commissioner~~**DIRECTOR** that a
 12 small employer carrier is in compliance with ~~the provisions of~~
 13 section 3705, based ~~upon~~**ON** the ~~person's~~**INDIVIDUAL'S** examination,
 14 including a review of the appropriate records and the actuarial
 15 assumptions and methods used by the carrier in establishing
 16 premiums for applicable health benefit plans.

17 (b) "Affiliation period" means a period of time required by a
 18 small employer carrier that must expire before health coverage
 19 becomes effective.

20 (c) "Base premium" means the lowest premium charged for a
 21 rating period under a rating system by a small employer carrier to
 22 small employers for a health benefit plan in a geographic area.

23 (d) "Carrier" means a person that provides health benefits,
 24 coverage, or insurance in this state. For the purposes of this
 25 chapter, carrier includes a health insurance company authorized to
 26 do business in this state, ~~a nonprofit health care corporation, a~~
 27 health maintenance organization, a multiple employer welfare

1 arrangement, or any other person providing a plan of health
 2 benefits, coverage, or insurance subject to state insurance
 3 regulation.

4 (e) "COBRA" means the consolidated omnibus budget
 5 reconciliation act of 1985, Public Law 99-272. ~~7, 100 Stat. 82.~~

6 (f) "Commercial carrier" means a small employer carrier other
 7 than a ~~nonprofit health care corporation or~~ health maintenance
 8 organization.

9 (g) "Creditable coverage" means, with respect to an
 10 individual, health benefits, coverage, or insurance provided under
 11 any of the following:

12 (i) A group health plan.

13 (ii) A health benefit plan.

14 (iii) Part A or part B of ~~title~~ **SUBCHAPTER** XVIII of the social
 15 security act, ~~chapter 531, 49 Stat. 620, 42 U.S.C. USC 1395c to~~
 16 ~~1395i and 1395i-2 to 1395i-5, and 42 U.S.C. 1395j to 1395t, 1395u~~
 17 ~~to 1395w, and 1395w-2 to 1395w-4.~~ **1395W-6.**

18 (iv) ~~Title~~ **SUBCHAPTER** XIX of the social security act, ~~chapter~~
 19 ~~531, 49 Stat. 620, 42 U.S.C. USC 1396 to 1396r-6 and 1396r-8 to~~
 20 ~~1396v, 1396W-5, other than coverage consisting solely of benefits~~
 21 ~~under section 1929 of title XIX of the social security act, 42~~
 22 ~~U.S.C. USC 1396t.~~

23 (v) Chapter 55 of title 10 of the United States Code, 10
 24 ~~U.S.C. USC 1071 to 1110.~~ **1110B.** For purposes of **COVERAGE UNDER**
 25 chapter 55 of title 10 of the United States Code, 10 ~~U.S.C. USC~~
 26 ~~1071 to 1110, 1110B,~~ "uniformed services" means the armed forces
 27 and the commissioned corps of the ~~national oceanic and atmospheric~~

~~administration~~ **NATIONAL OCEANIC AND ATMOSPHERIC ADMINISTRATION** and
of the ~~public health service~~. **PUBLIC HEALTH SERVICE.**

(vi) A medical care program of the Indian ~~health service~~
HEALTH SERVICE or of a tribal organization.

(vii) A state health benefits risk pool.

(viii) A health plan offered under ~~the employees health~~
~~benefits program~~, chapter 89 of title 5 of the United States Code,
5 ~~U.S.C.~~ **USC** 8901 to 8914.

(ix) A public health plan. ~~, which for purposes of this~~
~~chapter means a plan established or maintained by a state, county,~~
~~or other political subdivision of a state that provides health~~
~~insurance coverage to individuals enrolled in the plan.~~

(x) A health benefit plan under section 5(e) of title I of the
peace corps act, ~~Public Law 87-293~~, 22 ~~U.S.C.~~ **USC** 2504.

(h) "Eligible employee" means an employee who works on a full-
time basis with a normal workweek of 30 or more hours. Eligible
employee includes an employee who works on a full-time basis with a
normal workweek of 17.5 to 30 hours, if an employer so chooses and
if this eligibility criterion is applied uniformly among all of the
employer's employees and without regard to health status-related
factors.

(i) "Geographic area" means an area in this state that
includes not less than 1 entire county, **IS** established by a carrier
~~pursuant to~~ **UNDER** section 3705, and **IS** used for adjusting premiums
for a health benefit plan subject to this chapter. In addition, if
the geographic area includes 1 entire county and additional
counties or portions of counties, the counties or portions of

counties must be contiguous with at least 1 other county or portion of another county in that geographic area.

(j) "Group health plan" means an employee welfare benefit plan as defined in section 3(1) of subtitle A of title I of the employee retirement income security act of 1974, Public Law 93-406, 29 U.S.C.—**USC** 1002, to the extent that the plan provides medical care, including items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise. As used in this chapter, all of the following apply to the term group health plan:

(i) Any plan, fund, or program that would not be, but for ~~section 2721(c) of subpart 4 of part A of title XXVII of the public health service act, chapter 373, 110 Stat. 1967, 42 U.S.C. **USC** 300gg-21, **300GG-21(D)**~~, an employee welfare benefit plan and that is established or maintained by a partnership, to the extent that the plan, fund, or program provides medical care, including items and services paid for as medical care, to present or former partners in the partnership, or to their dependents, as defined under the terms of the plan, fund, or program, directly or through insurance, reimbursement or otherwise, ~~shall be treated, **IS**~~, subject to subparagraph (ii), ~~as~~ an employee welfare benefit plan that is a group health plan.

