SENATE 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, 2242, 3400, 3402, 3403, 3404, 3405, 3405a, 3406a, 3406c, 3406d, 3406e, 3406j, 3406k, 3406*l*, 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, 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, 500.2242, 500.3400, 500.3402, 500.3403, 500.3404, 500.3405, 500.3405a, 500.3406a, 500.3406c, 500.3406d, 500.3406e, 500.3406j, 500.3406k, 500.3406*l*, 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, 500.3475, 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, section 2213b as amended by 2016 PA 100, section 2236 as amended by 2014 PA 140, sections 2242, 3426, and 3705 as amended

and sections 3405a, 3428, and 3472 as added by 2013 PA 5, 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 3406*l* 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, section 3515 as amended by 2016 PA 97, sections 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:

Sec. 106. **AS USED IN THIS ACT:**

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

DEFINED IN SECTION 3501.

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

Sec. 116. As used in this act:

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

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

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

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

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

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

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

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

(G) "PARTICIPATING PROVIDER" MEANS A PROVIDER THAT, UNDER CONTRACT WITH AN INSURER THAT ISSUES POLICIES OF HEALTH INSURANCE OR WITH SUCH AN INSURER'S CONTRACTOR OR SUBCONTRACTOR, HAS AGREED TO PROVIDE HEALTH CARE SERVICES TO COVERED INDIVIDUALS AND TO ACCEPT PAYMENT BY THE INSURER, CONTRACTOR, OR SUBCONTRACTOR FOR COVERED SERVICES AS PAYMENT IN FULL, OTHER THAN COINSURANCE, COPAYMENTS, OR DEDUCTIBLES.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(15) As used in this section:

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

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

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

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

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

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

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

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

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

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

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

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

INSURANCE COMMISSIONERS' financial regulation standards and accreditation program.

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

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

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

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

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

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

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

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

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

(a) To the governor or the attorney general.

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

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

(d) To law enforcement officials.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(j) The age and collectibility of receivables.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

program.

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

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

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

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

(z) Compliance by the insurer with section 901.

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

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

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

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

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

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

condition.

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

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

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

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

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

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

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

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

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

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

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

(J) CORRECT CORPORATE GOVERNANCE PRACTICE DEFICIENCIES AND ADOPT AND USE GOVERNANCE PRACTICES THAT ARE ACCEPTABLE TO THE DIRECTOR.

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

Sec. 454. **(1)** Except as otherwise provided in this section, **THE DEPARTMENT SHALL NOT AUTHORIZE** an insurer ~~shall not be authorized~~ to do business in this state if its name is the same as or closely resembles the name of ~~any other~~ **ANOTHER** insurer organized under or authorized to do business under the laws of this

state. However, **THE DEPARTMENT MAY AUTHORIZE** an insurer ~~may be authorized~~ to do business in this state ~~by adding~~ **IF IT ADDS** to its corporate name a word, abbreviation, or other distinctive and distinguishing element.

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

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

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

Sec. 462. ~~An~~ **EXCEPT AS OTHERWISE PROVIDED IN THIS SECTION, AN** application for life or disability insurance ~~shall~~ **MUST** bear the signature of ~~a licensed agent.~~**AN INSURANCE PRODUCER. THIS SECTION DOES NOT APPLY TO AN APPLICATION FOR INSURANCE THROUGH THE INSURER'S INTERNET WEBSITE IF THE WEBSITE CONTAINS A STATEMENT THAT THE APPLICANT MAY USE AN INSURANCE PRODUCER TO ASSIST WITH THE**

APPLICATION AT NO COST TO THE APPLICANT.

Sec. 606. **(1)** "Disability" insurance is insurance ~~of any person~~ against bodily injury or death by accident, or against disability on account of sickness or accident. ~~including also the granting of specific hospital benefits and medical, surgical and sick care benefits~~ **UNLESS SPECIFICALLY EXCLUDED IN CHAPTER 34, DISABILITY INSURANCE INCLUDES HEALTH INSURANCE ISSUED** to ~~any person,~~ **AN INDIVIDUAL,** family, or group, subject to ~~such~~ limitations ~~as may be~~ **THAT ARE** prescribed with respect ~~thereto: Provided, The~~ **TO THE INSURANCE.**

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

SEC. 607. (1) AS USED IN THIS ACT, "GROUP DISABILITY INSURANCE" MEANS VOLUNTARY DISABILITY INSURANCE THAT COVERS 2 OR MORE EMPLOYEES OR MEMBERS, WITH OR WITHOUT THEIR ELIGIBLE DEPENDENTS, WRITTEN UNDER A MASTER POLICY ISSUED TO A GOVERNMENTAL CORPORATION, UNIT, AGENCY, OR DEPARTMENT OF A GOVERNMENTAL ENTITY, TO A CORPORATION, COPARTNERSHIP, OR INDIVIDUAL EMPLOYER, OR, ON APPLICATION OF AN EXECUTIVE OFFICER OR TRUSTEE OF THE ASSOCIATION,

TO AN ASSOCIATION THAT HAS A CONSTITUTION OR BYLAWS AND THAT IS FORMED IN GOOD FAITH FOR PURPOSES OTHER THAN THAT OF OBTAINING INSURANCE, AND UNDER WHICH OFFICERS, MEMBERS, EMPLOYEES, OR CLASSES OR DEPARTMENTS OF THE ASSOCIATION MAY BE INSURED FOR THEIR INDIVIDUAL BENEFIT.

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

SEC. 608. AS USED IN THIS ACT:

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

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

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

(2) Subject to chapter 58, ~~any~~ **A** mutual insurance company other than life may, by policy, treaty, or other agreement, cede to or accept from any insurance company or insurer reinsurance ~~upon~~ **ON** the whole or any part of any risk, which reinsurance ~~shall~~ **MUST** be without contingent liability or participation or membership unless provided otherwise. Reinsurance ~~shall~~ **MUST** not be effected with any

company or insurer disapproved by written order of the ~~commissioner~~ **DIRECTOR** filed in his or her office.

(3) An insurer authorized to transact multiple lines of insurance may, except with respect to policies of life and endowment insurance and contracts for the payment of annuities and pure endowments, reinsure risks of every kind or description.

(4) Reinsurance ~~shall~~ **MUST** not be ceded to or accepted by any insurer operating under the cooperative or assessment plan. Reinsurance of any insurer operating under the cooperative or assessment plan ~~shall~~ **MUST** be ceded only to insurers authorized under this act to transact a similar kind of insurance in this state and to accept reinsurance.

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

Sec. 1001. As used in this chapter:

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

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

board of directors ~~shall~~ **WILL** constitute the audit committee.

(c) "Group of insurers" means those licensed insurers included in the reporting requirements of chapter 13, or a set of insurers as identified by management, for the purpose of assessing the effectiveness of internal control over financial reporting.

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

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

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

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

(H) ~~(g)~~ "Internal control over financial reporting" means a process effected by an entity's board of directors, management, and

other personnel designed to provide reasonable assurance regarding the reliability of the financial statements filed with the ~~commissioner,~~ **DIRECTOR,** and includes the following:

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

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

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

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

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

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

(*l*) ~~(k)~~ "SOX compliant entity" means an entity that either is required to be compliant with, or voluntarily is compliant with,

all of the following provisions of the Sarbanes-Oxley act of 2002 **AND THE REGULATIONS PROMULGATED UNDER THAT ACT**:

(*i*) The preapproval requirements of section 201, section 10A(i) of the securities exchange act of 1934**, 15 USC 78J-1**.

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

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

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

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

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

Sec. 2006. (1) A person must pay on a timely basis to its insured, ~~an individual or entity~~ **A PERSON** directly entitled to

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

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

(3) An insurer shall specify in writing the materials that constitute a satisfactory proof of loss not later than 30 days after receipt of a claim unless the claim is settled within the 30 days. If proof of loss is not supplied as to the entire claim, the amount supported by proof of loss ~~shall be~~ **IS** considered paid on a timely basis if paid within 60 days after receipt of proof of loss by the insurer. Any part of the remainder of the claim that is later supported by proof of loss ~~shall be~~ **IS** considered paid on a timely basis if paid within 60 days after receipt of the proof of loss by the insurer. If the proof of loss provided by the claimant

contains facts that clearly indicate the need for additional medical information by the insurer in order to determine its liability under a policy of life insurance, the claim ~~shall be~~ **IS** considered paid on a timely basis if paid within 60 days after receipt of necessary medical information by the insurer. Payment of a claim ~~shall~~ **IS** not ~~be~~ untimely during any period in which the insurer is unable to pay the claim ~~when~~ **IF** there is no recipient who is legally able to give a valid release for the payment, or ~~where~~ **IF** the insurer is unable to determine who is entitled to receive the payment, if the insurer has promptly notified the claimant of that inability and has offered in good faith to promptly pay the claim upon determination of who is entitled to receive the payment.

(4) If benefits are not paid on a timely basis**,** the benefits paid ~~shall~~ bear simple interest from a date 60 days after satisfactory proof of loss was received by the insurer at the rate of 12% per annum, if the claimant is the insured or ~~an individual or entity~~ **A PERSON** directly entitled to benefits under the insured's **INSURANCE** contract**.** ~~of insurance.~~ If the claimant is a third party tort claimant, ~~then~~ the benefits paid ~~shall~~ bear interest from a date 60 days after satisfactory proof of loss was received by the insurer at the rate of 12% per annum if the liability of the insurer for the claim is not reasonably in dispute, the insurer has refused payment in bad faith**,** and the bad faith was determined by a court of law. The interest ~~shall~~ **MUST** be paid in addition to and at the time of payment of the loss. If the loss exceeds the limits of insurance coverage available, interest

~~shall be~~ **IS** payable based ~~upon~~ **ON** the limits of insurance coverage rather than the amount of the loss. If payment is offered by the insurer but is rejected by the claimant, and the claimant does not subsequently recover an amount in excess of the amount offered, interest is not due. Interest paid ~~pursuant to~~ **AS PROVIDED IN** this section ~~shall~~ **MUST** be offset by any award of interest that is payable by the insurer ~~pursuant to~~ **AS PROVIDED IN** the award.

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

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

(7) Subsections (1) to (6) do not apply and subsections (8) to (14) do apply to health plans when paying claims to health professionals, health facilities, home health care providers, and

durable medical equipment providers, that are not pharmacies and that do not involve claims arising out of ~~sections 3101 to 3177~~ **CHAPTER 31** or the worker's disability compensation act of 1969, 1969 PA 317, MCL 418.101 to 418.941. This section does not affect a health plan's ability to prescribe the terms and conditions of its contracts, other than as provided in this section for timely payment.

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

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

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

(c) A health professional, health facility, home health care provider, ~~and~~ **OR** durable medical equipment provider ~~have~~ **HAS** 45 days, and any additional time the health plan permits, after receipt of a notice under subdivision (b) to correct all known defects. The 45-day time period in subdivision (a) is tolled from the date of receipt of a notice to a health professional, health

facility, home health care provider, or durable medical equipment provider under subdivision (b) to the date of the health plan's receipt of a response from the health professional, health facility, home health care provider, or durable medical equipment provider.

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

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

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

(g) A health professional, health facility, home health care provider, or durable medical equipment provider shall not resubmit

the same claim to the health plan unless the time ~~frame in~~ **PERIOD UNDER** subdivision (a) has passed or as provided in subdivision (c).

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

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

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

(11) A health plan shall not terminate the affiliation status or the participation of a health professional, health facility, home health care provider, or durable medical equipment provider with a health maintenance organization provider panel or otherwise discriminate against a health professional, health facility, home health care provider, or durable medical equipment provider because

the health professional, health facility, home health care provider, or durable medical equipment provider claims that a health plan has violated subsections (7) to (10).

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

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

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

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

(*i*) Identifies the health professional, health facility, home health care provider, or durable medical equipment provider that

provided service sufficiently to verify, if necessary, affiliation status and includes any identifying numbers.

(*ii*) Sufficiently identifies the patient and health plan subscriber.

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

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

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

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

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

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

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

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

(*i*) An insurer providing benefits under ~~an expense-incurred hospital, medical, surgical, vision, or dental~~ **A HEALTH INSURANCE** policy**,** ~~or certificate,~~ including ~~any~~ **A** policy**,** ~~or~~ certificate**, OR CONTRACT** that provides coverage for specific diseases or accidents only, **AN EXPENSE-INCURRED VISION OR DENTAL POLICY,** or ~~any~~ **A** hospital indemnity, ~~medicare~~ **MEDICARE** supplement, long-term care, or 1-time limited duration policy or certificate, but not to

payments made to an administrative services only or cost-plus arrangement.

(*ii*) A MEWA regulated under chapter 70 that provides hospital, medical, surgical, vision, dental, and sick care benefits.

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

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

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

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

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

(2) Subsection (1) ~~shall~~ **DOES** not ~~be construed to~~ prohibit an ~~agent licensed under chapter 12~~ **INSURANCE PRODUCER** from marketing

or transacting any of the following:

~~(a) Subject to the health benefit agent act, health care 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, with specifications regarding requirements for the use of generic drugs.

(c) Emergency health coverages and benefits.

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

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

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

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

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

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

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

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

new subscribers.

(b) The professional credentials of **AFFILIATED OR** participating ~~health professionals,~~ **PROVIDERS,** including, but not limited to, **AFFILIATED OR** participating ~~health professionals~~ **PROVIDERS** who are board certified in the specialty of pain medicine and the evaluation and treatment of pain and have reported that certification to the insurer, including all of the following:

(*i*) Relevant professional degrees.

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

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

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

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

(e) ~~Indication of the~~ **THE** financial relationships between the insurer and any closed provider panel**,** including all of the

following as applicable:

(*i*) Whether a fee-for-service arrangement exists, under which the provider is paid a specified amount for each covered service rendered to the participant.

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

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

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

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

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

(A) THE STYLE, ARRANGEMENT, AND OVERALL APPEARANCE OF THE POLICY DO NOT GIVE UNDUE PROMINENCE TO ANY PORTION OF THE TEXT. EVERY PRINTED PORTION OF THE TEXT OF THE POLICY AND OF ANY ENDORSEMENTS OR ATTACHED PAPERS MUST BE PLAINLY PRINTED IN LIGHT-FACED TYPE OF A STYLE IN GENERAL USE, THE SIZE OF WHICH MUST BE UNIFORM AND NOT LESS THAN 10-POINT WITH A LOWERCASE UNSPACED ALPHABET LENGTH, NOT LESS THAN 120-POINT IN LENGTH OF LINE. AS USED IN THIS SUBDIVISION, "TEXT" INCLUDES 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.

(B) EXCEPT AS OTHERWISE PROVIDED IN THIS SUBDIVISION OR EXCEPT AS PROVIDED IN SECTIONS 3406 TO 3452, EXCEPTIONS AND REDUCTIONS OF INDEMNITY ARE SET FORTH IN THE POLICY AND ARE PRINTED, AT THE INSURER'S OPTION, WITH THE BENEFIT PROVISION TO WHICH THEY APPLY OR UNDER AN APPROPRIATE CAPTION SUCH AS "EXCEPTIONS" OR "EXCEPTIONS AND REDUCTIONS". IF AN EXCEPTION OR REDUCTION OF INDEMNITY SPECIFICALLY APPLIES ONLY TO A PARTICULAR BENEFIT OF THE POLICY, A STATEMENT OF THE EXCEPTION OR REDUCTION MUST BE INCLUDED WITH THE BENEFIT PROVISION TO WHICH IT APPLIES.

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

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

(5) ~~(4)~~ As used in this section, "board certified" means certified to practice in a particular medical or other health professional specialty by the American ~~board of medical specialties~~ **BOARD OF MEDICAL SPECIALTIES, THE AMERICAN OSTEOPATHIC ASSOCIATION BUREAU OF OSTEOPATHIC SPECIALISTS,** or another appropriate national health professional organization.

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

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

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

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

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

(c) If the insured is determined to ~~be terminally ill prior to~~ **HAVE AN ADVANCED ILLNESS BEFORE** a physician's termination or

knowledge of the termination and the physician was treating the ~~terminal~~ **ADVANCED** illness before the date of termination or knowledge of the termination, for the remainder of the insured's life for care directly related to the treatment of the ~~terminal~~ **ADVANCED** illness.

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

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

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

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

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

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

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

(6) This section does not create an obligation for an insurer to provide to an insured coverage beyond the maximum coverage limits permitted by the insurer's policy or certificate with the insured. This section does not create an obligation for an insurer to expand who may be a primary care physician under a policy or certificate.

(7) As used in this section:

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

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

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

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

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

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

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

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

(d) Timely notification ~~in plain English~~ to the insured or enrollee as to the progress of an investigation of a grievance.

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

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

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

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

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

(j) That when an adverse determination is made, a written statement ~~in plain English~~ containing the reasons for the adverse determination is provided to the insured or enrollee along with

written notifications as required under the patient's right to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929.

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

(*l*) That a determination will be made by the insurer ~~or health maintenance organization~~ not later than 72 hours after receipt of an expedited grievance. Within 10 days after receipt of a determination, the insured or enrollee may request a determination of the matter by the ~~commissioner~~ **DIRECTOR** or his or her designee or by an independent review organization under the patient's right to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929. If the determination by the insurer ~~or health maintenance organization~~ is made orally, the insurer ~~or health maintenance~~

~~organization~~ shall provide a written confirmation of the determination to the insured or enrollee not later than 2 business days after the oral determination. An expedited grievance under this subdivision applies if a grievance is submitted and a physician, orally or in writing, substantiates that the time frame for a grievance under subdivision (k) would seriously jeopardize the life or health of the insured or enrollee or would jeopardize the insured's or enrollee's ability to regain maximum function.

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

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

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

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

(5) A WRITTEN NOTICE REQUIRED TO BE GIVEN UNDER THIS SECTION MUST BE PROVIDED IN A CULTURALLY AND LINGUISTICALLY APPROPRIATE

MANNER, AS REQUIRED UNDER 45 CFR 147.136(B)(2)(II)(E).

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

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

(*i*) A determination ~~that an admission, availability of care, continued stay, or other health care service has been reviewed and denied, reduced, or terminated.~~ **BY AN INSURER OR ITS DESIGNEE UTILIZATION REVIEW ORGANIZATION THAT A REQUEST FOR A BENEFIT, ON APPLICATION OF ANY UTILIZATION REVIEW TECHNIQUE, DOES NOT MEET THE INSURER'S REQUIREMENTS FOR MEDICAL NECESSITY, APPROPRIATENESS, HEALTH CARE SETTING, LEVEL OF CARE, OR EFFECTIVENESS OR IS DETERMINED TO BE EXPERIMENTAL OR INVESTIGATIONAL AND THE REQUESTED BENEFIT IS THEREFORE DENIED, REDUCED, OR TERMINATED OR PAYMENT IS NOT PROVIDED OR MADE, IN WHOLE OR IN PART, FOR THE BENEFIT.**

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

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

(*iv*) A RESCISSION OF COVERAGE DETERMINATION.

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

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

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

(*ii*) Benefits or claims payment, handling, or reimbursement for health care services.

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

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

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

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

Sec. 2213a. (1) ~~All~~ **THE DIRECTOR SHALL CALCULATE** actual and necessary expenses incurred by the ~~commissioner~~ **DIRECTOR** under section 2213 ~~shall be calculated by the commissioner~~ by June 30 of each year for the immediately preceding fiscal year. Except as otherwise provided in subsection (2), the ~~commissioner~~ **DIRECTOR** shall divide these expenses among all insurers ~~who~~ **THAT** issue a policy or certificate under chapter 34 or ~~36~~ **35** in this state on a pro rata basis according to the direct written premiums **OF EACH INSURER AS** reported in ~~each~~ **THE** insurer's annual statement for the immediately preceding calendar year. ~~by each of those insurers.~~

~~This~~ **AN INSURER SHALL PAY THE** assessment ~~shall be paid~~ within 30 days after receipt of the assessment. ~~and~~ **THE ASSESSMENT** is in addition to the regulatory fee provided for in section 224.

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

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

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

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

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

(3) AT THE TIME OF RENEWAL OF A GROUP HEALTH INSURANCE POLICY

ISSUED UNDER CHAPTER 34, THE INSURER MAY MODIFY THE POLICY.

(4) ~~(3)~~ Guaranteed renewal **OF A HEALTH INSURANCE POLICY** is not required in cases of fraud, intentional misrepresentation of material fact, lack of payment, **NONCOMPLIANCE WITH MINIMUM CONTRIBUTION REQUIREMENTS, OR NONCOMPLIANCE WITH MINIMUM PARTICIPATION REQUIREMENTS,** if the insurer no longer offers that particular type of coverage in the market, or if the individual or group moves outside the service area.

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

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

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

(c) Acts uniformly without regard to any health status factor of enrolled individuals or individuals who may become eligible for

coverage in making the determination to discontinue coverage and in offering other plans or products.

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

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

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

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

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

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

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

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

(c) Does not cover any preexisting conditions.

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

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

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

(b) The gross written premium for all individual ~~expense-incurred hospital, medical, or surgical~~ **HEALTH INSURANCE** policies

~~or certificates~~ issued or delivered in this state during the preceding calendar year other than policies or certificates described in subdivision (a).

(11) ~~(10)~~ The director shall maintain copies of reports prepared under subsection ~~(9)~~ **(10)** on file with the annual statement of each reporting insurer.

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

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

(2) If ~~any such~~ **A** policy **DESCRIBED IN SUBSECTION (1) THAT WAS** delivered or issued for delivery to ~~any~~ **A** person in this state ~~shall be~~ **IS** reinstated or renewed ~~,~~ and the insured or ~~the~~ **A** beneficiary or assignee of ~~such~~ **THE** policy ~~shall make~~ **MAKES** a written request to the insurer for a copy of ~~the~~ **ANY** application ~~,~~

~~if any,~~ for ~~such~~ reinstatement or renewal, the insurer shall, within 15 days after ~~the receipt of such~~ **RECEIVING THE** request at ~~its~~ **THE** home office or ~~any~~ **A** branch office of the insurer, deliver or mail to the person making ~~such~~ **THE** request ~~,~~ a copy of ~~such~~ **THE** application. If ~~such~~ **THE** copy ~~shall~~ **IS** not ~~be so~~ delivered or mailed **AS REQUIRED BY THIS SUBSECTION**, the insurer ~~shall be~~ **IS** precluded from introducing ~~such~~ **THE** application as evidence in ~~any~~ **AN** action or proceeding based ~~upon~~ **ON** or involving ~~such~~ **THE** policy or ~~its~~ **THE** reinstatement or renewal.

Sec. 2236. (1) ~~A~~ **EXCEPT AS OTHERWISE PROVIDED IN THIS SECTION, AN INSURER SHALL NOT DELIVER OR ISSUE FOR DELIVERY IN THIS STATE A** basic insurance policy form or annuity contract form**;** ~~shall not be issued or delivered to any person in this state, and an insurance or annuity application form if a written application is required and is to be made a part of the policy or contract,~~ a printed rider or indorsement form or form of renewal certificate**;** ~~, and~~ **OR** a group certificate in connection with the policy or contract ~~, shall not be issued or delivered to a person in this state, until~~ **UNLESS** a copy of the form is filed with the department ~~of insurance and financial services~~ and approved by the director ~~of the department of insurance and financial services~~ as conforming with the requirements of this act and not inconsistent with the law. ~~Failure of~~ **A FORM IS CONSIDERED APPROVED IF** the director ~~of the department of insurance and financial services~~ **FAILS** to act within 30 days after **ITS** submittal ~~constitutes approval. A form described in this section, except a policy of disability insurance as defined~~ **UNDER THIS SECTION. EXCEPT FOR DISABILITY INSURANCE AS DESCRIBED** in

section 3400, ~~must be~~ **AN INSURER SHALL** plainly ~~printed~~ **PRINT THE FORM** with **A** type size **OF** not less than 8-point unless the director ~~of the department of insurance and financial services~~ determines that portions of the form **THAT ARE** printed with type less than 8-point ~~is~~ **ARE** not deceptive or misleading.

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

(3) ~~Beginning January 1, 1992, the~~ **THE** director ~~of the department of insurance and financial services~~ shall not approve a form filed under this section ~~providing~~ **THAT PROVIDES** for or ~~relating~~ **RELATES** to an insurance policy or an annuity contract for personal, family, or household purposes if the form fails to obtain

the following readability score or meet the other requirements of this subsection, as applicable:

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

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

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

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

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

(*iv*) Add the figures obtained in subparagraphs (*ii*) and (*iii*) and subtract this sum from 206.835. The figure obtained equals the 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 ~~riders, 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.**

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

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

(*i*) Topical captions.

(*ii*) An identification of exclusions.

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

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

(*i*) Contain a properly descriptive title.

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

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

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

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

(4) ~~After January 1, 1992, any~~ **AN INSURER SHALL SUBMIT FOR APPROVAL UNDER SUBSECTION (3) A** change or addition to a policy or annuity contract form for personal, family, or household purposes,

whether by indorsement, rider, or otherwise, or a change or addition to a rider or indorsement form ~~to~~ **ASSOCIATED WITH** the policy **FORM** or annuity contract form, ~~which policy or annuity contract~~ **IF THE** form has not been previously approved under subsection (3)**.** ~~, shall be submitted for approval under subsection (3).~~

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

(6) If a form is disapproved or approval is withdrawn under this act, the insurer is entitled ~~upon~~ **ON** demand to a hearing before the director ~~of the department of insurance and financial services~~ or a deputy director ~~of the department of insurance and~~

~~financial services~~ within 30 days after the notice of disapproval or of withdrawal of approval. After the hearing, the director ~~of the department of insurance and financial services~~ shall make findings of fact and law ~~,~~ and ~~either~~ affirm, modify, or withdraw his or her original order or decision. **AN INSURER SHALL NOT ISSUE THE FORM AFTER A FINAL DETERMINATION OF DISAPPROVAL OR WITHDRAWAL OF APPROVAL.**

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

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

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

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

(*ii*) Bridges, tunnels, or other instrumentalities of transportation and communication.

(*iii*) Aircraft and attached equipment.

(*iv*) Vessels and watercraft **THAT ARE** under construction**,** ~~or~~

ARE owned by or used in a business**,** or ~~having~~ **HAVE** a straight-line hull length of more than 24 feet.

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

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

(*ii*) Aircraft and attached equipment.

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

(c) Surety bonds other than fidelity bonds.

(d) Policies, riders, indorsements, or forms of unique character designed for and used with relation to insurance ~~upon~~ **ON** a particular subject, or that relate to the manner of distribution of benefits or to the reservation of rights and benefits under life or disability insurance policies and are used at the request of the individual policyholder, contract holder, or certificate holder. ~~Beginning September 1, 1968, the director of the department of insurance and financial services by~~ **BY** order**, THE DIRECTOR** may exempt from the filing requirements of this section and sections ~~2242, 3606,~~ **3401A** and 4430 for ~~so~~ **AS** long as he or she considers proper any insurance document or form, except that portion of the document or form that establishes a relationship between group disability insurance and personal protection insurance benefits subject to exclusions or deductibles under section 3109a, as specified in the order to which this section is not practicably

applied, or the filing and approval of which are considered unnecessary for the protection of the public. Insurance documents or forms providing medical payments or income replacement benefits, except that portion of the document or form that establishes a relationship between group disability insurance and personal protection insurance benefits subject to exclusions or deductibles under section 3109a, exempt by order of the director ~~of the department of insurance and financial services~~ from the filing requirements of this section and ~~sections 2242 and 3606~~ **SECTION 3401A** are considered approved by the director ~~of the department of insurance and financial services~~ for purposes of section 3430.

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

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

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

(9) NOTWITHSTANDING ANY PROVISION OF THIS ACT TO THE CONTRARY, A HEALTH INSURER MAY SATISFY A REQUIREMENT FOR THE DELIVERY OF AN INSURANCE FORM OR NOTICE REQUIRED BY THIS ACT TO A SUBSCRIBER, INSURED, ENROLLEE, OR CONTRACT HOLDER BY DOING ALL OF THE 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) SUBJECT TO THE REQUIREMENTS OF THIS SECTION, AN INSURER MAY FILE HEALTH INSURANCE POLICIES, CERTIFICATES, AND RIDERS QUARTERLY. THIS SUBSECTION DOES NOT LIMIT OR RESTRICT AN INSURER'S ABILITY TO FILE LARGE GROUP HEALTH INSURANCE POLICIES, CERTIFICATES, OR RIDERS AT ANY TIME DURING THE YEAR.

(11) ~~(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.

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

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

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

(2) ~~Subject to subsection (3), the commissioner~~ **THE DIRECTOR** may within ~~30~~ **60** days after the filing of a disability insurance policy form applicable to individual or family expense coverage, disapprove the form for any of the following, subject to the requirements as to notice, hearing, and appeal set forth in sections 244 and 2236:

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

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

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

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

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

(4) SUBJECT TO THE REQUIREMENTS OF THIS SECTION, AN INSURER MAY FILE HEALTH INSURANCE POLICIES, CERTIFICATES, RIDERS, AND RATES QUARTERLY. THIS SUBSECTION DOES NOT LIMIT OR RESTRICT AN INSURER'S ABILITY TO FILE LARGE GROUP HEALTH INSURANCE POLICIES, CERTIFICATES, OR RIDERS AT ANY TIME DURING THE YEAR.

<<(5) AFTER DECEMBER 31, 2016, THIS SECTION APPLIES TO FORMS FILED BY A NONPROFIT DENTAL CARE CORPORATION OPERATING UNDER 1963 PA 125, MCL 550.351 TO 550.373.>>

Sec. 3400. (1) ~~The term "policy of disability insurance" as~~ **AS** used in this chapter**:**

(A) "AFFILIATED PROVIDER" MEANS A HEALTH PROFESSIONAL, LICENSED HOSPITAL, LICENSED PHARMACY, OR OTHER PERSON THAT HAS ENTERED INTO A PARTICIPATING PROVIDER CONTRACT, DIRECTLY OR INDIRECTLY, WITH A HEALTH MAINTENANCE ORGANIZATION TO RENDER 1 OR MORE HEALTH SERVICES TO AN ENROLLEE. AFFILIATED PROVIDER INCLUDES A PERSON DESCRIBED IN THIS SUBDIVISION THAT HAS ENTERED INTO A WRITTEN ARRANGEMENT WITH ANOTHER PERSON, INCLUDING, BUT NOT LIMITED TO, A PHYSICIAN HOSPITAL ORGANIZATION OR PHYSICIAN ORGANIZATION, THAT CONTRACTS DIRECTLY WITH A HEALTH MAINTENANCE ORGANIZATION.

(B) "DISABILITY INSURANCE POLICY" includes ~~any~~ **AN INSURANCE** policy or **INSURANCE** contract ~~of insurance~~ **THAT INSURES** against loss resulting from sickness or from bodily injury or death by accident, or both, including also the granting of specific hospital benefits and medical, surgical**,** and sick-care benefits to ~~any person,~~ **AN INDIVIDUAL,** family**,** or group, subject to the exclusions ~~set forth or referred to in~~ **PROVIDED IN** this section.

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

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

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

(c) Life insurance, endowment**,** or annuity contracts, or 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 GROUP DISABILITY INSURANCE POLICY UNLESS A COPY OF THE FORM HAS BEEN FILED WITH AND APPROVED BY THE DIRECTOR.

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

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

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

(C) ~~(3) It~~ **THE POLICY** purports to insure only 1 ~~person,~~ **INDIVIDUAL,** except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family who ~~shall be deemed~~ **IS CONSIDERED TO BE** the policyholder, any 2 or more eligible members of that family, including husband, wife, dependent children, ~~or~~ any children under a specified age, ~~which shall not exceed 19 years~~ and any other ~~person~~ **INDIVIDUAL** dependent upon the policyholder, ~~; and~~**IF COVERAGE IS MADE AVAILABLE TO ANY DEPENDENT CHILD AT LEAST UNTIL THE CHILD TURNS 26 YEARS OF AGE FOR A HEALTH INSURANCE POLICY OR 19 YEARS OF AGE FOR A POLICY OF DISABILITY INSURANCE, A POLICY PROVIDING PEDIATRIC DENTAL BENEFITS, OR A POLICY PROVIDING PEDIATRIC VISION BENEFITS.**

~~(4) The style, arrangement and over all appearance of the policy give no undue prominence to any portion of the text, and unless every printed portion of the text of the policy and of any endorsements or attached papers is plainly printed in light faced 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 APPLICATIONS, IF ANY, OF THE EMPLOYEES OR MEMBERS INSURED, CONSTITUTE THE ENTIRE CONTRACT BETWEEN THE PARTIES. THE INSURER'S IDENTIFICATION OF WHAT CONSTITUTES THE ENTIRE CONTRACT CREATES A REBUTTABLE PRESUMPTION THAT THE IDENTIFIED ITEMS ARE THE ENTIRE CONTRACT.

(B) THAT A STATEMENT MADE BY THE EMPLOYER, THE EXECUTIVE OFFICER OR TRUSTEE OF AN ASSOCIATION, OR AN INDIVIDUAL EMPLOYEE OR MEMBER, IN THE ABSENCE OF FRAUD, IS A REPRESENTATION AND NOT A WARRANTY. AN INSURER SHALL NOT USE A STATEMENT MADE BY THE EMPLOYER, THE EXECUTIVE OFFICER OR TRUSTEE OF AN ASSOCIATION, OR AN

INDIVIDUAL EMPLOYEE OR MEMBER AS A DEFENSE TO A CLAIM UNDER THE POLICY, UNLESS THE STATEMENT IS CONTAINED IN A WRITTEN APPLICATION.

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

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

SEC. 3402B. (1) SUBJECT TO THE COORDINATION OF BENEFITS ACT, 1984 PA 64, MCL 550.251 TO 550.255, AN INSURER MAY INCLUDE IN A GROUP OR NONGROUP DISABILITY INSURANCE POLICY A PROVISION FOR THE COORDINATION OF BENEFITS OTHERWISE PAYABLE UNDER THE POLICY WITH BENEFITS PAYABLE FOR THE SAME LOSS UNDER OTHER GROUP OR NONGROUP DISABILITY INSURANCE. AN INSURER THAT DOES NOT INCLUDE IN A GROUP OR NONGROUP DISABILITY INSURANCE POLICY A PROVISION FOR THE COORDINATION OF BENEFITS AS DESCRIBED IN THIS SUBSECTION SHALL COORDINATE BENEFITS UNDER THE POLICY IN THE MANNER PRESCRIBED IN THE COORDINATION OF BENEFITS ACT, 1984 PA 64, MCL 550.251 TO 550.255.