(ii) The term "employer" also includes the partnership in relation to any partner.

(iii) The term "participant" also includes an individual who is, or may become, eligible to receive a benefit under the plan, or the individual's beneficiary who is, or may become, eligible to

1 receive a benefit under the plan. For a group health plan
 2 maintained by a partnership, the individual is a partner in
 3 relation to the partnership and for a group health plan maintained
 4 by a self-employed individual, under which 1 or more employees are
 5 participants, the individual is the self-employed individual.

6 (k) "Health benefit plan" or "plan" means an expense-incurred
 7 hospital, medical, or surgical policy or certificate, ~~nonprofit~~
 8 ~~health care corporation certificate, or health maintenance~~
 9 organization contract. Health benefit plan does not include
 10 accident-only, credit, dental, or disability income insurance;
 11 long-term care insurance; coverage issued as a supplement to
 12 liability insurance; coverage only for a specified disease or
 13 illness; worker's compensation or similar insurance; or automobile
 14 medical-payment insurance.

15 (l) "Index rate" means the arithmetic average during a rating
 16 period of the base premium and the highest premium charged per
 17 employee for each health benefit plan offered by each small
 18 employer carrier to small employers and sole proprietors in a
 19 geographic area.

20 ~~—— (m) "Nonprofit health care corporation" means a nonprofit~~
 21 ~~health care corporation operating pursuant to the nonprofit health~~
 22 ~~care corporation reform act, 1980 PA 350, MCL 550.1101 to 550.1704.~~

23 (M) ~~(n)~~ "Premium" means all money paid by a small employer, a
 24 ~~sole proprietor,~~ eligible employees, or eligible persons as a
 25 condition of receiving coverage from a small employer carrier,
 26 including any fees or other contributions associated with the
 27 health benefit plan.

1 (N) "PUBLIC HEALTH PLAN" MEANS A PLAN ESTABLISHED OR
 2 MAINTAINED BY A STATE, COUNTY, OR OTHER POLITICAL SUBDIVISION OF A
 3 STATE THAT PROVIDES HEALTH INSURANCE COVERAGE TO INDIVIDUALS
 4 ENROLLED IN THE PLAN.

5 (o) "Rating period" means the calendar period for which
 6 premiums established by a small employer carrier are assumed to be
 7 in effect, as determined by the small employer carrier.

8 (p) "Small employer" means any person ~~, firm, corporation,~~
 9 ~~partnership, limited liability company, or association~~ actively
 10 engaged in business ~~who, THAT,~~ on at least 50% of its working days
 11 during the preceding and current calendar years, employed ~~at least~~
 12 **NOT FEWER THAN 2** ~~but~~ **AND** not more than 50 eligible employees. In
 13 determining the number of eligible employees, ~~companies~~ **PERSONS**
 14 that are affiliated ~~companies~~ **WITH EACH OTHER** or that are eligible
 15 to file a combined tax return for state taxation purposes ~~shall be~~
 16 **ARE** considered 1 employer.

17 (q) "Small employer carrier" means ~~either of the following:~~

18 ~~—— (i) A~~ **A** carrier that offers health benefit plans covering the
 19 employees of a small employer.

20 ~~—— (ii) A carrier under section 3703(3).~~

21 ~~—— (r) "Sole proprietor" means an individual who is a sole~~
 22 ~~proprietor or sole shareholder in a trade or business through which~~
 23 ~~he or she earns at least 50% of his or her taxable income as~~
 24 ~~defined in section 30 of the income tax act of 1967, 1967 PA 281,~~
 25 ~~MCL 206.30, excluding investment income, and for which he or she~~
 26 ~~has filed the appropriate internal revenue service form 1040,~~
 27 ~~schedule C or F, for the previous taxable year; who is a resident~~

~~of this state; and who is actively employed in the operation of the business, working at least 30 hours per week in at least 40 weeks out of the calendar year.~~

(R) ~~(s)~~ "Waiting period" means, with respect to a health benefit plan and an individual who is a potential enrollee in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan. For purposes of calculating periods of creditable coverage under this chapter, a waiting period ~~shall~~ **IS** not ~~be~~ considered **AS** a gap in coverage.

Sec. 3703. (1) This chapter applies to any health benefit plan that provides coverage to 2 or more employees of a small employer.

(2) This chapter does not apply to individual health insurance policies that are subject to policy form and premium approval by the ~~commissioner~~ **DIRECTOR**.

~~—— (3) A nonprofit health care corporation shall make available upon request a health benefit plan to a sole proprietor. This chapter does apply to a nonprofit health care corporation providing a health benefit plan to a sole proprietor and to any other small employer carrier that elects to provide a health benefit plan to a sole proprietor.~~

Sec. 3705. (1) For adjusting premiums for health benefit plans subject to this chapter, a carrier ~~may establish up to 10~~ **SHALL USE THE DEFINED** geographic areas in this state. A nonprofit health care corporation ~~shall establish geographic areas that cover all counties in this state.~~ **ESTABLISHED BY THE DIRECTOR AND ALLOWED UNDER FEDERAL LAW.**

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

3 (a) ~~For a nonprofit health care corporation, only industry and~~
4 ~~age may be used for determining the premiums within a geographic~~
5 ~~area for a small employer or sole proprietor located in that~~
6 ~~geographic area. For a health maintenance organization, only~~
7 ~~industry, age, and group size may be used for determining the~~
8 ~~premiums within a geographic area for a small employer or sole~~
9 ~~proprietor located in that~~ **THE** geographic area. For a commercial
10 carrier, only industry, age, group size, and health status may be
11 used for determining the premiums within a geographic area for a
12 small employer ~~or sole proprietor located in that~~ **THE** geographic
13 area.