(2) SUBJECT TO SUBSECTION (1), AN INSURER MAY INCLUDE A PROVISION IN A GROUP OR NONGROUP DISABILITY INSURANCE POLICY THAT BENEFITS PAYABLE BY THE POLICY MAY BE LIMITED IF THERE IS OTHER VALID COVERAGE WITH ANOTHER INSURER THAT PROVIDES BENEFITS FOR THE SAME LOSS ON AN EXPENSE-INCURRED BASIS. THE INSURER MAY PROVIDE THAT IF IT IS NOT GIVEN WRITTEN NOTICE ON THE APPLICATION FOR

COVERAGE THAT THE OTHER VALID COVERAGE EXISTS, OR IF OTHER COVERAGE IS ACQUIRED AFTER THE EFFECTIVE DATE OF THE COVERAGE, THE ONLY LIABILITY UNDER ANY EXPENSE-INCURRED COVERAGE OF THE POLICY IS THE AMOUNT OF THE COVERED CLAIM THAT EXCEEDS THE BENEFITS PAYABLE BY THE OTHER COVERAGE. AN INSURER SHALL APPLY BENEFITS PAID OR PAYABLE BY THE PRIMARY INSURER TO SATISFY ANY DEDUCTIBLES, COINSURANCE, AND COPAYMENTS WITH THE POLICY. AN INSURER SHALL NOT APPLY PAYMENTS MADE BY A PRIMARY INSURER TO REDUCE THE POLICY MAXIMUM LIMITS ON THE POLICY. AS USED IN THIS SUBSECTION, "OTHER COVERAGE" INCLUDES A PLAN THAT PROVIDES COVERAGE UNDER A HEALTH INSURANCE POLICY, HOSPITAL OR MEDICAL SERVICE SUBSCRIBER CONTRACT, MEDICAL PRACTICE OR OTHER PREPAYMENT PLAN, OR OTHER EXPENSE-INCURRED PLAN OR PROGRAM. OTHER COVERAGE DOES NOT INCLUDE MEDICAID, HOSPITAL DAILY INDEMNITY PLANS, SPECIFIED DISEASE ONLY POLICIES, OR LIMITED OCCURRENCE POLICIES THAT PROVIDE ONLY FOR INTENSIVE CARE OR CORONARY CARE AT A HOSPITAL, FIRST AID OUTPATIENT MEDICAL EXPENSES RESULTING FROM ACCIDENTS, OR SPECIFIED ACCIDENTS SUCH AS TRAVEL ACCIDENTS.

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

SEC. 3402C. (1) FOR PURPOSES OF THIS CHAPTER, FAMILY EXPENSE INSURANCE IS ACCIDENT AND HEALTH INSURANCE THAT IS WRITTEN UNDER 1 POLICY ISSUED TO THE HEAD OF A FAMILY WHO MAY BE EITHER SPOUSE AND THAT INSURES THE HEAD OF THE FAMILY AND 1 OR MORE DEPENDENTS,

INCLUDING A NONDEPENDENT SPOUSE. BENEFITS UNDER A FAMILY EXPENSE INSURANCE POLICY, EXCEPT AS APPLIED TO THE HEAD OF THE FAMILY, DO NOT INCLUDE INDEMNIFICATION FOR LOSS OF TIME FROM ANY CAUSE.

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

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

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

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

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

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

(5) A FAMILY EXPENSE INSURANCE POLICY IS SUBJECT TO SECTIONS

3474 AND 3474A.

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

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

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

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

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

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

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

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

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

POLICIES.

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

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

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

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

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

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

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

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

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

Sec. 3403. (1) ~~Individual disability insurance policies providing~~ **AN INSURER THAT DELIVERS, ISSUES FOR DELIVERY, OR RENEWS IN THIS STATE A HEALTH INSURANCE POLICY THAT OFFERS DEPENDENT** coverage ~~on an expense incurred basis which provide coverage for a family member of the insured shall, as to that family member's coverage, also provide that~~ **SHALL INCLUDE BOTH OF THE FOLLOWING PROVISIONS IN THE POLICY:**

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

(B) ~~(2) The~~ **THAT THE** coverage for newly born children ~~shall~~

~~consist~~ **CONSISTS** of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

~~(3) If payment of a specific premium is required to provide coverage for a child, the policy may require that notification of birth of a newly born child and payment of the required premium shall be furnished to the insurer within 31 days after the date of birth in order to have the coverage continue beyond the 31-day period.~~

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

(A) THE CHILD WAS BORN OUT OF WEDLOCK.

(B) THE CHILD IS NOT CLAIMED AS A DEPENDENT ON THE INSURED'S FEDERAL INCOME TAX RETURN.

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

Sec. 3404. ~~If any~~ **THE DIRECTOR MAY REQUIRE THAT A** policy ~~is~~ issued by an insurer domiciled in this state for delivery to a person residing in another state ~~, and~~ **MEET THE STANDARDS PRESCRIBED IN SECTIONS 2212A, 3402, AND 3406 TO 3466** if the

official ~~having responsibility~~ **THAT IS RESPONSIBLE** for the administration of the insurance laws of ~~such~~ **THE** other state ~~shall have advised~~ **ADVISES** the ~~commissioner~~ **DIRECTOR** that ~~any such~~ **THE** policy is not subject to approval or disapproval by ~~such~~ **THE** official. ~~, the commissioner may by ruling require that such policy meet the standards set forth in section 3402 and in sections 3406 through 3466.~~

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

(2) An insurer may offer ~~disability~~ **HEALTH** insurance policies under which the insured persons shall be required, as a condition of coverage, to obtain ~~hospital, nursing, medical, surgical, or sick care~~ **HEALTH 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.~~

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

(7) ~~(8)~~ Notwithstanding any ~~other~~ provision of this act **TO THE CONTRARY**, if coverage under a prudent purchaser agreement provides for benefits for services that are within the scope of practice of chiropractic, an insurer is not required to provide coverage or reimburse for a practice of chiropractic service unless that 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.

(8) ~~(9)~~ Notwithstanding any ~~other~~ provision of this act **TO THE CONTRARY**, if coverage under a prudent purchaser agreement provides for benefits for services that are provided by a licensed physical therapist or physical therapist assistant under the supervision of a licensed physical therapist, an insurer is not required to provide coverage or reimburse for services provided by a physical therapist or a physical therapist assistant unless that 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.

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

(2) Subject to subsection (3), beginning February 1, 2013, an insurer or a health maintenance organization shall not use a most

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

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

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

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

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

(c) Requires, or grants a contracting insurer or health maintenance organization an option to require, termination or renegotiation of an existing provider contract if a provider agrees

to provide health care services to any other party at a lower rate than the payment or reimbursement rate specified in the contract with the insurer or health maintenance organization.

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

(5) AS USED IN THIS SECTION, AFTER DECEMBER 31, 2016, "INSURER" INCLUDES A NONPROFIT DENTAL CARE CORPORATION OPERATING UNDER 1963 PA 125, MCL 550.351 TO 550.373.

Sec. 3406a. ~~A hospital, medical or surgical expense incurred~~ **AN INSURER THAT DELIVERS, ISSUES FOR DELIVERY, OR RENEWS IN THIS STATE A HEALTH INSURANCE** policy shall offer benefits for prosthetic devices to maintain or replace the body parts of an individual who has undergone a mastectomy. This coverage ~~shall~~ **MUST** provide that reasonable charges for medical care and attendance for an individual who receives reconstructive surgery following a mastectomy or who is fitted with a prosthetic device ~~shall be~~ **ARE** covered benefits after the individual's attending physician has certified the medical necessity or desirability of a proposed course of rehabilitative treatment. The cost and fitting of a prosthetic device following a mastectomy is included within the type of coverage ~~intended by~~ **REQUIRED UNDER** this section.

Sec. 3406c. (1) An insurer that delivers, issues for delivery, or renews in this state ~~an expense incurred hospital, medical, or surgical~~ **A HEALTH INSURANCE** policy that provides coverage for inpatient hospital care shall offer to include coverage for hospice

care. As used in this section, "hospice" means ~~hospice as defined in section 20106 of the public health code, Act No. 368 of the Public Acts of 1978, being section 333.20106 of the Michigan Compiled Laws.~~**A HEALTH CARE PROGRAM THAT PROVIDES A COORDINATED SET OF SERVICES RENDERED AT HOME OR IN OUTPATIENT OR INSTITUTIONAL SETTINGS FOR INDIVIDUALS SUFFERING FROM A DISEASE OR CONDITION WITH A TERMINAL PROGNOSIS.**

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

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

(2) Subject to dollar limits, deductibles, and coinsurance provisions that are not less favorable than those for physical illness generally, an insurer ~~which~~ **THAT** delivers, issues for delivery, or renews in this state a ~~hospital, medical, or surgical expense incurred~~ **HEALTH INSURANCE** policy shall offer or include the following coverage for breast cancer screening mammography:

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

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

(3) As used in this section:

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

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

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

(d) "Breast cancer outpatient treatment services" means a procedure intended to treat cancer of the human breast, delivered on an outpatient basis, including but not limited to surgery, radiation therapy, chemotherapy, hormonal therapy, and related medical follow-up services.

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

Sec. 3406e. An insurer ~~which~~ **THAT** delivers, issues for delivery, or renews in this state a ~~hospital, medical, or surgical expense incurred~~ **HEALTH INSURANCE** policy shall provide coverage in

each policy for a drug used in antineoplastic therapy and the reasonable cost of its administration. Coverage ~~shall~~ **MUST** be provided for any ~~federal food and drug administration~~ **UNITED STATES FOOD AND DRUG ADMINISTRATION** approved drug regardless of whether the specific neoplasm for which the drug is being used as treatment is the specific neoplasm for which the drug has received approval by the ~~federal food and drug administration~~ **UNITED STATES FOOD AND DRUG ADMINISTRATION** if all of the following conditions are met:

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

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

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

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

(e) The physician has obtained informed consent from the patient for the treatment regimen ~~which~~ **THAT** includes ~~federal food and drug administration~~ **UNITED STATES FOOD AND DRUG ADMINISTRATION** approved drugs for off-label indications.

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

victim of domestic violence.

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

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

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

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

Sec. 3406k. (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 coverage for emergency health services ~~and a health maintenance organization contract~~ shall provide coverage for medically necessary services provided to an insured for the sudden onset of a medical condition that manifests itself by signs and symptoms of sufficient severity, including severe pain, such that **A PRUDENT LAYPERSON WHO POSSESSES AN AVERAGE KNOWLEDGE OF HEALTH AND MEDICINE COULD REASONABLY EXPECT** the absence of immediate medical attention ~~could reasonably be expected~~

to result in serious jeopardy to the individual's health or to a pregnancy in the case of a pregnant woman, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. An insurer shall not require a physician to transfer a patient before the physician determines that the patient has reached the point of stabilization. An insurer shall not deny payment for emergency health services up to the point of stabilization provided to an insured under this subsection because of either of the following:

(a) The final diagnosis.

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

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

Sec. 3406*l*. (1) Except as otherwise provided in subsections (2) and (3), an ~~expense-incurred hospital, medical, or surgical~~ **INSURER THAT DELIVERS, ISSUES FOR DELIVERY, OR RENEWS IN THIS STATE A HEALTH INSURANCE** policy ~~or certificate~~ that provides benefits for emergency services shall provide for direct reimbursement to any provider of covered medical transportation services or shall provide that payment be made jointly to the insured and the provider, if ~~that~~ **THE** provider has not received payment for those services from any other source.

(2) Subsection (1) does not apply to a transaction between an insurer and a medical transportation service provider if the

parties have entered into a contract providing for direct payment.

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

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

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

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

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

(3) ~~A~~ **AN INSURER SHALL INCLUDE A** description of the coverage

~~provided by~~ **REQUIRED UNDER** this section ~~shall be included by the insurer~~ in a communication sent to the insured or group purchaser of coverage.

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

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

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

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

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

(c) Provide for exceptions from the formulary limitation when a nonformulary alternative is a medically necessary and appropriate alternative. This subdivision does not prevent an insurer from

establishing prior authorization requirements or another process for consideration of coverage or higher cost-sharing for nonformulary alternatives. ~~Notice as to whether or not an exception under this subdivision has been granted shall be given by the insurer within 24 hours after receiving all information necessary to determine whether the exception should be granted.~~

(2) ON A REQUEST FOR AN EXPEDITED REVIEW OF COVERAGE FOR A NONFORMULARY ALTERNATIVE BASED ON EXIGENT CIRCUMSTANCES, AN INSURER SHALL MAKE A DETERMINATION AND NOTIFY THE ENROLLEE OR THE ENROLLEE'S DESIGNEE AND THE PRESCRIBING PHYSICIAN, OR OTHER PRESCRIBER, AS APPROPRIATE, OF THE DETERMINATION WITHIN 24 HOURS AFTER THE INSURER RECEIVES ALL INFORMATION NECESSARY TO DETERMINE WHETHER THE EXCEPTION SHOULD BE GRANTED. FOR PURPOSES OF THIS SUBSECTION, EXIGENT CIRCUMSTANCES EXIST WHEN AN ENROLLEE IS SUFFERING FROM A HEALTH CONDITION THAT MAY SERIOUSLY JEOPARDIZE THE ENROLLEE'S LIFE, HEALTH, OR ABILITY TO REGAIN MAXIMUM FUNCTION OR WHEN AN ENROLLEE IS UNDERGOING A CURRENT COURSE OF TREATMENT USING A NONFORMULARY DRUG.

(3) IF SUBSECTION (2) DOES NOT APPLY, AN INSURER SHALL MAKE A DETERMINATION ON COVERAGE FOR A NONFORMULARY ALTERNATIVE AND NOTIFY THE ENROLLEE OR THE ENROLLEE'S DESIGNEE AND THE PRESCRIBING PHYSICIAN, OR OTHER PRESCRIBER, AS APPROPRIATE, OF THE DETERMINATION WITHIN 72 HOURS AFTER THE INSURER RECEIVES ALL INFORMATION NECESSARY TO DETERMINE WHETHER THE EXCEPTION SHOULD BE GRANTED.

Sec. 3406p. (1) An insurer ~~providing an expense-incurred hospital, medical, or surgical policy or certificate delivered or~~

~~issued~~ **THAT DELIVERS, ISSUES** for delivery**, OR RENEWS** in this state ~~and a health maintenance organization~~ **A HEALTH INSURANCE POLICY** shall establish and provide to insureds, enrollees, and ~~participating~~ **AFFILIATED** providers a program to prevent the onset of clinical diabetes. This program for ~~participating~~ **AFFILIATED** providers ~~shall~~ **MUST** emphasize best practice guidelines to prevent the onset of clinical diabetes and to treat diabetes, including, but not limited to, diet, lifestyle, physical exercise and fitness, and early diagnosis and treatment.

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

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

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

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

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

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

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

(6) Coverage under this section is not subject to dollar limits, deductibles, or copayment provisions that are greater than 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 plan's~~ **INSURER'S** formulary procedures.

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

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

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

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

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

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

(4) This section does not prohibit the use of a copayment, deductible, sanction, or ~~a~~ mechanism for appropriately controlling the utilization of a drug that is prescribed for a use different from the use for which the drug has been approved by the ~~food and drug administration.~~ **UNITED STATES FOOD AND DRUG ADMINISTRATION.** This may include prior approval or a drug utilization review program. Any copayment, deductible, sanction, prior approval, drug utilization review program, or mechanism described in this subsection ~~shall~~ **MUST** not be more restrictive than for prescription coverage generally.

(5) As used in this section:

(a) "Chronic and seriously debilitating" means a disease or

condition that requires ongoing treatment to maintain remission or prevent deterioration and that causes significant long-term morbidity.

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

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

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

(2) ~~Effective March 1, 2005, a health maintenance organization contract and an expense-incurred hospital, medical, or surgical policy or certificate~~ **AN INSURER THAT DELIVERS, ISSUES FOR DELIVERY, OR RENEWS IN THIS STATE A POLICY OF HEALTH INSURANCE** that provides coverage for obstetrical and gynecological services shall include coverage for obstetrical and gynecological services whether performed by a physician or a nurse midwife acting within the scope of his or her license or specialty certification or shall do 1 or

both of the following:

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

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

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

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

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

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

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

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

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

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

(2) This section does not limit benefits that are otherwise available to an insured or enrollee under a policy, contract, or certificate. An insurer ~~or health maintenance organization~~ shall utilize evidence-based care and managed care cost-containment practices pursuant to the insurer's ~~or health maintenance organization's~~ procedures ~~so long as that~~ **IF THE** care and ~~those~~ practices are consistent with this section. ~~The~~ **AN INSURER MAY SUBJECT** coverage under this section ~~may be subject~~ to other general exclusions and limitations of the policy, contract, or certificate, including, but not limited to, coordination of benefits, ~~participating~~ **AFFILIATED** provider requirements, restrictions on services provided by family or household members, utilization review of health care services including review of medical necessity, case management, and other managed care provisions.

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

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

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

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

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

(4) ~~Beginning January 1, 2014, a~~ **A** qualified health plan offered through an American health benefit exchange established in this state pursuant to the federal act is not required to provide coverage under this section to the extent that it exceeds coverage that is included in the essential health benefits as required pursuant to the federal act. As used in this subsection, "federal act" means the ~~federal~~ patient protection and affordable care act, Public Law 111-148, as amended by the ~~federal~~ health care and education reconciliation act of 2010, Public Law 111-152, and any

regulations promulgated under those acts.

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

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

(7) As used in this section:

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

(b) "Autism diagnostic observation schedule" means the protocol available through ~~western psychological services~~ **WESTERN PSYCHOLOGICAL SERVICES** for diagnosing and assessing autism spectrum disorders or any other standardized diagnostic measure for autism spectrum disorders that is approved by the ~~commissioner,~~ **DIRECTOR,** if the ~~commissioner~~ **DIRECTOR** determines that the diagnostic measure

is recognized by the health care industry and is an evidence-based diagnostic tool.

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

(*i*) Autistic disorder.

(*ii*) Asperger's disorder.

(*iii*) Pervasive developmental disorder not otherwise specified.

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

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

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

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

(f) "Diagnostic and ~~statistical manual" or "DSM"~~ **STATISTICAL MANUAL"** means the ~~diagnostic and statistical manual of mental disorders~~ **DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS** published by the American ~~psychiatric association~~ **PSYCHIATRIC**

ASSOCIATION or ~~other~~ **ANOTHER** manual that contains common language and standard criteria for the classification of mental disorders and that is approved by the ~~commissioner,~~ **DIRECTOR,** if the ~~commissioner~~ **DIRECTOR** determines that the manual is recognized by the health care industry and the classification of mental disorders is at least as comprehensive as the manual published by the American ~~psychiatric association~~ **PSYCHIATRIC ASSOCIATION** on ~~the effective date of this section.~~**APRIL 18, 2012.**

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

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

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

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

(k) "Treatment of autism spectrum disorders" means evidence-based treatment that includes the following care prescribed or ordered for an individual diagnosed with 1 of the autism spectrum disorders by a licensed physician or a licensed psychologist who determines the care to be medically necessary:

(*i*) Behavioral health treatment.

(*ii*) Pharmacy care.

(*iii*) Psychiatric care.

(*iv*) Psychological care.

(*v*) Therapeutic care.

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

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

ENTIRE CONTRACT; CHANGES: This policy, including the **APPLICABLE RIDERS AND** endorsements**; THE APPLICATION FOR COVERAGE IF SPECIFIED BY THE INSURER; THE IDENTIFICATION CARD IF SPECIFIED BY THE INSURER;** and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy ~~shall be~~ **IS** valid until approved by an executive officer of the insurer and unless ~~such~~ **THE** approval ~~be~~ **IS** endorsed ~~hereon~~ **ON THIS POLICY** or attached ~~hereto. No agent has~~ **TO THIS POLICY. AN INSURANCE PRODUCER DOES NOT HAVE** authority to change this policy or to waive any of its provisions.

Sec. 3407b. (1) An ~~expense incurred hospital, medical, or surgical~~ **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~~ shall not require an insured or his or her dependent or an asymptomatic applicant for insurance or his or her asymptomatic dependent to do either of the following:

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

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

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

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

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

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

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

(*iii*) Establishing prenatal and clinical diagnosis or prognosis.

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

(*v*) ~~Tests~~ **TESTING** for metabolites if undertaken with high probability that an excess or deficiency of the metabolite indicates or suggests the presence of heritable mutations in single genes.

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

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

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

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

(A) ONE OF THE FOLLOWING, AS APPLICABLE:

(*i*) TIME LIMIT ON CERTAIN DEFENSES: ~~(a)~~ After 3 years from the date of issue of this policy**,** ~~no misstatements,~~ **THE INSURER WILL NOT USE A MISSTATEMENT,** except **A** fraudulent ~~misstatements,~~ **MISSTATEMENT,** made by the applicant in the application for ~~such~~ **THE** policy ~~shall be used~~ to void the policy or to deny a claim for loss incurred or disability**,** ~~(as~~ **AS** defined in the ~~policy) commencing~~ **POLICY, BEGINNING** after the expiration of ~~such~~ **THE** 3-year period.

~~(The foregoing~~ **THIS** policy ~~provisions shall~~ **PROVISION DOES** not ~~be so construed as to~~ affect ~~any~~ **A** legal requirement for avoidance of a policy or denial of a claim during ~~such~~ **THE** initial 3-year

period, ~~nor to~~ **AND DOES NOT** limit the application of sections 3432**,** ~~(change of occupation),~~ 3434**,** ~~(misstatement of age),~~ 3436**,** ~~(other insurance same insurer),~~ 3438**,** ~~(insurance with other insurers provision of service or expense incurred basis),~~ and 3440 ~~(insurance with other insurers) in the event of~~ **IF A** misstatement with respect to age or occupation or other ~~insurance.)~~**INSURANCE IS MADE.**

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

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

(b) ~~No~~ **A** claim for **A** loss incurred or disability**,** ~~(as~~ **AS** defined in the policy**,** ~~) commencing~~ **BEGINNING** after 3 years from the date of issue of this policy ~~shall~~ **WILL NOT** be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss ~~had~~ existed ~~prior to~~ **BEFORE** the effective date of coverage of this policy.

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

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

Cancellation during first 10 days: During a period of 10 days after the date the policyholder receives ~~the~~ **THIS** policy, the policyholder may cancel the policy and receive from the insurer a prompt refund of any premium paid for the policy, including a policy fee or other charge, by mailing or otherwise surrendering the policy to the insurer together with a written request for cancellation. If a policyholder or purchaser pursuant to ~~such~~ **THIS** notice returns the policy or contract to the company or association at its home or branch office or to the agent through whom it was

purchased, it ~~shall be~~ **IS** void from the beginning and the parties ~~shall be~~ **ARE** in the same position as if no policy or contract had been issued.

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

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

Cancellation during the first 30 days: During a period of 30 days after the date the policyholder receives ~~the~~ **THIS** policy, the policyholder may cancel the policy and receive from the insurer a prompt refund of any premium paid for the policy, including a policy fee or other charge, by mailing or otherwise surrendering the policy to the insurer together with a written request for cancellation. If a policyholder or purchaser pursuant to ~~such~~ **THIS** notice returns the policy or contract to the company or association at its home or branch office or to the agent through whom it was

purchased, it ~~shall be~~ **IS** void from the beginning and the parties ~~shall be~~ **ARE** in the same position as if no policy or contract had been issued.

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

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

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

REINSTATEMENT: If any renewal premium ~~be~~ **IS** not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by ~~any~~ **AN** agent duly authorized by the insurer to accept ~~such~~ **THE** premium, without requiring in connection ~~therewith~~ **WITH THE ACCEPTANCE OF THE PREMIUM** an application for reinstatement, ~~shall reinstate~~ **IS A REINSTATEMENT OF** the ~~policy. Provided, however, That~~ **POLICY. HOWEVER,** if the insurer or ~~such~~ **ITS**

agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy ~~will be~~ **IS** reinstated upon approval of ~~such~~ **THE** application by the insurer or, ~~lacking such approval, upon~~ **IF NOT APPROVED BY THE INSURER, ON** the forty-fifth day ~~following~~ **AFTER** the date of ~~such~~ **THE** conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of ~~such~~ **THE** application. ~~The~~ **UNDER THE** reinstated policy, ~~shall~~ **THE INSURER WILL** cover only loss resulting from ~~such~~ accidental injury ~~as may be~~ **THAT IS** sustained after the date of reinstatement and loss due to ~~such~~ sickness ~~as may begin~~ **THAT BEGINS** more than 10 days after ~~such~~ **THAT** date. In all other respects, the insured and insurer ~~shall~~ have the same rights ~~thereunder~~ **UNDER THE POLICY** as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed ~~hereon~~ **ON THE POLICY** or attached ~~hereto~~ **TO THE POLICY** in connection with the reinstatement. ~~Any~~ **THE INSURER WILL APPLY ANY** premium accepted in connection with a reinstatement ~~shall be applied~~ to a period for which premium has not been previously paid, but not to any period more than 60 days ~~prior to~~ **BEFORE** the date of reinstatement.

(2) ~~(The~~ **AN INSURER MAY OMIT THE** last sentence of the ~~above~~ provision ~~may be omitted~~ **REQUIRED UNDER SUBSECTION (1)** from ~~any~~ **A** policy ~~which~~ **THAT** the insured has the right to continue in force subject to its terms by the timely payment of premium ~~(1)~~ until at least age 50 or, ~~(2) in the case of~~ **FOR** a policy issued after age 44, for at least 5 years ~~from~~ **AFTER** its date of ~~issue.)~~**ISSUE.**

Sec. 3412. **(1)** ~~There~~ **EXCEPT AS OTHERWISE PROVIDED IN**

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

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

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

Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity ~~may be~~ **IS** payable for at least 2 years, ~~he shall,~~ **THE INSURED WILL,** at least once in every 6 months after having given notice of claim, give to the insurer notice of continuance of ~~said~~ **THE** disability, ~~except in the event of legal incapacity.~~ **UNLESS THE INSURED IS LEGALLY INCAPACITATED.** The period of 6 months following any filing of proof by the insured or any payment by the insurer on account of ~~such~~ **THE** claim or any denial of liability in whole or in part by the insurer ~~shall be~~ **IS** excluded in applying this provision. Delay in ~~the~~ giving ~~of such~~ **THE** notice ~~shall~~ **REQUIRED UNDER THIS**

PROVISION DOES not impair the insured's right to any indemnity ~~which~~ **THAT** would otherwise have accrued during the ~~period of~~ 6 months preceding the date on which ~~such~~ **THE** notice is actually ~~given.)~~**GIVEN.**

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

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

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

PROOFS OF LOSS: Written proof of loss must be furnished to the insurer at its ~~said~~ **DESIGNATED** office**.** ~~in case of~~ **PROOF OF LOSS FOR A** claim for loss for which this policy provides any periodic payment **THAT IS** contingent upon continuing loss **MUST BE FURNISHED** within 90 days after the termination of the period for which the insurer is liable**.** ~~and in case of~~ **PROOF OF LOSS FOR A** claim for any other loss **MUST BE FURNISHED** within 90 days after the date of ~~such~~ **THE** loss. Failure to furnish ~~such~~ **THE** proof within the time

required ~~shall~~ **UNDER THIS PROVISION DOES** not invalidate ~~nor~~ **OR** reduce ~~any~~ **THE** claim if it was not reasonably possible to give proof within ~~such~~ **THE** time ~~, provided such~~ **REQUIRED IF THE** proof is furnished as soon as reasonably possible and, ~~in no event, except in the absence of legal capacity,~~ **UNLESS THE CLAIMANT IS LEGALLY INCAPACITATED, NOT** later than 1 year ~~from~~ **AFTER** the time proof is otherwise required.

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

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

Sec. 3418. **(1)** ~~There~~ **EXCEPT AS OTHERWISE PROVIDED IN SUBSECTION (2), AN INSURER** shall ~~be~~ **INCLUDE IN A DISABILITY INSURANCE POLICY, OTHER THAN A HEALTH INSURANCE POLICY,** a provision as follows:

PAYMENT OF CLAIMS: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting ~~such~~ **THE** payment, which may be prescribed ~~herein~~ **IN THIS**

POLICY, and effective at the time of payment. If ~~no such~~ **A** designation or provision is ~~then effective, such~~ **NOT IN EFFECT, THE** indemnity ~~shall be~~ **IS** payable to the estate of the insured. ~~Any other~~ **OTHER** accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to ~~such~~ **THE** beneficiary or to ~~such~~ **THE** estate. All other indemnities ~~will be~~ **ARE** payable to the insured.

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

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

(B) Subject to any written direction of the insured in the application or otherwise**,** all or a portion of any indemnities provided by this policy on account of ~~hospital, nursing, medical, or surgical~~ **HEALTH CARE** services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of ~~such~~ **THE** loss, be paid directly to the

hospital or person rendering ~~such services.)~~**THE HEALTH CARE SERVICES.**

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

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

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

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

Sec. 3424. **(1)** ~~There~~ **EXCEPT AS OTHERWISE PROVIDED IN SUBSECTION (2), AN INSURER** shall ~~be~~ **INCLUDE IN A DISABILITY INSURANCE POLICY, OTHER THAN A HEALTH INSURANCE POLICY,** a provision as follows:

CHANGE OF BENEFICIARY: Unless the insured makes an irrevocable designation of beneficiary, the **INSURED HAS THE** right to change ~~of~~

THE beneficiary ~~is reserved to the insured and the consent~~ **UNDER THIS POLICY. CONSENT** of ~~the~~ **A** beneficiary ~~or beneficiaries shall~~ **IS** not ~~be requisite~~ **REQUIRED** to surrender ~~or~~ **THIS POLICY, FOR THE** assignment of ~~this~~ **THE** policy, ~~or~~ to ~~any~~ change ~~of~~ **A** beneficiary, ~~or beneficiaries,~~ or to **MAKE** any other changes in ~~this~~ **THE** policy.

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

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

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

(A) ~~(b)~~ "Intermediate care" means the use, in a full 24-hour residential therapy setting, or in a partial, less than 24-hour, residential therapy setting, of any or all of the following therapeutic techniques, as identified in a treatment plan for individuals physiologically or psychologically dependent ~~upon~~ **ON** or

abusing alcohol or drugs:

(*i*) Chemotherapy.

(*ii*) Counseling.

(*iii*) Detoxification services.

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

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

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

(*i*) Chemotherapy.

(*ii*) Counseling.

(*iii*) Detoxification services.

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

(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.

(2) ~~Each~~ **AN** insurer ~~providing~~ **THAT DELIVERS, ISSUES FOR DELIVERY, OR RENEWS IN THIS STATE** an individual or family ~~expense incurred hospital, medical, or surgical policy delivered, issued for delivery, or renewed in this state and each health maintenance organization~~ **HEALTH INSURANCE POLICY** may offer individual and

family 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 approved by the insurer. ~~or health maintenance organization.~~ The insured or enrollee shall provide evidence of demonstrative maintenance or improvement of the individual's or family's health behaviors as determined by assessments of agreed-upon health status indicators between the insured ~~or enrollee~~ and the insurer. ~~or health maintenance organization.~~ Any rebate of premium provided by the insurer ~~or health maintenance organization~~ is presumed to be appropriate unless credible data demonstrate otherwise, but ~~shall~~ **MUST** not exceed ~~30%~~ **50%** of paid premiums, unless otherwise approved by the ~~commissioner. Each~~ **DIRECTOR. AN** insurer ~~and each health maintenance organization~~ shall make available to individuals and families all wellness coverage plans that the insurer ~~or health maintenance organization~~ markets to individuals and families in this state.

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

(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 sickness~~ **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 policy anniversary date immediately preceding receipt of ~~such~~ **THE** proof, whichever is the more recent. In applying this provision, the classification of occupational risk and the premium rates ~~shall be such as have been~~ **MUST BE THOSE THAT WERE** last filed by the insurer ~~prior to~~ **BEFORE** the occurrence of the loss for which the

insurer is liable or ~~prior to~~ **BEFORE THE** date of proof of change in **THE** occupation with the state official ~~having supervision of~~ **THAT SUPERVISES** insurance in the state where the insured resided at the time this policy was issued. ~~, but~~ **HOWEVER,** if ~~such~~ **THAT** filing was not required ~~, then~~ **IN THAT STATE,** the classification of occupational risk and the premium rates ~~shall~~ **MUST** be those last made effective by the insurer in ~~such~~ **THAT** state ~~prior to~~ **BEFORE** the occurrence of the loss or ~~prior to~~ **BEFORE** the date of proof of change in **THE** occupation.

Sec. 3438. **(1)** ~~There~~ **AN INSURER** may ~~be~~ **INCLUDE IN AN INDIVIDUAL DISABILITY INSURANCE POLICY** a provision as follows:

INSURANCE WITH OTHER INSURERS: If ~~there be~~ **THIS INSURER HAS NOT BEEN GIVEN WRITTEN NOTICE BEFORE THE OCCURRENCE OR COMMENCEMENT OF LOSS THAT THE INSURED UNDER THIS POLICY HAS** other valid coverage, not with this insurer, ~~providing~~ **AND THAT OTHER VALID COVERAGE PROVIDES** benefits for the same loss on a provision of service basis or on an expense incurred basis, ~~and of which this insurer has not been given written notice prior to the occurrence or commencement of loss,~~ the only liability under any expense incurred coverage of this policy ~~shall be~~ **IS** for ~~such~~ **THE** proportion of the loss as the amount ~~which~~ **THAT** would otherwise have been payable ~~hereunder~~ **UNDER THIS POLICY** plus the total of the like amounts under all ~~such~~ other valid coverages for the ~~same~~ loss of which this insurer had notice bears to the total like amounts under all valid coverages for ~~such~~ **THE** loss, and for the return of ~~such~~ **THE** portion of the ~~premiums~~ **PREMIUM** paid ~~as shall exceed~~ **THAT EXCEEDS** the pro rata portion for the amount so determined. For the

purpose of applying this provision when other coverage is on a provision of service basis, the **TERM** "like amount" ~~of such~~ **MEANS WITH RESPECT TO THE** other coverage ~~shall be taken as~~ the amount ~~which~~ **THAT** the services rendered would have cost in the absence of ~~such~~ **THE** coverage.

(2) ~~(If~~ **IF** the ~~foregoing~~ policy provision **DESCRIBED IN SUBSECTION (1)** is included in ~~a~~ **AN INDIVIDUAL** policy ~~which~~ **OF DISABILITY INSURANCE THAT** also contains the policy provision ~~set out~~ **DESCRIBED** in section 3440, ~~there~~ **THE INSURER** shall ~~be added~~ **ADD** to the caption of the ~~foregoing~~ **POLICY** provision the phrase **"—EXPENSE INCURRED BENEFITS".** The insurer may, at its option, include in this provision a definition of "other valid coverage", approved as to form by the ~~commissioner,~~ **DIRECTOR,** which definition ~~shall~~ **MUST** be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, ~~and~~ **TO COVERAGE PROVIDED** by hospital or medical service organizations, and to any other coverage the inclusion of which may be approved by the ~~commissioner.~~ **DIRECTOR.** In the absence of ~~such~~ **A** definition, ~~such~~ **THE** term ~~shall~~ **MUST** not include group insurance, automobile medical payments insurance, or coverage provided by hospital or medical service organizations, ~~or~~ by union welfare plans, or **BY** employer or employee benefit organizations.