14 (b) For a health benefit plan delivered, issued for delivery,
15 or renewed in this state on or after January 1, 2014, the premiums
16 charged during a rating period to small employers ~~shall~~ **MUST** be
17 determined only by using the rating factors set forth in section
18 3474a.

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

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

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

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

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

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

27 Sec. 3711. (1) Except as **OTHERWISE** provided in this section, a

1 small employer carrier that offers health coverage in the small
 2 employer group market in connection with a health benefit plan
 3 shall renew or continue in force ~~that~~ **THE** plan at the option of the
 4 small employer. ~~or sole proprietor.~~

5 (2) Guaranteed renewal under subsection (1) is not required in
 6 ~~eases of:~~ **ANY OF THE FOLLOWING CIRCUMSTANCES:**

7 (A) **THERE IS** fraud or intentional misrepresentation ~~of~~ **BY** the
 8 small employer. ~~or, for~~

9 (B) **FOR** coverage of an insured individual, **THERE IS** fraud or
 10 misrepresentation by the insured individual or the individual's
 11 representative. ~~+~~ ~~lack~~

12 (C) **LACK** of payment. ~~+~~ ~~noncompliance~~

13 (D) **NONCOMPLIANCE WITH MINIMUM CONTRIBUTION REQUIREMENTS.**

14 (E) **NONCOMPLIANCE** with minimum participation requirements. ~~+~~
 15 ~~if the~~

16 (F) **THE** small employer carrier no longer offers that
 17 particular type of coverage in the market. ~~+~~ ~~or if the sole~~
 18 ~~proprietor or~~

19 (G) **THE** small employer moves outside the geographic area.

20 (3) **A SMALL EMPLOYER CARRIER THAT OFFERS HEALTH COVERAGE IN**
 21 **THE SMALL EMPLOYER GROUP MARKET MAY MODIFY A HEALTH BENEFIT PLAN IF**
 22 **THE MODIFICATION IS CONSISTENT WITH STATE LAW AND EFFECTIVE ON A**
 23 **UNIFORM BASIS AMONG ALL SMALL EMPLOYERS WITH COVERAGE UNDER THE**
 24 **HEALTH BENEFIT PLAN.**

25 Sec. 3723. ~~The provisions of this~~ **THIS** chapter ~~apply~~ **APPLIES**
 26 to ~~each~~ **A** health benefit plan for a small employer ~~or sole~~
 27 ~~proprietor~~ that is delivered, issued for delivery, renewed, or

1 continued in this state ~~on or after the effective date of this~~
2 ~~chapter.~~ **JANUARY 22, 2004.** For purposes of this section, the date a
3 health benefit plan is continued is the first rating period that
4 begins ~~on or after the effective date of this chapter.~~ **JANUARY 22,**
5 **2004.**

6 Sec. 4601. As used in this chapter:

7 (a) "Affiliated company" means a company in the same corporate
8 system as a parent, an industrial insured, or a member organization
9 by virtue of common ownership, control, operation, or management.

10 (b) "Alien captive insurance company" means an insurer formed
11 to write insurance business for its parents and affiliates and
12 licensed pursuant to the laws of a country other than the United
13 States or ~~any~~ **A** state, district, commonwealth, territory, or
14 possession of the United States.

15 (c) "Association" means a legal group of individuals,
16 corporations, limited liability companies, partnerships, political
17 subdivisions, or groups that has been in continuous existence for
18 at least 1 year and the member organizations of which collectively,
19 or ~~which~~ **THAT** does itself, own, control, or hold, with power to
20 vote, all of the outstanding voting securities of an association
21 captive insurance company incorporated as a stock insurer or
22 organized as a limited liability company; or has complete voting
23 control over an association captive insurance company organized as
24 a mutual insurer.

25 (d) "Association captive insurance company" means a company
26 that insures risks of the member organizations of the association
27 and their affiliated companies.

1 (e) "Branch business" means any insurance business transacted
2 by a branch captive insurance company in this state.

3 (f) "Branch captive insurance company" means an alien captive
4 insurance company authorized by the ~~commissioner~~**DIRECTOR** to
5 transact the business of insurance in this state through a business
6 unit with a principal place of business in this state.

7 (g) "Branch operations" means any business operations of a
8 branch captive insurance company in this state.

9 (h) "Captive insurance company" means a pure captive insurance
10 company, association captive insurance company, sponsored captive
11 insurance company, special purpose captive insurance company, or
12 industrial insured captive insurance company authorized under this
13 chapter. For purposes of this chapter, a branch captive insurance
14 company ~~shall~~**MUST** be a pure captive insurance company with respect
15 to operations in this state, unless otherwise permitted by the
16 ~~commissioner~~**DIRECTOR**.