(3) For the purpose of applying the ~~foregoing~~ policy provision ~~with respect~~ **UNDER THIS SECTION** to any insured, any amount of benefit provided for ~~such~~ **THE** insured ~~pursuant to any~~ **UNDER A**

compulsory benefit statute, ~~(including any workmen's~~ **INCLUDING A WORKER'S DISABILITY** compensation or employer's liability ~~statute)~~ **STATUTE,** whether provided by a governmental agency or ~~otherwise shall~~ **OTHER ENTITY, MUST** in all cases be ~~deemed~~ **CONSIDERED** to be ~~"other~~ **OTHER** valid ~~coverage"~~ **COVERAGE** of which the insurer has had notice. In applying the ~~foregoing~~ policy provision ~~no~~ **UNDER THIS SECTION, AN INSURER SHALL NOT INCLUDE** third party liability coverage ~~shall be included~~ as ~~"other~~ **OTHER** valid ~~coverage".)~~ **COVERAGE.**

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

INSURANCE WITH OTHER INSURERS: If ~~there be~~ **THIS INSURER HAS NOT BEEN GIVEN WRITTEN NOTICE BEFORE THE OCCURRENCE OR COMMENCEMENT OF LOSS THAT THE INSURED UNDER THIS POLICY HAS** other valid coverage, not with this insurer, ~~providing~~ **AND THAT OTHER VALID COVERAGE PROVIDES** benefits for the same loss on other than an expense incurred basis, ~~and of which this insurer has not been given written notice prior to the occurrence or commencement of loss,~~ the only liability for ~~such~~ **THE** benefits under this policy ~~shall be~~ **IS** for ~~such~~ **THE** proportion of the indemnities otherwise provided ~~hereunder~~ **UNDER THIS POLICY** for ~~such~~ **THE** loss as the like indemnities of which the insurer had notice, including the indemnities under this policy, bear to the total amount of all like indemnities for ~~such~~ **THE** loss, and for the return of ~~such~~ **THE** portion of the premium paid ~~as shall exceed~~ **THAT EXCEEDS** the pro rata portion for the indemnities ~~thus~~ determined **UNDER THIS PROVISION**.

(2) If the ~~foregoing~~ policy provision **DESCRIBED IN SUBSECTION (1)** is included in ~~a~~ **AN INDIVIDUAL** policy ~~which~~ **OF DISABILITY INSURANCE THAT** also contains the policy provision ~~set out~~ **DESCRIBED** in section 3438**,** ~~there~~ **THE INSURER** shall ~~be added~~ **ADD** to the caption of the ~~foregoing~~ **POLICY** provision the phrase **"—OTHER BENEFITS".** The insurer may, at its option, include in this provision a definition of "other valid coverage", approved as to form by the ~~commissioner,~~ **DIRECTOR,** which definition ~~shall~~ **MUST** be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and to any other coverage the inclusion of which ~~may be~~ **IS** approved by the ~~commissioner.~~ **DIRECTOR.** In the absence of ~~such~~ **A** definition**,** ~~such~~ **THE** term ~~shall~~ **MUST** not include group insurance ~~,~~ or benefits provided by union welfare plans or by employer or employee benefit organizations. For the purpose of applying the ~~foregoing~~ policy provision with respect to any insured, any amount of benefit provided for ~~such~~ **THE** insured ~~pursuant to~~ **UNDER** any compulsory benefit statute, including ~~any~~ worker's **DISABILITY** compensation or employer's liability statute, whether provided by a governmental agency or ~~otherwise shall~~ **OTHER ENTITY, MUST** in all cases be ~~deemed~~ **CONSIDERED** to be "other valid coverage" of which the insurer has had notice, unless the policy contains provisions for the reduction of benefits otherwise payable under the policy by the amount of income from other sources that the insured or the insured's dependents are qualified to receive ~~due to~~ **BECAUSE OF** the insured's age or disability from worker's **DISABILITY** compensation

or federal social security, if at the time the policy was issued, the premium had been appropriately reduced to reflect ~~such~~ **THE** anticipated reduction in benefits. In applying the ~~foregoing~~ policy provision, ~~no~~ **AN INSURER SHALL NOT INCLUDE** third party liability coverage ~~shall be included~~ as ~~"other~~ **OTHER** valid ~~coverage".~~**COVERAGE.**

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

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

(2) AS USED IN THIS SECTION:

(A) "WILLFUL CRIMINAL ACTIVITY" INCLUDES, BUT IS NOT LIMITED TO, ANY OF THE FOLLOWING:

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

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

(B) "WILLFUL CRIMINAL ACTIVITY" DOES NOT INCLUDE A CIVIL INFRACTION OR OTHER ACTIVITY THAT DOES NOT RISE TO THE LEVEL OF A MISDEMEANOR OR FELONY.

Sec. 3472. (1) ~~Beginning January 1, 2014, during~~ **DURING** an applicable open enrollment period, an insurer **THAT OFFERS,**

DELIVERS, ISSUES FOR DELIVERY, OR RENEWS IN THIS STATE A HEALTH INSURANCE POLICY shall not deny or condition the issuance or effectiveness of ~~a~~ **THE** policy and shall not discriminate in the pricing of ~~a~~ **THE** policy on the basis of health status, claims experience, receipt of health care, or medical condition.

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

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

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

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

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

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

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

MCL 333.18201 to 333.18237; by a podiatrist licensed under part 180 of the public health code, 1978 PA 368, MCL 333.18001 to 333.18058; 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 ARE NOT TIED TO SPECIFIC MEDICAL DECISIONS OR PROHIBIT THE USE OF RISK SHARING AS OTHERWISE AUTHORIZED IN THIS CHAPTER.

Sec. 3501. As used in this chapter:

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

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

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

(*ii*) Ambulatory services.

(*iii*) Inpatient hospital services. ~~, other than those for the treatment of mental illness.~~

(*iv*) Emergency health services.

(*v*) ~~Outpatient mental~~ **MENTAL** health **AND SUBSTANCE USE DISORDER** services. ~~, not fewer than 20 visits per year.~~

~~(*vi*) Intermediate and outpatient care for substance abuse as follows:~~

~~(A) For group contracts, if the fees for a group contract would be increased by 3% or more because of the provision of services under this subparagraph, the group subscriber may decline the services. For individual contracts, if the total fees for all individual contracts would be increased by 3% or more because of the provision of the services required under this subparagraph in all of those contracts, the named subscriber of each contract may decline the services.~~

~~(B) Charges, terms, and conditions for the services required to be provided under this subparagraph shall not be less favorable than the maximum prescribed for any other comparable service.~~

~~(C) The services required to be provided under this subparagraph shall not be reduced by terms or conditions that apply to other services in a group or individual contract. This sub-subparagraph shall not be construed to prohibit contracts that provide for deductibles and copayment provisions for services for intermediate and outpatient care for substance abuse.~~

~~(D) The services required to be provided under this subparagraph shall, at a minimum, provide for up to $2,968.00 in services for intermediate and outpatient care for substance abuse per individual per year. This minimum shall be adjusted annually by March 31 each year in accordance with the annual average percentage increase or decrease in the United States consumer price index for~~

~~the 12-month period ending the preceding December 31.~~

~~(E) As used in this subparagraph, "intermediate care", "outpatient care", and "substance abuse" have those meanings ascribed to them in section 3425.~~

(*vi*) ~~(*vii*)~~ Diagnostic laboratory and diagnostic and therapeutic radiological services.

(*vii*) ~~(*viii*)~~ Home health services.

(*viii*) ~~(*ix*)~~ Preventive health services.

(c) "Credentialing verification" means the process of obtaining and verifying information about a health professional and evaluating ~~that~~ **THE** health professional when ~~that~~ **THE** health professional applies to become a participating provider with a health maintenance organization.

~~(d) "Enrollee" means an individual who is entitled to receive health maintenance services under a health maintenance contract.~~

(D) ~~(e)~~ "Health maintenance contract" means a contract between a health maintenance organization and a subscriber or group of subscribers ~~,~~ to provide ~~, when medically indicated, designated~~ **OR ARRANGE FOR THE PROVISION OF** health ~~maintenance~~ services ~~, as described in and pursuant to the terms of the contract, including, at a minimum, basic health maintenance services.~~ **WITHIN THE HEALTH MAINTENANCE ORGANIZATION'S SERVICE AREA.** Health maintenance contract includes a prudent purchaser ~~contract.~~**AGREEMENT UNDER SECTION 3405.**

(E) ~~(f)~~ "Health maintenance organization" means ~~an entity~~ **A PERSON** that**, AMONG OTHER THINGS,** does the following:

(*i*) Delivers health ~~maintenance~~ services that are medically

~~indicated~~ **NECESSARY** to enrollees under the terms of its health maintenance contract, directly or through contracts with affiliated providers, in exchange for a fixed prepaid sum or per capita prepayment, without regard to the frequency, extent, or kind of health services.

(*ii*) Is responsible for the availability, accessibility, and quality of the health ~~maintenance~~ services provided.

~~(g) "Health maintenance services" means services provided to enrollees of a health maintenance organization under their health maintenance contract.~~

(F) ~~(h)~~ "Health professional" means an individual licensed, certified, or authorized in accordance with state law to practice a health profession in his or her respective state.

~~(i) "Primary verification" means verification by the health maintenance organization of a health professional's credentials based upon evidence obtained from the issuing source of the credential.~~

~~(j) "Prudent purchaser contract" means a contract offered by a health maintenance organization to groups or to individuals under which enrollees who select to obtain health care services directly from the organization or through its affiliated providers receive a financial advantage or other advantage by selecting those providers.~~

~~(k) "Secondary verification" means verification by the health maintenance organization of a health professional's credentials based upon evidence obtained by means other than direct contact with the issuing source of the credential.~~

(G) "HEALTH SERVICES" MEANS SERVICES PROVIDED TO ENROLLEES OF A HEALTH MAINTENANCE ORGANIZATION UNDER THEIR HEALTH MAINTENANCE CONTRACT.

(H) ~~*(l)*~~ "Service area" means a defined geographical area in which **COVERED** health ~~maintenance~~ services are generally available and readily accessible to enrollees and where health maintenance organizations may market their contracts.

~~(m) "Subscriber" means an individual who enters into a health maintenance contract, or on whose behalf a health maintenance contract is entered into, with a health maintenance organization that has received a certificate of authority under this chapter and to whom a health maintenance contract is issued.~~

Sec. 3503. (1) ~~All~~ **UNLESS SPECIFICALLY EXCLUDED, OR OTHERWISE SPECIFICALLY PROVIDED FOR IN THIS CHAPTER, ALL** of the provisions of this act that apply to a domestic insurer authorized to issue ~~an expense incurred hospital, medical, or surgical policy or certificate, including, but not limited to, sections 223 and 7925 and chapters 34 and 36,~~ **A HEALTH INSURANCE POLICY** apply to a health maintenance organization**.** ~~under this chapter unless specifically excluded, or otherwise specifically provided for in this chapter.~~

(2) Sections 408, 410, 411, **AND** 901, and ~~5208, chapter~~ **CHAPTERS** 77 ~~,~~ and ~~, except as otherwise provided in subsection (1), chapter~~ 79 do not apply to a health maintenance organization.

Sec. 3505. (1) A health maintenance organization shall ~~receive~~ **NOT ISSUE A HEALTH MAINTENANCE CONTRACT BEFORE IT RECEIVES** a certificate of authority under this ~~chapter before issuing health maintenance contracts. A health maintenance organization license~~

~~issued under former part 210 of the public health code, 1978 PA 368, automatically becomes a certificate of authority under this chapter on the effective date of this chapter.~~**ACT.**

(2) ~~"Health~~ **A PERSON SHALL NOT USE THE TERM HEALTH** maintenance ~~organization" shall not be used~~ **ORGANIZATION** to describe or refer to ~~any entity or~~ **A** person**,** and ~~an entity or~~ **A** person shall not use any other descriptive words that may mislead, deceive, or imply that it is a health maintenance organization, unless the ~~entity or~~ person **DESCRIBED OR REFERRED TO** has a certificate of authority as a health maintenance organization under this ~~chapter.~~**ACT.**

(3) ~~A~~ **EXCEPT AS OTHERWISE PROVIDED IN THIS SUBSECTION, A** health maintenance organization shall not use in its name, contracts, or literature the words "insurance", "casualty", "surety", **OR** "mutual" ~~,~~ or any other words descriptive of an insurance, casualty, or surety business or deceptively similar to the name or description of an insurance or surety corporation doing business in this state. **A HEALTH MAINTENANCE ORGANIZATION MAY USE A NAME OR DESCRIPTION THAT IS SIMILAR TO ITS AFFILIATE.**

Sec. 3507. The ~~commissioner~~ **DIRECTOR** shall establish a system of authorizing and regulating health maintenance organizations in this state to protect and promote the public health through the assurance that the organizations provide **ALL OF THE FOLLOWING**:

(a) An acceptable quality of health care by qualified personnel.

(b) Health care facilities, equipment, and personnel that may reasonably be required to economically provide health ~~maintenance~~ services.

(c) Operational arrangements that integrate the delivery of various services.

(d) ~~A financially~~ **FINANCIALLY** sound prepayment ~~plan~~ **PLANS** for meeting health care costs.

Sec. 3508. (1) A health maintenance organization shall develop and maintain a quality assessment program ~~to assess the quality of health care provided to enrollees~~ that includes, at a minimum, systematic collection, analysis, and reporting of relevant data in accordance with statutory and regulatory requirements. ~~A health maintenance organization shall make available its quality assessment program as prescribed by the commissioner.~~

(2) A health maintenance organization shall establish and maintain a quality improvement program to design, measure, assess, and improve the processes and outcomes of health care as identified in the program. A health maintenance organization shall ~~make available its quality improvement program as prescribed by the commissioner. The~~ **PLACE THE** quality improvement program ~~shall be~~ under the direction of ~~the health maintenance organization's~~ **ITS** medical director and ~~shall~~ include **ALL OF THE FOLLOWING IN THE PROGRAM**:

(a) A written statement of the program's objectives, lines of authority and accountability, evaluation tools, including data collection responsibilities, and performance improvement activities.

(b) An annual effectiveness review of the program.

(c) A written quality improvement plan that, at a minimum, describes how the health maintenance organization analyzes both the

processes and outcomes of care, identifies the targeted diagnoses and treatments to be reviewed each year, uses a range of appropriate methods to analyze quality, compares program findings with past performance and internal goals and external standards, measures the performance of affiliated providers, and conducts peer review activities.

Sec. 3509. (1) An application to the ~~commissioner~~ **DIRECTOR** for a certificate of authority ~~shall~~ **MUST** be on a form prescribed and provided by the ~~commissioner.~~**DIRECTOR.**

(2) A certificate of authority issued **TO A HEALTH MAINTENANCE ORGANIZATION** under this ~~chapter~~ **ACT** is limited to the service area described in the application ~~upon~~ **ON** which the certificate of authority was issued. **APPROVED PARTS OF A HEALTH MAINTENANCE ORGANIZATION'S SERVICE AREA ARE NOT REQUIRED TO BE CONTIGUOUS.**

(3) A health maintenance organization seeking to change the approved service area shall submit an application to change service area to the ~~commissioner~~ **DIRECTOR** and shall not change the service area until approval is received. The ~~commissioner~~ **DIRECTOR** shall specify the information required to be in the application under this subsection.

Sec. 3511. (1) ~~By the end of the first 12 months of operation, a~~ **A HEALTH MAINTENANCE ORGANIZATION'S GOVERNING BODY MUST INCLUDE NO LESS THAN 1 INDIVIDUAL WHO REPRESENTS THE HEALTH MAINTENANCE ORGANIZATION'S MEMBERSHIP.**

(2) A health maintenance ~~organization's governing body~~ **ORGANIZATION THAT IS UNDER A CONTRACT WITH THIS STATE TO PROVIDE MEDICAL SERVICES AUTHORIZED UNDER SUBCHAPTER XIX OR XXI OF THE**

SOCIAL SECURITY ACT, 42 USC 1396 TO 1396W-5 AND 1397AA TO 1397MM, shall ~~have a~~ **COMPLY WITH EITHER OF THE FOLLOWING REQUIREMENTS:**

(A) A minimum of 1/3 of its **GOVERNING BODY MUST BE REPRESENTATIVES OF ITS** membership consisting of ~~adult~~ enrollees of the organization who are not compensated officers, employees, ~~stockholders who own more than 5% of the organization's shares,~~ or other individuals responsible for the conduct of, or financially interested in, the organization's affairs. ~~The enrollee board members shall be elected by a simple plurality of the voting subscribers. Each subscriber shall have 1 vote. The enrollee board members shall hold office for 3 years after their election, except that the terms of office following the first enrollee election may be adjusted to allow the terms of enrollee board members to expire on a staggered basis. A vacancy among enrollee board members shall be filled by appointment by a simple majority of the remaining enrollee members of the board from individuals meeting the qualifications of this section. A vacancy shall be filled only for the unexpired portion of the original term, at which time the enrollee member shall be elected in the manner prescribed by this chapter.~~

(B) THE HEALTH MAINTENANCE ORGANIZATION MUST ESTABLISH A CONSUMER ADVISORY COUNCIL THAT REPORTS TO THE GOVERNING BODY. THE CONSUMER ADVISORY COUNCIL MUST INCLUDE AT LEAST 1 ENROLLEE, 1 FAMILY MEMBER OR LEGAL GUARDIAN OF AN ENROLLEE, AND 1 CONSUMER ADVOCATE.

(3) ~~(2)~~ A health maintenance organization's governing body shall meet at least quarterly unless specifically exempted from

this requirement by the ~~commissioner.~~**DIRECTOR.**

Sec. 3513. (1) The ~~commissioner~~ **DIRECTOR** shall regulate health delivery aspects of health maintenance organization operations ~~for the purpose of assuring~~ **TO ENSURE** that health maintenance organizations are capable of providing care and services promptly, appropriately, and in a manner that ~~assures~~ **ENSURES** continuity and acceptable quality of health care. The ~~commissioner~~ **DIRECTOR** shall encourage health maintenance organizations to ~~utilize~~ **USE** a wide variety of health-related disciplines and facilities and to develop services that contribute to the prevention of disease and disability and ~~to~~ the restoration of health.

(2) The ~~commissioner~~ **DIRECTOR** shall ~~regulate the business and financial aspects of health maintenance organization operations for the purpose of assuring that the organizations are financially sound and follow acceptable business practices. The commissioner shall assure~~ **ENSURE** that ~~the~~ **HEALTH MAINTENANCE** organizations operate in the interest of enrollees consistent with overall health care cost containment while delivering acceptable quality of care and services that are available and accessible to enrollees with appropriate administrative costs and health care provider incentives. A health maintenance organization shall do all of the following:

(a) Provide, as promptly as appropriate, health ~~maintenance~~ services in a manner that ~~assures~~ **ENSURES** continuity and imparts quality health care under conditions the ~~commissioner~~ **DIRECTOR** considers to be in the public interest.

(b) Provide ~~, within the geographic area served by the health~~

~~maintenance organization,~~ health ~~maintenance~~ services **WITHIN ITS SERVICE AREA** that are ~~available, accessible, and provided as 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 services, and coinsurance, stated as percentages for the cost of covered services. ~~Coinsurance for basic health services, excluding deductibles, shall not exceed 50% of a health maintenance organization's reimbursement to an affiliated provider for providing the service to an enrollee and shall not be based on the provider's standard charge for the service.~~ This subsection does not limit the ~~commissioner's~~ **DIRECTOR'S** authority to regulate and establish fair, sound, and reasonable copayment and coinsurance limits including out of pocket maximums.

(3) 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 disability.

(4) A health maintenance organization may accept from governmental agencies and from private persons payments covering any part of the cost of health maintenance contracts.

Sec. 3517. (1) A health maintenance contract shall not provide for payment of cash or other material benefit to an enrollee ~~,~~ ~~except~~ **OTHER THAN** as ~~stated in this chapter.~~**PERMITTED UNDER THE LAW OF THIS STATE OR AS APPROVED BY THE DIRECTOR UNDER SECTION 2236.**

(2) Subsection (1) does not prohibit a health maintenance organization from promoting optimum health by offering to all

currently enrolled subscribers or to all currently covered enrollees 1 or more healthy lifestyle programs. ~~A~~ **AS USED IN THIS SUBSECTION,** "healthy lifestyle program" means a program recognized by a health maintenance organization that enhances health**, EDUCATES ENROLLEES ON HEALTH-RELATED MATTERS,** or reduces risk of disease, including, but not limited to, promoting nutrition and physical exercise and compliance with disease management programs and preventive service guidelines that are supported by evidence-based medical practice. **A HEALTHY LIFESTYLE PROGRAM MAY INCLUDE OTHER REQUIREMENTS IN ADDITION TO THOSE THAT ENHANCE HEALTH, EDUCATE ENROLLEES ON HEALTH-RELATED MATTERS, OR REDUCE RISK OF DISEASE IF THE HEALTHY LIFESTYLE PROGRAM, TAKEN AS A WHOLE, MEETS THE INTENT OF THIS SUBSECTION.** Subsection (1) does not prohibit a health maintenance organization from offering a currently enrolled subscriber or currently covered enrollee goods, vouchers, or equipment that supports achieving optimal health goals. An offering of goods, vouchers, or equipment under this subsection is not a violation of subsection (1) and ~~shall~~ **IS** not ~~be considered~~ valuable consideration, a material benefit, a gift, a rebate, or an inducement under this act.

(3) For an emergency episode of illness or injury that requires immediate treatment before it can be secured through the health maintenance organization, or for an out-of-area service specifically authorized by the health maintenance organization, an enrollee may ~~utilize~~ **USE** a provider ~~within~~ **IN** or ~~without~~ **OUTSIDE OF** this state not normally engaged by the health maintenance organization to render service to its enrollees. The **HEALTH**

MAINTENANCE organization shall pay reasonable expenses or fees to the provider or enrollee as appropriate in an individual case. These transactions are not ~~considered~~ acts of insurance and, except as provided in this chapter and section 3406k, are not otherwise subject to this act.

Sec. 3519. (1) A health maintenance organization contract and the contract's rates, including any deductibles, copayments, and coinsurances, between the organization and its subscribers ~~shall~~ **MUST** be fair, sound, and reasonable in relation to the services provided, and the procedures for offering and terminating contracts ~~shall~~ **MUST** not be unfairly discriminatory.

(2) A health maintenance organization contract and the contract's rates ~~shall~~ **MUST** not discriminate on the basis of race, color, creed, national origin, residence within the approved service area of the health maintenance organization, lawful occupation, sex, handicap, or marital status, except that marital status may be used to classify individuals or risks for the purpose of insuring family units. The ~~commissioner~~ **DIRECTOR** 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~~ **DIRECTOR'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~~ **A** health maintenance organization ~~contracts~~ **CONTRACT** 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.~~

~~(c) 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.~~

~~(c) 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, for unauthorized services or for services by nonaffiliated providers in accordance with the terms of the contract and subject to copayments, coinsurances, deductibles, or other financial penalties designed to encourage enrollees to obtain services from ~~the organization's~~ **AFFILIATED** providers.

~~(2) Prudent purchaser contracts and the rates charged for them are subject to the same regulatory requirements as health maintenance contracts. The rates charged by an organization for coverage under contracts issued under this section shall not be~~

~~unreasonably lower than what is necessary to meet the expenses of the organization for providing this coverage and shall not have an anticompetitive effect or result in predatory pricing in relation to prudent purchaser agreement coverages offered by other organizations.~~

~~(3) A health maintenance organization shall not issue prudent purchaser contracts unless it is in full compliance with the requirements for adequate working capital, statutory deposits, and reserves as provided in this chapter and it is not operating under any limitation to its authorization to do business in this state.~~

~~(4) A health maintenance organization shall maintain financial records for its prudent purchaser contracts and activities in a form separate or separable from the financial records of other operations and activities carried on by the organization.~~

Sec. 3535. Solicitation of enrollees or advertising of the services, charges, or other nonprofessional aspects of the health maintenance organization's operation under this section ~~shall~~ **IS** not ~~be construed to be~~ in violation of laws relating to solicitation or advertising by health professionals. ~~, but~~ **A HEALTH MAINTENANCE ORGANIZATION** shall not**, IN ITS SOLICITATION OR ADVERTISING ALLOWED UNDER THIS SECTION,** include advertising that makes ~~any~~ **A** qualitative judgment as to a health professional who provides services for ~~a~~ **THE** health maintenance organization. A **HEALTH MAINTENANCE ORGANIZATION SHALL NOT, IN ITS** solicitation or advertising ~~shall not~~ **ALLOWED UNDER THIS SECTION,** offer a material benefit or other thing of value as an inducement to prospective subscribers other than the services of the **HEALTH MAINTENANCE**

organization.

SEC. 3544. (1) A HEALTH MAINTENANCE ORGANIZATION MAY PROCESS AND PAY CLAIMS ON BEHALF OF A NONINSURED BENEFIT PLAN ONLY AFTER THE HEALTH MAINTENANCE ORGANIZATION HAS RECEIVED ADEQUATE MONEY FROM THE NONINSURED BENEFIT PLAN SPONSOR TO FULLY COVER THE CLAIM PAYMENTS.

(2) AS USED IN THIS SECTION, "NONINSURED BENEFIT PLAN" MEANS THAT TERM AS DEFINED IN SECTION 5208.

Sec. 3545. With the ~~commissioner's~~ **DIRECTOR'S** prior approval, a health maintenance organization may acquire obligations from another managed care entity. The ~~commissioner~~ **DIRECTOR** shall not grant prior approval unless the ~~commissioner~~ **DIRECTOR** determines that the transaction will not jeopardize the health maintenance organization's financial security.

Sec. 3547. (1) The ~~commissioner~~ **DIRECTOR** at any time may visit or examine the health care service operations of a health maintenance organization and consult with enrollees to the extent necessary to carry out the intent of this ~~chapter.~~**ACT.**

(2) ~~In addition to~~ **THE DIRECTOR HAS** the authority granted under chapter 2 ~~, the commissioner:~~**WITH REGARD TO A HEALTH MAINTENANCE ORGANIZATION UNDER THIS CHAPTER.**

(3) ~~(a) Shall have~~ **A HEALTH MAINTENANCE ORGANIZATION SHALL GIVE THE DIRECTOR** access to all information of the health maintenance organization relating to the delivery of health services, including, but not limited to books, papers, computer databases, and documents, in a manner that preserves the confidentiality of the health records of individual enrollees.

(4) ~~(b) May require the submission of~~ **AT THE REQUEST OF THE DIRECTOR, A HEALTH MAINTENANCE ORGANIZATION SHALL SUBMIT** information regarding a proposed contract between ~~a~~ **THE** health maintenance organization and an affiliated provider ~~as~~ **THAT** the ~~commissioner~~ **DIRECTOR** considers necessary to ~~assure~~ **ENSURE** that the contract is in compliance with this ~~chapter.~~**ACT.**

Sec. 3548. (1) A health maintenance organization shall keep all of its books, records, and files at or under the control of its principal place of doing business in this state, and shall keep a record of all of its securities, notes, mortgages, or other evidences of indebtedness, representing investment of funds at its principal place of doing business in this state in the same manner as provided for in section 5256.

(2) A health maintenance organization shall maintain financial records for its health maintenance activities separate from the financial records of any other operation or activity**.** ~~carried on by the person licensed under this chapter to operate the health maintenance organization.~~

(3) A health maintenance organization shall hold and maintain legal title to all assets, including cash and investments. ~~Health~~ **A HEALTH** maintenance organization **SHALL NOT COMMINGLE** funds ~~and~~ **OR** assets ~~shall not be commingled with affiliates or other entities~~ in pooling or cash management type arrangements **WITH AFFILIATES OR OTHER PERSONS**. ~~All~~ **A** health maintenance organization **SHALL HOLD ALL OF ITS** assets ~~shall be held~~ separate from all other activities of other members in a holding company system.

Sec. 3551. (1) A health maintenance ~~organization's~~

ORGANIZATION SHALL DETERMINE ITS minimum net worth ~~shall be determined~~ using accounting procedures approved by the ~~commissioner that~~ **DIRECTOR. THE ACCOUNTING PROCEDURES MUST** ensure that a health maintenance organization is financially and actuarially sound.

~~(2) A health maintenance organization licensed under former part 210 of the public health code, 1978 PA 368, on the effective date of this chapter that automatically received a certificate of authority under section 3505(1) shall possess and maintain unimpaired net worth as required under former section 21034 of the public health code, 1978 PA 368, until the earlier of the following:~~

~~(a) The health maintenance organization attains a level of net worth as provided in subsection (3) at which time the health maintenance organization shall continue to maintain that level of net worth.~~

~~(b) December 31, 2003.~~

(2) ~~(3) A health maintenance organization applying for~~ **TO 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.

Sec. 3553. ~~(1) Minimum deposit requirements for a health maintenance organization shall be determined as provided under this section and using accounting procedures approved by the commissioner that ensure that a health maintenance organization is financially and actuarially sound.~~

~~(2) A health maintenance organization licensed under former part 210 of the public health code, 1978 PA 368, on the effective date of this chapter that automatically received a certificate of authority under section 3505(1) shall possess and maintain a~~

~~deposit as required under former section 21034 of the public health code, 1978 PA 368, until the earlier of the following:~~

~~(a) The health maintenance organization attains the level of deposit as provided in subsection (3) at which time the health maintenance organization shall continue to maintain that level of deposit.~~

~~(b) December 31, 2001.~~

(1) ~~(3) A~~ **TO OBTAIN OR MAINTAIN A CERTIFICATE OF AUTHORITY IN THIS STATE, A** health maintenance organization ~~applying for a certificate of authority on or after the effective date of this chapter and a health maintenance organization wishing to maintain a certificate of authority in this state after December 31, 2001~~ shall possess and maintain a deposit in an amount determined adequate by the ~~commissioner~~ **DIRECTOR** to continue to comply with section 403 but not less than $100,000.00 plus 5% of annual subscription revenue up to a $1,000,000.00 maximum deposit.

(2) ~~(4) The~~ **A HEALTH MAINTENANCE ORGANIZATION SHALL MAKE THE** deposit required under ~~this section shall be made~~ **SUBSECTION (1)** with the state treasurer or with a federal or state chartered financial institution under a trust indenture acceptable to the ~~commissioner~~ **DIRECTOR** for the sole benefit of the subscribers and enrollees in case of insolvency.

Sec. 3555. A health maintenance organization shall maintain a financial plan evaluating, at a minimum, cash flow needs and adequacy of working capital. The plan ~~shall~~ **UNDER THIS SUBSECTION MUST** do all of the following:

(a) Demonstrate compliance with all health maintenance

organization financial requirements provided for in this ~~chapter.~~**ACT.**

(b) Provide for adequate working capital, which ~~shall~~ **MUST** not be negative at any time. The ~~commissioner~~ **DIRECTOR** may establish a minimum working capital requirement for a health maintenance organization to ensure the prompt payment of liabilities.

(c) Identify the means of achieving and maintaining a positive cash flow, including provisions for retirement of existing or proposed indebtedness.

Sec. 3557. A health maintenance organization shall file notice with the ~~commissioner~~ **DIRECTOR** of any substantive changes in operations ~~no later than~~ **WITHIN** 30 days after the substantive change in operations **OCCURS**. A substantive change in operations includes, but is not limited to, any of the following:

(a) A change in the health maintenance organization's officers or directors. In addition to the notification, the health maintenance organization shall file a disclosure statement on a form prescribed by the ~~commissioner~~ **DIRECTOR** for each newly appointed or elected officer or director.

(b) A change in the location of corporate offices.

(c) A change in the organization's articles of incorporation or bylaws. A **HEALTH MAINTENANCE ORGANIZATION SHALL INCLUDE A** copy of the revised articles of incorporation or bylaws ~~shall be included~~ with the notice.

(d) A change in contractual arrangements under which the health maintenance organization is managed.

(e) Any other significant change in operations.

Sec. 3559. (1) Subject to subsection (2), a health maintenance organization shall obtain a reinsurance contract or establish a plan of self-insurance as ~~may be~~ necessary to ensure solvency or to protect subscribers in the event of insolvency. A reinsurance contract ~~shall~~ **MUST** be with an insurer that is authorized or eligible to transact insurance in ~~Michigan.~~**THIS STATE.**

(2) A **HEALTH MAINTENANCE ORGANIZATION SHALL FILE A** reinsurance contract or plan under subsection (1) ~~shall be filed~~ for approval with the ~~commissioner not later than~~ **DIRECTOR WITHIN** 30 days after the finalization of the contract or plan. A reinsurance contract or plan ~~shall~~ **MUST** clearly state all services to be received by the health maintenance organization. A reinsurance contract or plan ~~shall be~~ **IS** considered approved 30 days after it is filed with the ~~commissioner~~ **DIRECTOR** unless disapproved in writing by the ~~commissioner~~ **DIRECTOR** before the expiration of ~~those~~ **THE** 30 days.

(3) A health maintenance organization shall maintain insurance coverage to protect the health maintenance organization that includes, at a minimum, fire, theft, fidelity, general liability, errors and omissions, director's and officer's liability coverage, and malpractice insurance. A health maintenance organization shall obtain the ~~commissioner's~~ **DIRECTOR'S** prior approval before self-insuring for these coverages.

Sec. 3561. A health maintenance organization shall have a plan for handling insolvency that allows for continuation of benefits for the duration of the **HEALTH MAINTENANCE** contract period for which premiums have been paid and continuation of benefits to any ~~member~~ **ENROLLEE** who is confined on the date of insolvency in an

inpatient facility until his or her discharge from ~~that~~ **THE** facility. Continuation of benefits in the event of insolvency is satisfied if the health maintenance organization has at least 1 of the following, as approved by the ~~commissioner:~~**DIRECTOR:**

(a) A financial guarantee contract insured by a surety bond issued by an independent insurer with a secure rating from a rating agency that meets the requirements of section 436a(1)(p).

(b) A reinsurance contract issued by an authorized or eligible insurer to cover the expenses to be paid for continued benefits after an insolvency.

(c) A contract between the health maintenance organization and its affiliated providers that provides for the continuation of provider services in the event of the health maintenance organization's insolvency. A **HEALTH MAINTENANCE ORGANIZATION SHALL INCLUDE IN A** contract under this subdivision ~~shall provide~~ a mechanism for appropriate sharing by the health maintenance organization of the continuation of provider services as approved by the ~~commissioner~~ **DIRECTOR** and shall not ~~provide~~ **INCLUDE A PROVISION** that continuation of provider services is solely the responsibility of the affiliated providers.

(d) An irrevocable letter of credit.

(e) An insolvency reserve account established with a federal or state chartered financial institution under a trust indenture acceptable to the ~~commissioner~~ **DIRECTOR** for the sole benefit of subscribers and enrollees, equal to 3 months' premium income.

Sec. 3563. (1) If a health maintenance organization becomes insolvent, upon the ~~commissioner's~~ **DIRECTOR'S** order all other

health ~~maintenance organizations and health~~ insurers that participated in the enrollment process with the insolvent health maintenance organization at a group's last regular enrollment period shall offer the insolvent health maintenance organization's ~~and health insurer's~~ group enrollees a 30-day enrollment period beginning on the date of the ~~commissioner's~~ **DIRECTOR'S** order. Each health ~~maintenance organization and health~~ insurer shall offer the insolvent health maintenance organization's enrollees the same coverages and rates that it had offered to the enrollees of the group at its last regular enrollment period.

(2) If no other health ~~maintenance organization or health~~ insurer ~~had been~~ **WAS** offered to some groups enrolled in ~~the~~ **AN** insolvent health maintenance organization, or if the ~~commissioner~~ **DIRECTOR** determines that the other health ~~maintenance organizations or health~~ insurers lack sufficient health care delivery resources to ~~assure~~ **ENSURE** that health care services will be available and accessible to all of the group enrollees of the insolvent health maintenance organization, ~~then~~ the ~~commissioner~~ **DIRECTOR** shall allocate equitably the insolvent health maintenance organization's group contracts for these groups among all health maintenance organizations that operate within a portion of the insolvent health maintenance organization's service area, taking into consideration the health care delivery resources of each health maintenance organization. Each health maintenance organization to which a group or groups are ~~so~~ allocated **UNDER THIS SUBSECTION** shall offer the group or groups the health maintenance organization's existing coverage that is most similar to each group's coverage with the

insolvent health maintenance organization at rates determined in accordance with the successor health maintenance organization's existing rating methodology.