17 ~~—— (i) "Commissioner" means the commissioner of the office of~~
18 ~~financial and insurance regulation or the commissioner's designee.~~

19 (I) ~~(j)~~ "Control", including the terms "controlling",
20 "controlled by", and "under common control with", means the
21 possession, direct or indirect, of the power to direct or cause the
22 direction of the management and policies of a person, whether
23 through the ownership of voting securities, by contract other than
24 a commercial contract for goods or nonmanagement services, or
25 otherwise, unless the power is the result of an official position
26 with or corporate office held by the person. Control is presumed to
27 exist if a person, directly or indirectly, owns, controls, holds

1 with the power to vote, or holds proxies representing 10% or more
 2 of the voting securities of another person. A showing that control
 3 does not exist may rebut this presumption.

4 (J) ~~(k)~~ "Controlled unaffiliated business" means a company
 5 ~~that meets~~ **TO WHICH** all of the following **APPLY**:

6 (i) ~~Is~~ **THE COMPANY IS** not in the corporate system of a parent
 7 and affiliated companies.

8 (ii) ~~Has~~ **THE COMPANY HAS** an existing contractual relationship
 9 with a parent or affiliated company.

10 (iii) ~~Has~~ **THE COMPANY HAS** risks managed by a captive insurance
 11 company in accordance with this chapter.

12 (K) ~~(l)~~ "Foreign captive insurer" means an insurer formed
 13 under the laws of the District of Columbia, or ~~some~~ **A** state,
 14 commonwealth, territory, or possession of the United States other
 15 than ~~the~~ **THIS** state. ~~of Michigan.~~

16 (I) ~~(m)~~ "GAAP" means generally accepted accounting principles.

17 (M) ~~(n)~~ "Industrial insured" means an insured ~~that meets~~ **TO**
 18 **WHICH** all of the following **APPLY**:

19 (i) ~~That~~ **THE INSURED** procures insurance by use of the services
 20 of a full-time employee acting as a risk manager or insurance
 21 manager or utilizing the services of a regularly and continuously
 22 qualified insurance consultant.

23 (ii) ~~Whose~~ **THE INSURED'S** aggregate annual premiums for
 24 insurance on all risks total at least \$25,000.00.

25 (iii) ~~That~~ **THE INSURED** has at least 25 full-time employees.

26 (N) ~~(o)~~ "Industrial insured captive insurance company" means a
 27 company that insures risks of the industrial insureds that comprise

1 the industrial insured group and their affiliated companies.

2 (O) ~~(p)~~—"Industrial insured group" means a group that meets
3 either of the following criteria:

4 (i) ~~Is~~ **THE GROUP IS** a group of industrial insureds that
5 collectively own, control, or hold, with power to vote, all of the
6 outstanding voting securities of an industrial insured captive
7 insurance company incorporated as a stock insurer or limited
8 liability company or have complete voting control over an
9 industrial insured captive insurance company incorporated as a
10 mutual insurer.

11 (ii) ~~Is~~ **THE GROUP IS** a group created under the liability risk
12 retention act of 1986, 15 USC 3901 to 3906, and chapter 18, as a
13 corporation or other limited liability association taxable as a
14 stock insurance company or a mutual insurer under this chapter.

15 (P) ~~(q)~~—"Irrevocable letter of credit" means a letter of
16 credit that meets the description in section 1105(c).

17 (Q) ~~(r)~~—"Member organization" means ~~any~~ **AN** individual,
18 corporation, limited liability company, partnership, or association
19 that belongs to an association.

20 (R) ~~(s)~~—"Office" means the ~~office of financial and insurance~~
21 ~~regulation~~ **DEPARTMENT**.

22 (S) ~~(t)~~—"Organizational document" means the articles of
23 incorporation, articles of organization, bylaws, operating
24 agreement, or other foundational documents that create a legal
25 entity or prescribe its existence.

26 (T) ~~(u)~~—"Parent" means ~~any~~ **A** corporation, limited liability
27 company, partnership, or individual that directly or indirectly

owns, controls, or holds with power to vote more than 50% of the outstanding voting interests of a company.

(U) ~~(v)~~—"Participant" means an entity as described in section 4667, and any affiliates of ~~that~~ **THE** entity, that are insured by a sponsored captive insurance company, ~~where~~ **IF** the recovery of the participant is limited through a participant contract to the assets of a protected cell.

(V) ~~(w)~~—"Participant contract" means a contract by which a sponsored captive insurance company insures the risks of a participant and limits the recovery of the participant to the assets of a protected cell.

(W) ~~(x)~~—"Protected cell" means a segregated account established and maintained by a sponsored captive insurance company for 1 participant.

(X) ~~(y)~~—"Pure captive insurance company" means a company that insures risks of its parent, affiliated companies, controlled unaffiliated ~~business~~, **BUSINESSES**, or a combination of its parent, affiliated companies, and controlled unaffiliated ~~business~~. **BUSINESSES**.

(Y) ~~(z)~~—"Qualified United States financial institution" means that term as defined in section 1101.

(Z) ~~(aa)~~—"Safe, reliable, and entitled to public confidence" means that term as defined in section ~~116(d)~~. **116**.

(AA) ~~(bb)~~—"Special purpose captive insurance company" means a captive insurance company that is authorized under this chapter and chapter 47 that does not meet the definition of any other type of captive insurance company defined in this section.

1 **(BB)** ~~(ee)~~—"Sponsor" means an entity that meets the
 2 requirements of section 4665 and is approved by the ~~commissioner~~
 3 **DIRECTOR** to provide all or part of the capital and retained
 4 earnings required by applicable law and to organize and operate a
 5 sponsored captive insurance company.

6 **(CC)** ~~(dd)~~—"Sponsored captive insurance company" means a
 7 captive insurance company in which the minimum capital and retained
 8 earnings required by applicable law is provided by 1 or more
 9 sponsors, **THAT** is authorized under this chapter, **THAT** insures the
 10 risks of separate participants through the participant contract,
 11 and **THAT** segregates each participant's liability through 1 or more
 12 protected cells.

13 **(DD)** ~~(ee)~~—"Surplus" means unassigned funds for an entity using
 14 statutory accounting principles, with capital and surplus including
 15 all capital stock, paid in capital and contributed surplus, and
 16 other surplus funds with corresponding items under GAAP consisting
 17 of retained earnings and accumulated other comprehensive income,
 18 with capital and retained earnings including all capital stock,
 19 additional paid in capital, and other equity funds.

20 **(EE)** ~~(ff)~~—"Treasury rates" means the United States treasury
 21 strips asked yield as published in the Wall Street Journal as of a
 22 balance sheet date.

23 **(FF)** ~~(gg)~~—"Voting security" includes any security convertible
 24 into or evidencing the right to acquire a voting security.

25 Sec. 4701. As used in this chapter:

26 (a) "Affiliated company" means a company in the same corporate
 27 system as a parent, by virtue of common ownership, control,

1 operation, or management.

2 (b) "Captive LLC" means a limited liability company
 3 established under the Michigan limited liability company act, 1993
 4 PA 23, MCL 450.4101 to 450.5200, or ~~A comparable provisions of any~~
 5 ~~other~~ **LAW OF ANOTHER** state, ~~law,~~ including the District of
 6 Columbia, by a parent, counterparty, affiliated company, or SPFC
 7 for the purpose of issuing SPFC securities, entering an SPFC
 8 contract with a counterparty, or otherwise facilitating an
 9 insurance securitization.

10 ~~— (c) "Commissioner" means the commissioner of the office of~~
 11 ~~financial and insurance regulation or the commissioner's designee.~~

12 (C) ~~(d)~~ "Contested case" means a proceeding in which the legal
 13 rights, duties, obligations, or privileges of a party are required
 14 by law to be determined by the circuit court after an opportunity
 15 for hearing.

16 (D) ~~(e)~~ "Control" including the terms "controlling",
 17 "controlled by", and "under common control with" means the
 18 possession, direct or indirect, of the power to direct or cause the
 19 direction of the management and policies of a person, whether
 20 through the ownership of voting securities, by contract other than
 21 a commercial contract for goods or nonmanagement services, or
 22 otherwise, unless the power is the result of an official position
 23 with or corporate office held by the person. Control ~~shall be~~ **IS**
 24 presumed to exist if a person, directly or indirectly, owns,
 25 controls, holds with the power to vote, or holds proxies
 26 representing 10% or more of the voting securities of another
 27 person. This presumption may be rebutted by a showing that control

1 does not exist. However, for purposes of this chapter, the fact
 2 that an SPFC exclusively provides reinsurance to a ceding insurer
 3 under an SPFC contract is not by itself sufficient grounds for a
 4 finding that the SPFC and ceding insurer are under common control.

5 (E) ~~(f)~~ "Counterparty" means an SPFC's parent or affiliated
 6 company, or, subject to the prior approval of the ~~commissioner,~~
 7 **DIRECTOR**, a nonaffiliated company as ceding insurer to the SPFC
 8 contract.

9 (F) ~~(g)~~ "Fair value" means the following:

10 (i) For cash, the amount of the cash.

11 (ii) For ~~assets~~ **AN ASSET** other than cash, the amount at which
 12 ~~that~~ **THE** asset could be bought or sold in a current transaction
 13 between arm's length, willing parties. If available, the quoted
 14 mid-market price for the asset in active markets ~~shall~~ **MUST** be
 15 used; and if quoted mid-market prices are not available, a value
 16 ~~shall~~ **MUST** be determined using the best information available
 17 considering values of similar assets and other valuation methods,
 18 such as present value of future cash flows, historical value of the
 19 same or similar assets, or comparison to values of other asset
 20 classes, the value of which have been historically related to the
 21 subject asset.

22 (G) ~~(h)~~ "Foreign captive" means a captive insurer formed under
 23 the laws of the District of Columbia or ~~some~~ **A** state, commonwealth,
 24 territory, or possession of the United States other than ~~the state~~
 25 ~~of Michigan.~~ **THIS STATE.**

26 (H) ~~(i)~~ "Insolvency" or "insolvent" means 1 or more of the
 27 following:

1 (i) That the SPFC is unable to pay its obligations within 30
2 days after they are due, unless those obligations are the subject
3 of a bona fide dispute.

4 (ii) That the admitted assets of the SPFC do not exceed
5 liabilities plus minimum capital and surplus for a period of time
6 in excess of 30 days.

7 (iii) That the Ingham ~~county~~**COUNTY** circuit court has issued
8 an order as provided for in section 8113, 8117, or 8120 in
9 connection with a delinquency proceeding under chapter 81
10 instituted against the SPFC.