(3) The ~~commissioner~~ **DIRECTOR** shall allocate equitably the insolvent health maintenance organization's nongroup enrollees who are unable to obtain other coverage among all health maintenance organizations that operate within a portion of the insolvent health maintenance organization's service area, taking into consideration the health care delivery resources of each health maintenance organization. Each health maintenance organization to which nongroup enrollees are allocated **UNDER THIS SUBSECTION** shall offer the nongroup enrollees ~~the health maintenance organization's existing~~ coverage without a preexisting condition limitation for individual ~~or conversion~~ coverage as determined by the enrollee's type of coverage in the insolvent health maintenance organization at rates ~~determined in accordance with~~ **UNDER** the successor health maintenance organization's existing rating methodology. Successor health maintenance organizations that do not offer direct nongroup enrollment may aggregate all of the allocated nongroup enrollees into 1 group for rating and coverage purposes.

(4) If a health maintenance organization that contracts with a state funded health care program becomes insolvent, the ~~commissioner~~ **DIRECTOR** shall inform the state agency responsible for the program of the insolvency. Notwithstanding any other provision of this section **TO THE CONTRARY**, enrollees of an insolvent health maintenance organization covered by a state funded health care program may be reassigned ~~in accordance with~~ **UNDER** state and

federal statutes governing the ~~particular~~ program.

(5) NOTWITHSTANDING ANY PROVISION OF THIS SECTION TO THE CONTRARY, AN ENROLLEE OF AN INSOLVENT HEALTH MAINTENANCE ORGANIZATION WHO IS ELIGIBLE TO OBTAIN COVERAGE AS EITHER AN INDIVIDUAL OR A MEMBER OF A SMALL GROUP UNDER AN AMERICAN HEALTH BENEFIT EXCHANGE ESTABLISHED OR OPERATING IN THIS STATE PURSUANT TO THE PATIENT PROTECTION AND AFFORDABLE CARE ACT, PUBLIC LAW 111-148, AS AMENDED BY THE HEALTH CARE AND EDUCATION RECONCILIATION ACT OF 2010, PUBLIC LAW 111-152, MAY OBTAIN SUBSTITUTE COVERAGE THROUGH THE EXCHANGE.

Sec. 3569. (1) Except as provided in section 3515(2), a health maintenance organization shall assume full financial risk on a prospective basis for the provision of health ~~maintenance~~ services **UNDER A HEALTH MAINTENANCE ORGANIZATION CONTRACT**. ~~However, the~~ **A HEALTH MAINTENANCE** organization may do any of the following:

(a) Require an affiliated provider to assume financial risk under the terms of its contract.

(b) Obtain insurance.

(c) Make other arrangements for the cost of providing to an enrollee health ~~maintenance~~ services the aggregate value of which is more than $5,000.00 in a year for that enrollee.

(2) If the health maintenance organization requires an affiliated provider to assume financial risk under the terms of its contract, the contract ~~shall~~ **MUST** require both of the following:

(a) The health maintenance organization to pay the affiliated provider, including a subcontracted provider, directly or through a licensed third party administrator for health ~~maintenance~~ services

provided to its enrollees.

(b) The health maintenance organization to keep all pooled funds and withhold amounts and account for them on its financial books and records and reconcile them at year end ~~in accordance with the written agreement between the affiliated provider and the health maintenance organization.~~**PURSUANT TO THE CONTRACT.**

(3) ~~As used in~~ **FOR PURPOSES OF** this section, ~~"requiring~~ **A HEALTH MAINTENANCE ORGANIZATION REQUIRES** an affiliated provider to assume financial ~~risk" means a transaction whereby~~ **RISK IF IT SHARES WITH THE AFFILIATED PROVIDER, IN RETURN FOR CONSIDERATION,** a portion of the chance of loss, including expenses incurred, related to the delivery of health ~~maintenance~~ services ~~is shared with an affiliated provider in return for a consideration.~~ **TO ENROLLEES.** ~~These~~ **THE TYPE OF** transactions **UNDER WHICH A HEALTH MAINTENANCE ORGANIZATION MAY REQUIRE AN AFFILIATED PROVIDER TO ASSUME FINANCIAL RISK UNDER THIS SECTION** include, but are not limited to, full or partial capitation agreements, withholds, risk corridors, and indemnity agreements.

Sec. 3571. ~~A health maintenance organization is not precluded from meeting the requirements of, receiving money from, and enrolling beneficiaries or recipients of state and federal health programs.~~ A health maintenance organization that participates in a state or federal health program shall meet the solvency and financial requirements of this act, unless the health maintenance organization is in receivership or under supervision. ~~, but~~ **NOTWITHSTANDING ANY PROVISION OF THIS ACT TO THE CONTRARY, A HEALTH MAINTENANCE ORGANIZATION THAT PARTICIPATES IN A STATE OR FEDERAL**

HEALTH PROGRAM is not required to offer benefits or services that exceed the requirements of the ~~state or federal health~~ **APPLICABLE** program. This section does not apply to state employee or federal employee health programs.

Sec. 3573. **(1)** A person ~~proposing~~ **THAT PROPOSES** to operate a system of health care delivery and financing ~~that is~~ to be offered to individuals, whether or not as members of groups, in exchange for a fixed payment and **TO BE** organized so that providers and the organization are in some part at risk for the cost of services in a manner similar to a health maintenance organization, but **THAT** fails to meet the requirements ~~set forth in this chapter,~~ **OF THIS ACT FOR A HEALTH MAINTENANCE ORGANIZATION,** may operate ~~such a~~ **THE** system **OF HEALTH CARE DELIVERY AND FINANCING** if the ~~commissioner~~ **DIRECTOR** finds that the proposed operation will benefit persons who will be served by it. The **DIRECTOR SHALL AUTHORIZE AND REGULATE THE** operation ~~shall be authorized and regulated~~ **OF THE SYSTEM** in the same manner as a health maintenance organization under this ~~chapter~~ **ACT,** including the filing of periodic reports, except to the extent that the ~~commissioner~~ **DIRECTOR** finds that the regulation is inappropriate to the system of health care delivery and financing.

(2) A person operating a system of health care delivery and financing under this section shall not advertise or solicit or in any way identify itself in a manner implying to the public that it is a health maintenance organization authorized under this ~~chapter.~~**ACT.**

Sec. 3701. As used in this chapter:

(a) "Actuarial certification" means a written statement by a

member of the American ~~academy of actuaries~~ **ACADEMY OF ACTUARIES** or another individual acceptable to the ~~commissioner~~ **DIRECTOR** that a small employer carrier is in compliance with ~~the provisions of~~ section 3705, based ~~upon~~ **ON** the ~~person's~~ **INDIVIDUAL'S** examination, including a review of the appropriate records and the actuarial assumptions and methods used by the carrier in establishing premiums for applicable health benefit plans.

(b) "Affiliation period" means a period of time required by a small employer carrier that must expire before health coverage becomes effective.

(c) "Base premium" means the lowest premium charged for a rating period under a rating system by a small employer carrier to small employers for a health benefit plan in a geographic area.

(d) "Carrier" means a person that provides health benefits, coverage, or insurance in this state. For the purposes of this chapter, carrier includes a health insurance company authorized to do business in this state, ~~a nonprofit health care corporation,~~ a health maintenance organization, a multiple employer welfare arrangement, or any other person providing a plan of health benefits, coverage, or insurance subject to state insurance regulation.

(e) "COBRA" means the consolidated omnibus budget reconciliation act of 1985, Public Law 99-272**.** ~~, 100 Stat. 82.~~

(f) "Commercial carrier" means a small employer carrier other than a ~~nonprofit health care corporation or~~ health maintenance organization.

(g) "Creditable coverage" means, with respect to an

individual, health benefits, coverage, or insurance provided under any of the following:

(*i*) A group health plan.

(*ii*) A health benefit plan.

(*iii*) Part A or part B of ~~title~~ **SUBCHAPTER** XVIII of the social security act, ~~chapter 531, 49 Stat. 620,~~ 42 ~~U.S.C.~~ **USC** 1395c to ~~1395i and 1395i-2 to 1395i-5, and 42 U.S.C. 1395j to 1395t, 1395u to 1395w, and 1395w-2 to 1395w-4.~~**1395W-6.**

(*iv*) ~~Title~~ **SUBCHAPTER** XIX of the social security act, ~~chapter 531, 49 Stat. 620,~~ 42 ~~U.S.C.~~ **USC** 1396 to ~~1396r-6 and 1396r-8 to 1396v,~~ **1396W-5,** other than coverage consisting solely of benefits under ~~section 1929 of title XIX of the social security act,~~ 42 ~~U.S.C.~~ **USC** 1396t.

(*v*) Chapter 55 of title 10 of the United States Code, 10 ~~U.S.C.~~ **USC** 1071 to ~~1110.~~ **1110B.** For purposes of **COVERAGE UNDER** chapter 55 of title 10 of the United States Code, 10 ~~U.S.C.~~ **USC** 1071 to ~~1110,~~ **1110B,** "uniformed services" means the armed forces 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) "FULL-TIME EMPLOYEES" MEANS THE TERM AS CALCULATED IN 26 USC 4890H(C)(4), INCLUDING APPLICATION OF THE SPECIAL RULES FOR DETERMINING GROUP SIZE AS DEFINED IN 26 USC 4980H(C)(2) AND THE SPECIFICATION THAT FULL-TIME EQUIVALENTS ARE TREATED AS FULL-TIME EMPLOYEES FOR PURPOSES OF DETERMINING GROUP SIZE, AS DESCRIBED IN 26 USC 4980H(C)(2)(E).

(J) ~~(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.

(K) ~~(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(e) 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 receive a benefit under the plan. For a group health plan maintained by a partnership, the individual is a partner in

relation to the partnership and for a group health plan maintained by a self-employed individual, under which 1 or more employees are participants, the individual is the self-employed individual.

(*l*) ~~(k)~~ "Health benefit plan" or "plan" means an expense-incurred hospital, medical, or surgical policy or certificate, ~~nonprofit health care corporation certificate,~~ or health maintenance organization contract. Health benefit plan does not include accident-only, credit, dental, or disability income insurance; long-term care insurance; coverage issued as a supplement to liability insurance; coverage only for a specified disease or illness; worker's compensation or similar insurance; or automobile medical-payment insurance.

(M) ~~(*l*)~~ "Index rate" means the arithmetic average during a rating period of the base premium and the highest premium charged per employee for each health benefit plan offered by each small employer carrier to small employers and sole proprietors in a geographic area.

~~(m) "Nonprofit health care corporation" means a nonprofit health care corporation operating pursuant to the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1101 to 550.1704.~~

(n) "Premium" means all money paid by a small employer, ~~a sole proprietor,~~ eligible employees, or eligible persons as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with the health benefit plan.

(O) "PUBLIC HEALTH PLAN" 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.

(P) ~~(o)~~ "Rating period" means the calendar period for which premiums established by a small employer carrier are assumed to be in effect, as determined by the small employer carrier.

(Q) ~~(p)~~ "Small employer" means any person ~~, firm, corporation, partnership, limited liability company, or association~~ actively engaged in business ~~who,~~ **THAT,** on at least 50% of its working days during the preceding and current calendar years, employed ~~at least~~ **NOT FEWER THAN** 2 ~~but~~ **AND** not more than 50 eligible employees. **BEGINNING JANUARY 1, <<2018>>, "SMALL EMPLOYER" MEANS ANY PERSON ENGAGED IN BUSINESS THAT, DURING THE PRECEDING CALENDAR YEAR, EMPLOYED AN AVERAGE OF AT LEAST 1 BUT NOT MORE THAN 50 FULL-TIME EMPLOYEES AND WHO EMPLOYS AT LEAST 1 EMPLOYEE ON THE FIRST DAY OF THE PLAN YEAR.** In determining the number of ~~eligible employees, companies~~ **FULL-TIME EQUIVALENT EMPLOYEES, PERSONS** that are affiliated ~~companies~~ **WITH EACH OTHER** or that are eligible to file a combined tax return for state taxation purposes ~~shall be~~ **ARE** considered 1 employer.

(R) ~~(q)~~ "Small employer carrier" means ~~either of the following:~~

~~(*i*) A~~ **A** carrier that offers health benefit plans covering the employees of a small employer.

~~(*ii*) A carrier under section 3703(3).~~

~~(r) "Sole proprietor" means an individual who is a sole proprietor or sole shareholder in a trade or business through which he or she earns at least 50% of his or her taxable income as~~

~~defined in section 30 of the income tax act of 1967, 1967 PA 281, MCL 206.30, excluding investment income, and for which he or she has filed the appropriate internal revenue service form 1040, 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.~~

(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.**

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

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

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

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

THE health benefit plan by more than 45% of the index rate.

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

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

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

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

(5) A small employer carrier shall apply all rating factors consistently with respect to all small employers ~~and sole proprietors~~ in a geographic area. Except as otherwise provided in subsection (4), a small employer carrier shall bill a small employer group only with a composite rate and shall not bill so

that 1 or more employees in a small employer group are charged a higher premium than another employee in ~~that~~ **THE** small employer group.

Sec. 3711. (1) Except as **OTHERWISE** provided in this section, a small employer carrier that offers health coverage in the small employer group market in connection with a health benefit plan shall renew or continue in force ~~that~~ **THE** plan at the option of the small employer. ~~or sole proprietor.~~

(2) Guaranteed renewal under subsection (1) is not required in ~~cases of:~~ **ANY OF THE FOLLOWING CIRCUMSTANCES:**

(A) THERE IS fraud or intentional misrepresentation ~~of~~ **BY** the small employer. ~~or, for~~

(B) FOR coverage of an insured individual, **THERE IS** fraud or misrepresentation by the insured individual or the individual's representative. ~~; lack~~

(C) LACK of payment. ~~; noncompliance~~

(D) NONCOMPLIANCE WITH MINIMUM CONTRIBUTION REQUIREMENTS.

(E) NONCOMPLIANCE with minimum participation requirements. ~~; if the~~

(F) THE small employer carrier no longer offers that particular type of coverage in the market. ~~; or if the sole proprietor or~~

(G) THE small employer moves outside the geographic area.

(3) A SMALL EMPLOYER CARRIER THAT OFFERS HEALTH COVERAGE IN THE SMALL EMPLOYER GROUP MARKET MAY MODIFY A HEALTH BENEFIT PLAN IF THE MODIFICATION IS CONSISTENT WITH STATE LAW AND EFFECTIVE ON A UNIFORM BASIS AMONG ALL SMALL EMPLOYERS WITH COVERAGE UNDER THE

HEALTH BENEFIT PLAN.

Sec. 3723. ~~The provisions of this~~ **THIS** chapter ~~apply~~ **APPLIES** to ~~each~~ **A** health benefit plan for a small employer ~~or sole proprietor~~ that is delivered, issued for delivery, renewed, or continued in this state ~~on or~~ after ~~the effective date of this chapter.~~ **JANUARY 22, 2004.** For purposes of this section, the date a health benefit plan is continued is the first rating period that begins ~~on or~~ after ~~the effective date of this chapter.~~**JANUARY 22, 2004.**

Sec. 4601. As used in this chapter:

(a) "Affiliated company" means a company in the same corporate system as a parent, an industrial insured, or a member organization by virtue of common ownership, control, operation, or management.

(b) "Alien captive insurance company" means an insurer formed to write insurance business for its parents and affiliates and licensed pursuant to the laws of a country other than the United States or ~~any~~ **A** state, district, commonwealth, territory, or possession of the United States.

(c) "Association" means a legal group of individuals, corporations, limited liability companies, partnerships, political subdivisions, or groups that has been in continuous existence for at least 1 year and the member organizations of which collectively, or ~~which~~ **THAT** does itself**,** own, control, or hold, with power to vote, all of the outstanding voting securities of an association captive insurance company incorporated as a stock insurer or organized as a limited liability company; or has complete voting control over an association captive insurance company organized as

a mutual insurer.

(d) "Association captive insurance company" means a company that insures risks of the member organizations of the association and their affiliated companies.

(e) "Branch business" means any insurance business transacted by a branch captive insurance company in this state.

(f) "Branch captive insurance company" means an alien captive insurance company authorized by the ~~commissioner~~ **DIRECTOR** to transact the business of insurance in this state through a business unit with a principal place of business in this state.

(g) "Branch operations" means any business operations of a branch captive insurance company in this state.

(h) "Captive insurance company" means a pure captive insurance company, association captive insurance company, sponsored captive insurance company, special purpose captive insurance company, or industrial insured captive insurance company authorized under this chapter. For purposes of this chapter, a branch captive insurance company ~~shall~~ **MUST** be a pure captive insurance company with respect to operations in this state, unless otherwise permitted by the ~~commissioner.~~**DIRECTOR.**

~~(i) "Commissioner" means the commissioner of the office of financial and insurance regulation or the commissioner's designee.~~

(I) ~~(j)~~ "Control", including the terms "controlling", "controlled by", and "under common control with", means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than

a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control is presumed to exist if a person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing 10% or more of the voting securities of another person. A showing that control does not exist may rebut this presumption.

(J) ~~(k)~~ "Controlled unaffiliated business" means a company ~~that meets~~ **TO WHICH** all of the following **APPLY**:

(*i*) ~~Is~~ **THE COMPANY IS** not in the corporate system of a parent and affiliated companies.