11 (I) ~~(j)~~—"Insurance securitization" means a package of related
12 risk transfer instruments, capital market offerings, and
13 facilitating administrative agreements by which all of the
14 following apply:

15 (i) The proceeds of the sale of SPFC securities are obtained,
16 in a transaction that complies with applicable securities laws, by
17 an SPFC directly through the issuance of the SPFC securities by the
18 SPFC or indirectly through the issuance of preferred securities by
19 the SPFC in exchange for some or all of the proceeds of the sale of
20 SPFC securities by the SPFC's parent, an affiliated company of the
21 SPFC, a counterparty, or a captive LLC.

22 (ii) The proceeds of the issuance of the SPFC securities
23 secure the obligations of the SPFC under 1 or more SPFC contracts
24 with a counterparty.

25 (iii) The obligation to the holders of the SPFC securities is
26 secured by assets obtained with proceeds of the SPFC securities in
27 accordance with the transaction terms.

1 (J) ~~(k)~~—"Irrevocable letter of credit" means a letter of
2 credit that meets the description in section 1105(c).

3 (K) ~~(l)~~—"Management" means the board of directors, managing
4 board, or other individual or individuals vested with overall
5 responsibility for the management of the affairs of the SPFC,
6 including the election and appointment of officers or other agents
7 to act on behalf of the SPFC.

8 (I) ~~(m)~~—"Office" means the ~~office of financial and insurance~~
9 ~~regulation.~~ **DEPARTMENT.**

10 (M) ~~(n)~~—"Organizational document" means the SPFC's articles of
11 incorporation, articles of organization, bylaws, operating
12 agreement, or other foundational documents that establish the SPFC
13 as a legal entity or prescribes its existence.

14 (N) ~~(o)~~—"Parent" means ~~any~~ **A** corporation, limited liability
15 company, partnership, or individual that directly or indirectly
16 owns, controls, or holds with power to vote more than 50% of the
17 outstanding voting securities of an SPFC.

18 (O) ~~(p)~~—"Permitted investments" means those investments that
19 meet the qualifications in section 4727(1).

20 (P) ~~(q)~~—"Preferred securities" means securities, whether stock
21 or debt, issued by an SPFC to the issuer of the SPFC securities in
22 exchange for some or all of the proceeds of the issuance of the
23 SPFC securities.

24 (Q) ~~(r)~~—"Protected cell" means a segregated account
25 established and maintained by an SPFC for 1 or more SPFC contracts
26 that are part of a single securitization transaction as further
27 provided for in chapter 48.

1 (R) ~~(s)~~—"Qualified United States financial institution" means
2 that term as defined in section 1101.

3 (S) ~~(t)~~—"Reserves" means that term as used in chapter 8.

4 (T) ~~(u)~~—"Safe, reliable, and entitled to public confidence"
5 means that term as defined in section ~~116(d)~~.116.

6 (U) ~~(v)~~—"Securities" means those different types of debt
7 obligations, equity, surplus certificates, surplus notes, funding
8 agreements, derivatives, and other legal forms of financial
9 instruments.

10 (V) ~~(w)~~—"Securities commissioner" means the
11 ~~commissioner~~.**SECURITIES ADMINISTRATOR IN THE DEPARTMENT OF**
12 **LICENSING AND REGULATORY AFFAIRS.**

13 (W) ~~(x)~~—"SPFC" or "special purpose financial captive" means a
14 captive insurance company, a captive LLC, or a company otherwise
15 qualified as an authorized insurer that has received a limited
16 certificate of authority from the ~~commissioner~~**DIRECTOR** for the
17 purposes provided for in this chapter.

18 (X) ~~(y)~~—"SPFC contract" means a contract between the SPFC and
19 the counterparty pursuant to which the SPFC agrees to provide
20 insurance or reinsurance protection to the counterparty for risks
21 associated with the counterparty's insurance or reinsurance
22 business.

23 (Y) ~~(z)~~—"SPFC securities" means the securities issued pursuant
24 to an insurance securitization, the proceeds of which are used in
25 the manner described in subdivision ~~(j)~~.**(I)**.

26 (Z) ~~(aa)~~—"Surplus note" means an unsecured subordinated debt
27 obligation possessing characteristics consistent with accounting

practices and procedures designated by the ~~commissioner~~**DIRECTOR**.

(AA) ~~(bb)~~—"Third party" means a person unrelated to an SPFC or its counterparty, or both, that has been aggrieved by a decision of a ~~commissioner~~**DIRECTOR** regarding that SPFC or its activities.

Sec. 6428. (1) ~~Every~~**AN** insurer transacting business under subdivision (1) of section 6406 ~~(disability and related insurances)~~ shall be ~~6406(1)~~ **IS** subject to the provisions of sections 2242 ~~(filing and approval of policy forms)~~, **SECTION** 2260 ~~(claims administration not waiver)~~, **AND** chapter 34. ~~(disability insurance policies)~~, and chapter 36 ~~(group and blanket disability insurance)~~.

(2) ~~Every~~**AN** insurer transacting business under subdivision (2) of section 6406 ~~(loss of position insurance)~~ shall be ~~6406(2)~~ **IS** subject to the provisions of section 6616, ~~and~~ and all policies issued after January 1, 1948, shall **MUST** grant such ~~such~~**THE** nonforfeiture values under annuity contracts as ~~as~~**THAT** are required of life insurers under this ~~insurance code~~**ACT**.

(3) ~~On and after January 1, 1949, every~~**AN** insurer transacting business under subdivision (3) of section 6406 ~~(life insurance)~~ shall be ~~6406(3)~~ **IS** subject to the provisions of chapters 40 ~~(life insurance policies and annuity contracts)~~ and 42. ~~(industrial life insurance)~~.

Sec. 7060. A MEWA transacting business in this state is also subject to the following additional sections and chapters of this act, as applicable, in the same manner as an insurer authorized to transact insurance in this state:

(a) ~~Sections~~**SECTION** 240(1)(c), (d), **AND** (h). ~~and (j)~~.

(b) Chapter 12.

1 (c) Chapter 20.

2 (d) Chapter 22.

3 (e) Chapter 34.

4 ~~(f) Chapter 36.~~

5 (F) ~~(g)~~ Chapter 44.

6 (G) ~~(h)~~ Chapter 81.

7 Sec. 7705. As used in this chapter:

8 (a) "Account" means either of the 2 accounts created under
9 section 7706.

10 (b) "Association" means the Michigan life and health insurance
11 guaranty association created under section 7706.

12 (c) "Authorized assessment" or "authorized" when used in the
13 context of assessments means a resolution or motion passed by the
14 association's board of directors that directs that an assessment be
15 called immediately or in the future from member insurers for a
16 specific amount. An assessment is authorized when the resolution or
17 motion is passed.

18 (d) "Benefit plan" means a specific employee, union, or
19 association of natural persons benefit plan.

20 (e) "Called assessment" or "called" when used in the context
21 of assessments means that a notice has been issued by the
22 association to member insurers requiring that an authorized
23 assessment be paid within the time frame set forth within the
24 notice. An authorized assessment becomes a called assessment when
25 notice is mailed by the association to member insurers.

26 (f) "Contractual obligation" means an obligation under covered
27 policies.

1 (g) "Covered policy" means a policy, ~~or contract~~, or
2 certificate under a group policy or contract, or portion ~~thereof~~,
3 **OF A GROUP POLICY OR CONTRACT**, for which coverage is provided under
4 section 7704.

5 (h) "Health insurance" means disability insurance as ~~defined~~
6 **DESCRIBED** in section 606.

7 (i) "Impaired insurer" means a member insurer considered by
8 the ~~commissioner after May 1, 1982~~, **DIRECTOR** to be potentially
9 unable to fulfill the insurer's contractual obligations or that is
10 placed under an order of rehabilitation or conservation by a court
11 of competent jurisdiction. Impaired insurer does not mean an
12 insolvent insurer.

13 (j) "Insolvent insurer" means a member insurer that ~~after May~~
14 ~~1, 1982~~, becomes insolvent and is placed under an order of
15 liquidation ~~by~~ a court of competent jurisdiction with a finding
16 of insolvency.

17 (k) "Member insurer" means a person authorized to transact a
18 kind of insurance or annuity business in this state for which
19 coverage is provided under section 7704 and includes an insurer
20 whose certificate of authority in this state may have been
21 suspended, revoked, not renewed, or voluntarily withdrawn. Member
22 insurer does not include the following:

23 (i) A fraternal benefit society.

24 (ii) A cooperative plan insurer authorized under chapter 64.

25 (iii) A health maintenance organization authorized or licensed
26 under chapter 35.

27 (iv) A mandatory state pooling plan.

1 (v) A mutual assessment or any ~~entity~~ **PERSON** that operates on
2 an assessment basis.

3 (vi) A nonprofit dental care corporation operating under 1963
4 PA 125, MCL 550.351 to 550.373.

5 ~~—— (vii) A nonprofit health care corporation operating under the~~
6 ~~nonprofit health care corporation reform act, 1980 PA 350, MCL~~
7 ~~550.1101 to 550.1704.~~

8 **(vii)** ~~(viii)~~ An insurance exchange.

9 **(viii)** ~~(ix)~~ An organization that has a certificate or license
10 limited to the issuance of charitable gift annuities.

11 **(ix)** ~~(x)~~ Any entity similar to the entities described in this
12 subdivision.

13 (l) "Moody's corporate bond yield average" means the monthly
14 average corporates as published by Moody's ~~investors service, inc.,~~
15 **INVESTORS SERVICE, INC.**, or a successor to that service.

16 (m) "Owner" of a contract or policy and "contract owner" and
17 "policy owner" mean the person who is identified as the legal owner
18 under the terms of the contract or policy or who is otherwise
19 vested with the legal title to the contract or policy through a
20 valid assignment completed in accordance with the terms of the
21 contract or policy and properly recorded as the owner on the books
22 of the insurer. The terms owner, contract owner, and policy owner
23 do not include persons with a mere beneficial interest in a
24 contract or policy.

25 (n) "Person" means an individual, corporation, partnership,
26 association, or voluntary organization.

27 (o) "Plan sponsor" means the following:

1 (i) For a benefit plan established or maintained by a single
2 employer, the single employer.

3 (ii) For a benefit plan established or maintained by an
4 employee organization, the employee or organization.

5 (iii) For a benefit plan established or maintained by 2 or
6 more employers or jointly by 1 or more employers and 1 or more
7 employee organizations, the association, committee, joint board of
8 trustees, or other similar group of representatives of the parties
9 who establish or maintain the benefit plan.

10 (p) "Premiums" means amounts or considerations, by whatever
11 name called, received on covered policies or contracts less
12 returned premiums, considerations, and deposits and less dividends
13 and experience credits. The term "premiums" does not include an
14 amount or consideration received for a policy or contract, or a
15 portion of a policy or contract for which coverage is not provided
16 under section 7704. However, accessible premiums ~~shall~~**MUST** not be
17 reduced ~~on account~~**BECAUSE** of sections 7704(5)(c) relating to
18 interest limitations and 7704(6)(b), (c), and (e) relating to
19 limitations with respect to any 1 individual, any 1 participant,
20 and any 1 contract holder. Premiums ~~shall~~**DO** not include premiums
21 in excess of the following:

22 (i) \$5,000,000.00 on an unallocated annuity contract not
23 issued under a governmental retirement plan established under
24 section 401(k), 403(b), or 457 of the internal revenue code of
25 1986, 26 USC 401, 403, and 457.

26 (ii) For multiple nongroup policies of life insurance owned by
27 1 owner, whether the policyowner is an individual, firm,

1 corporation, or other person, and whether the persons insured are
2 officers, managers, employees, or other persons, \$5,000,000.00 with
3 respect to these policies or contracts, regardless of the number of
4 policies or contracts held by the owner.

5 (q) "Principal place of business" of a plan sponsor or a
6 person other than a natural person means the state in which the
7 natural persons who establish policy for the direction, control,
8 and coordination of the entity as a whole primarily exercise that
9 function. In making this determination, the association, in its
10 reasonable judgment, shall consider all of the following factors:

11 (i) The state in which the primary executive and
12 administrative headquarters of the entity is located.

13 (ii) The state in which the principal office of the chief
14 executive officer of the entity is located.

15 (iii) The state in which the board of directors, or the
16 entity's similar governing person or persons, conducts the majority
17 of its meetings.

18 (iv) The state in which the executive or management committee
19 of the board of directors, or the entity's similar governing person
20 or persons, conducts the majority of its meetings.

21 (v) The state from which the management of the overall
22 operations of the entity is directed.

23 (vi) For a benefit plan sponsored by affiliated companies
24 comprising a consolidated corporation, the state in which the
25 holding company or controlling affiliate has its principal place of
26 business as determined using subparagraphs (i) to (v). However, for
27 a plan sponsor, if more than 50% of the participants in the benefit

1 plan are employed in a single state, that state is the principal
2 place of business of the plan sponsor.

3 (vii) For a plan sponsor of a benefit plan, the principal
4 place of business of the association, committee, joint board of
5 trustees, or other similar group of representatives of the parties
6 who establish or maintain the benefit plan ~~shall be~~ **IS** based ~~upon~~
7 **ON** the location of the principal place of business of the employer
8 or employee organization that has the largest investment in the
9 benefit plan ~~in lieu~~ **INSTEAD** of a specific or clear designation of
10 a principal place of business.

11 (r) "Receivership court" means the court in the insolvent
12 insurer's or impaired insurer's state having jurisdiction over the
13 conservation, rehabilitation, or liquidation of the insurer.

14 (s) "Resident" means a person who resides in this state at the
15 time a member insurer is determined to be an impaired insurer or
16 insolvent insurer and to whom contractual obligations are owed. A
17 person may be considered a resident of only 1 state, which, ~~in the~~
18 ~~ease of~~ **FOR** a person other than a natural person, is its principal
19 place of business. Citizens of the United States who are either
20 residents of foreign countries or residents of the United States
21 possessions, territories, or protectorates that do not have an
22 association similar to the association created by this chapter
23 ~~shall be~~ **ARE** considered residents of this state if the insurer that
24 issued the policies or contracts is domiciled in this state.

25 (t) "State" means a state, the District of Columbia, Puerto
26 Rico, or a United States possession, territory, or protectorate.

27 (u) "Structured settlement annuity" means an annuity purchased

1 in order to fund periodic payments for a plaintiff or other
 2 claimant in payment for or with respect to personal injury suffered
 3 by the plaintiff or other claimant.

4 (v) "Supplemental contract" means a written agreement entered
 5 into for the distribution of proceeds under a life, health, or
 6 annuity policy or contract.

7 (w) "Unallocated annuity contract" means an annuity contract
 8 or group annuity certificate that is not issued to and owned by an
 9 individual, except to the extent of an annuity benefit guaranteed
 10 to an individual by an insurer under the contract or certificate.

11 ~~The term shall also include,~~ **UNALLOCATED ANNUITY CONTRACT INCLUDES,**
 12 but is not limited to, **A** guaranteed investment ~~contracts and~~
 13 **CONTRACT OR A** deposit administration ~~contracts.~~ **CONTRACT.**

14 Enacting section 1. Sections 2242, 3401, 3406f, 3406g, 3439,
 15 3521, 3523, 3525, 3527, 3537, 3539, 3541, 3542, 3543, 3549, 3565,
 16 3567, 3580, and 3706 and chapter 36 of the insurance code of 1956,
 17 1956 PA 218, MCL 500.2242, 500.3401, 500.3406f, 500.3406g,
 18 500.3439, 500.3521, 500.3523, 500.3525, 500.3527, 500.3537,
 19 500.3539, 500.3541, 500.3542, 500.3543, 500.3549, 500.3565,
 20 500.3567, 500.3580, 500.3600 to 500.3650, and 500.3706, are
 21 repealed.

22 Enacting section 2. This amendatory act does not take effect
 23 unless all of the following bills of the 98th Legislature are
 24 enacted into law:

25 (a) House Bill No. 4933.

26 (b) House Bill No. 4934.