(*ii*) ~~Has~~ **THE COMPANY HAS** an existing contractual relationship with a parent or affiliated company.

(*iii*) ~~Has~~ **THE COMPANY HAS** risks managed by a captive insurance company in accordance with this chapter.

(K) ~~(*l*)~~ "Foreign captive insurer" means an insurer formed under the laws of the District of Columbia, or ~~some~~ **A** state, commonwealth, territory, or possession of the United States other than ~~the~~ **THIS** state**.** ~~of Michigan.~~

(*l*) ~~(m)~~ "GAAP" means generally accepted accounting principles.

(M) ~~(n)~~ "Industrial insured" means an insured ~~that meets~~ **TO WHICH** all of the following **APPLY**:

(*i*) ~~That~~ **THE INSURED** procures insurance by use of the services of a full-time employee acting as a risk manager or insurance manager or utilizing the services of a regularly and continuously qualified insurance consultant.

(*ii*) ~~Whose~~ **THE INSURED'S** aggregate annual premiums for

insurance on all risks total at least $25,000.00.

(*iii*) ~~That~~ **THE INSURED** has at least 25 full-time employees.

(N) ~~(o)~~ "Industrial insured captive insurance company" means a company that insures risks of the industrial insureds that comprise the industrial insured group and their affiliated companies.

(O) ~~(p)~~ "Industrial insured group" means a group that meets either of the following criteria:

(*i*) ~~Is~~ **THE GROUP IS** a group of industrial insureds that collectively own, control, or hold, with power to vote, all of the outstanding voting securities of an industrial insured captive insurance company incorporated as a stock insurer or limited liability company or have complete voting control over an industrial insured captive insurance company incorporated as a mutual insurer.

(*ii*) ~~Is~~ **THE GROUP IS** a group created under the liability risk retention act of 1986, 15 USC 3901 to 3906, and chapter 18, as a corporation or other limited liability association taxable as a stock insurance company or a mutual insurer under this chapter.

(P) ~~(q)~~ "Irrevocable letter of credit" means a letter of credit that meets the description in section 1105(c).

(Q) ~~(r)~~ "Member organization" means ~~any~~ **AN** individual, corporation, limited liability company, partnership, or association that belongs to an association.

(R) ~~(s)~~ "Office" means the ~~office of financial and insurance regulation.~~**DEPARTMENT.**

(S) ~~(t)~~ "Organizational document" means the articles of incorporation, articles of organization, bylaws, operating

agreement, or other foundational documents that create a legal entity or prescribe its existence.

(T) ~~(u)~~ "Parent" means ~~any~~ **A** corporation, limited liability 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.

(BB) ~~(cc)~~ "Sponsor" means an entity that meets the requirements of section 4665 and is approved by the ~~commissioner~~ **DIRECTOR** to provide all or part of the capital and retained earnings required by applicable law and to organize and operate a sponsored captive insurance company.

(CC) ~~(dd)~~ "Sponsored captive insurance company" means a captive insurance company in which the minimum capital and retained earnings required by applicable law is provided by 1 or more sponsors, **THAT** is authorized under this chapter, **THAT** insures the risks of separate participants through the participant contract, and **THAT** segregates each participant's liability through 1 or more protected cells.

(DD) ~~(ee)~~ "Surplus" means unassigned funds for an entity using statutory accounting principles, with capital and surplus including all capital stock, paid in capital and contributed surplus, and other surplus funds with corresponding items under GAAP consisting of retained earnings and accumulated other comprehensive income, with capital and retained earnings including all capital stock, additional paid in capital, and other equity funds.

(EE) ~~(ff)~~ "Treasury rates" means the United States treasury strips asked yield as published in the Wall Street Journal as of a balance sheet date.

(FF) ~~(gg)~~ "Voting security" includes any security convertible

into or evidencing the right to acquire a voting security.

Sec. 4701. As used in this chapter:

(a) "Affiliated company" means a company in the same corporate system as a parent, by virtue of common ownership, control, operation, or management.

(b) "Captive LLC" means a limited liability company established under the Michigan limited liability company act, 1993 PA 23, MCL 450.4101 to 450.5200, or **A** comparable ~~provisions of any other~~ **LAW OF ANOTHER** state**,** ~~law,~~ including the District of Columbia**,** by a parent, counterparty, affiliated company, or SPFC for the purpose of issuing SPFC securities, entering an SPFC contract with a counterparty, or otherwise facilitating an insurance securitization.

~~(c) "Commissioner" means the commissioner of the office of financial and insurance regulation or the commissioner's designee.~~

(C) ~~(d)~~ "Contested case" means a proceeding in which the legal rights, duties, obligations, or privileges of a party are required by law to be determined by the circuit court after an opportunity for hearing.

(D) ~~(e)~~ "Control" including the terms "controlling", "controlled by", and "under common control with" means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control ~~shall be~~ **IS**

presumed to exist if a person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing 10% or more of the voting securities of another person. This presumption may be rebutted by a showing that control does not exist. However, for purposes of this chapter, the fact that an SPFC exclusively provides reinsurance to a ceding insurer under an SPFC contract is not by itself sufficient grounds for a finding that the SPFC and ceding insurer are under common control.

(E) ~~(f)~~ "Counterparty" means an SPFC's parent or affiliated company, or, subject to the prior approval of the ~~commissioner,~~ **DIRECTOR,** a nonaffiliated company as ceding insurer to the SPFC contract.

(F) ~~(g)~~ "Fair value" means the following:

(*i*) For cash, the amount of the cash.

(*ii*) For ~~assets~~ **AN ASSET** other than cash, the amount at which ~~that~~ **THE** asset could be bought or sold in a current transaction between arm's length, willing parties. If available, the quoted mid-market price for the asset in active markets ~~shall~~ **MUST** be used; and if quoted mid-market prices are not available, a value ~~shall~~ **MUST** be determined using the best information available considering values of similar assets and other valuation methods, such as present value of future cash flows, historical value of the same or similar assets, or comparison to values of other asset classes, the value of which have been historically related to the subject asset.

(G) ~~(h)~~ "Foreign captive" means a captive insurer formed under the laws of the District of Columbia or ~~some~~ **A** state, commonwealth,

territory, or possession of the United States other than ~~the state of Michigan.~~**THIS STATE.**

(H) ~~(i)~~ "Insolvency" or "insolvent" means 1 or more of the following:

(*i*) That the SPFC is unable to pay its obligations within 30 days after they are due, unless those obligations are the subject of a bona fide dispute.

(*ii*) That the admitted assets of the SPFC do not exceed liabilities plus minimum capital and surplus for a period of time in excess of 30 days.

(*iii*) That the Ingham ~~county~~ **COUNTY** circuit court has issued an order as provided for in section 8113, 8117, or 8120 in connection with a delinquency proceeding under chapter 81 instituted against the SPFC.

(I) ~~(j)~~ "Insurance securitization" means a package of related risk transfer instruments, capital market offerings, and facilitating administrative agreements by which all of the following apply:

(*i*) The proceeds of the sale of SPFC securities are obtained, in a transaction that complies with applicable securities laws, by an SPFC directly through the issuance of the SPFC securities by the SPFC or indirectly through the issuance of preferred securities by the SPFC in exchange for some or all of the proceeds of the sale of SPFC securities by the SPFC's parent, an affiliated company of the SPFC, a counterparty, or a captive LLC.

(*ii*) The proceeds of the issuance of the SPFC securities secure the obligations of the SPFC under 1 or more SPFC contracts

with a counterparty.

(*iii*) The obligation to the holders of the SPFC securities is secured by assets obtained with proceeds of the SPFC securities in accordance with the transaction terms.

(J) ~~(k)~~ "Irrevocable letter of credit" means a letter of credit that meets the description in section 1105(c).

(K) ~~(*l*)~~ "Management" means the board of directors, managing board, or other individual or individuals vested with overall responsibility for the management of the affairs of the SPFC, including the election and appointment of officers or other agents to act on behalf of the SPFC.

(*l*) ~~(m)~~ "Office" means the ~~office of financial and insurance regulation.~~**DEPARTMENT.**

(M) ~~(n)~~ "Organizational document" means the SPFC's articles of incorporation, articles of organization, bylaws, operating agreement, or other foundational documents that establish the SPFC as a legal entity or prescribes its existence.

(N) ~~(o)~~ "Parent" means ~~any~~ **A** corporation, limited liability company, partnership, or individual that directly or indirectly owns, controls, or holds with power to vote more than 50% of the outstanding voting securities of an SPFC.

(O) ~~(p)~~ "Permitted investments" means those investments that meet the qualifications in section 4727(1).

(P) ~~(q)~~ "Preferred securities" means securities, whether stock or debt, issued by an SPFC to the issuer of the SPFC securities in exchange for some or all of the proceeds of the issuance of the SPFC securities.

(Q) ~~(r)~~ "Protected cell" means a segregated account established and maintained by an SPFC for 1 or more SPFC contracts that are part of a single securitization transaction as further provided for in chapter 48.

(R) ~~(s)~~ "Qualified United States financial institution" means that term as defined in section 1101.

(S) ~~(t)~~ "Reserves" means that term as used in chapter 8.

(T) ~~(u)~~ "Safe, reliable, and entitled to public confidence" means that term as defined in section ~~116(d).~~**116.**

(U) ~~(v)~~ "Securities" means those different types of debt obligations, equity, surplus certificates, surplus notes, funding agreements, derivatives, and other legal forms of financial instruments.

(V) ~~(w)~~ "Securities commissioner" means the ~~commissioner.~~**SECURITIES ADMINISTRATOR IN THE DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS.**

(W) ~~(x)~~ "SPFC" or "special purpose financial captive" means a captive insurance company, a captive LLC, or a company otherwise qualified as an authorized insurer that has received a limited certificate of authority from the ~~commissioner~~ **DIRECTOR** for the purposes provided for in this chapter.

(X) ~~(y)~~ "SPFC contract" means a contract between the SPFC and the counterparty pursuant to which the SPFC agrees to provide insurance or reinsurance protection to the counterparty for risks associated with the counterparty's insurance or reinsurance business.

(Y) ~~(z)~~ "SPFC securities" means the securities issued pursuant

to an insurance securitization, the proceeds of which are used in the manner described in subdivision ~~(j).~~**(I).**

(Z) ~~(aa)~~ "Surplus note" means an unsecured subordinated debt 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 all policies ~~issued after January 1, 1948, shall~~ **MUST** grant ~~such~~ **THE** nonforfeiture values under annuity contracts ~~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.

(c) Chapter 20.

(d) Chapter 22.

(e) Chapter 34.

~~(f) Chapter 36.~~

(F) ~~(g)~~ Chapter 44.

(G) ~~(h)~~ Chapter 81.

Sec. 7705. As used in this chapter:

(a) "Account" means either of the 2 accounts created under section 7706.

(b) "Association" means the Michigan life and health insurance guaranty association created under section 7706.

(c) "Authorized assessment" or "authorized" when used in the context of assessments means a resolution or motion passed by the association's board of directors that directs that an assessment be called immediately or in the future from member insurers for a specific amount. An assessment is authorized when the resolution or motion is passed.

(d) "Benefit plan" means a specific employee, union, or association of natural persons benefit plan.

(e) "Called assessment" or "called" when used in the context of assessments means that a notice has been issued by the association to member insurers requiring that an authorized assessment be paid within the time frame set forth within the

notice. An authorized assessment becomes a called assessment when notice is mailed by the association to member insurers.

(f) "Contractual obligation" means an obligation under covered policies.

(g) "Covered policy" means a policy, ~~or~~ contract, or certificate under a group policy or contract, or portion ~~thereof,~~ **OF A GROUP POLICY OR CONTRACT,** for which coverage is provided under section 7704.

(h) "Health insurance" means disability insurance as ~~defined~~ **DESCRIBED** in section 606.

(i) "Impaired insurer" means a member insurer considered by the ~~commissioner after May 1, 1982,~~ **DIRECTOR** to be potentially unable to fulfill the insurer's contractual obligations or that is placed under an order of rehabilitation or conservation by a court of competent jurisdiction. Impaired insurer does not mean an insolvent insurer.

(j) "Insolvent insurer" means a member insurer that ~~after May 1, 1982,~~ becomes insolvent and is placed under an order of liquidation ~~,~~ by a court of competent jurisdiction with a finding of insolvency.

(k) "Member insurer" means a person authorized to transact a kind of insurance or annuity business in this state for which coverage is provided under section 7704 and includes an insurer whose certificate of authority in this state may have been suspended, revoked, not renewed, or voluntarily withdrawn. Member insurer does not include the following:

(*i*) A fraternal benefit society.

(*ii*) A cooperative plan insurer authorized under chapter 64.

(*iii*) A health maintenance organization authorized or licensed under chapter 35.

(*iv*) A mandatory state pooling plan.

(*v*) A mutual assessment or any ~~entity~~ **PERSON** that operates on an assessment basis.

(*vi*) A nonprofit dental care corporation operating under 1963 PA 125, MCL 550.351 to 550.373.

~~(*vii*) A nonprofit health care corporation operating under the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1101 to 550.1704.~~

(*vii*) ~~(*viii*)~~ An insurance exchange.

(*viii*) ~~(*ix*)~~ An organization that has a certificate or license limited to the issuance of charitable gift annuities.

(*ix*) ~~(*x*)~~ Any entity similar to the entities described in this subdivision.

(*l*) "Moody's corporate bond yield average" means the monthly average corporates as published by Moody's ~~investors service, inc.,~~ **INVESTORS SERVICE, INC.,** or a successor to that service.

(m) "Owner" of a contract or policy and "contract owner" and "policy owner" mean the person who is identified as the legal owner under the terms of the contract or policy or who is otherwise vested with the legal title to the contract or policy through a valid assignment completed in accordance with the terms of the contract or policy and properly recorded as the owner on the books of the insurer. The terms owner, contract owner, and policy owner do not include persons with a mere beneficial interest in a

contract or policy.

(n) "Person" means an individual, corporation, partnership, association, or voluntary organization.

(o) "Plan sponsor" means the following:

(*i*) For a benefit plan established or maintained by a single employer, the single employer.

(*ii*) For a benefit plan established or maintained by an employee organization, the employee or organization.

(*iii*) For a benefit plan established or maintained by 2 or more employers or jointly by 1 or more employers and 1 or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan.

(p) "Premiums" means amounts or considerations, by whatever name called, received on covered policies or contracts less returned premiums, considerations, and deposits and less dividends and experience credits. The term "premiums" does not include an amount or consideration received for a policy or contract, or a portion of a policy or contract for which coverage is not provided under section 7704. However, accessible premiums ~~shall~~ **MUST** not be reduced ~~on account~~ **BECAUSE** of sections 7704(5)(c) relating to interest limitations and 7704(6)(b), (c), and (e) relating to limitations with respect to any 1 individual, any 1 participant, and any 1 contract holder. Premiums ~~shall~~ **DO** not include premiums in excess of the following:

(*i*) $5,000,000.00 on an unallocated annuity contract not issued under a governmental retirement plan established under

section 401(k), 403(b), or 457 of the internal revenue code of 1986, 26 USC 401, 403, and 457.

(*ii*) For multiple nongroup policies of life insurance owned by 1 owner, whether the policyowner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons, $5,000,000.00 with respect to these policies or contracts, regardless of the number of policies or contracts held by the owner.

(q) "Principal place of business" of a plan sponsor or a person other than a natural person means the state in which the natural persons who establish policy for the direction, control, and coordination of the entity as a whole primarily exercise that function. In making this determination, the association, in its reasonable judgment, shall consider all of the following factors:

(*i*) The state in which the primary executive and administrative headquarters of the entity is located.

(*ii*) The state in which the principal office of the chief executive officer of the entity is located.

(*iii*) The state in which the board of directors, or the entity's similar governing person or persons, conducts the majority of its meetings.

(*iv*) The state in which the executive or management committee of the board of directors, or the entity's similar governing person or persons, conducts the majority of its meetings.

(*v*) The state from which the management of the overall operations of the entity is directed.

(*vi*) For a benefit plan sponsored by affiliated companies

comprising a consolidated corporation, the state in which the holding company or controlling affiliate has its principal place of business as determined using subparagraphs (*i*) to (*v*). However, for a plan sponsor, if more than 50% of the participants in the benefit plan are employed in a single state, that state is the principal place of business of the plan sponsor.

(*vii*) For a plan sponsor of a benefit plan, the principal place of business of the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan ~~shall be~~ **IS** based ~~upon~~ **ON** the location of the principal place of business of the employer or employee organization that has the largest investment in the benefit plan ~~in lieu~~ **INSTEAD** of a specific or clear designation of a principal place of business.

(r) "Receivership court" means the court in the insolvent insurer's or impaired insurer's state having jurisdiction over the conservation, rehabilitation, or liquidation of the insurer.

(s) "Resident" means a person who resides in this state at the time a member insurer is determined to be an impaired insurer or insolvent insurer and to whom contractual obligations are owed. A person may be considered a resident of only 1 state, which, ~~in the case of~~ **FOR** a person other than a natural person, is its principal place of business. Citizens of the United States who are either residents of foreign countries or residents of the United States possessions, territories, or protectorates that do not have an association similar to the association created by this chapter ~~shall be~~ **ARE** considered residents of this state if the insurer that

issued the policies or contracts is domiciled in this state.

(t) "State" means a state, the District of Columbia, Puerto Rico, or a United States possession, territory, or protectorate.

(u) "Structured settlement annuity" means an annuity purchased in order to fund periodic payments for a plaintiff or other claimant in payment for or with respect to personal injury suffered by the plaintiff or other claimant.

(v) "Supplemental contract" means a written agreement entered into for the distribution of proceeds under a life, health, or annuity policy or contract.

(w) "Unallocated annuity contract" means an annuity contract or group annuity certificate that is not issued to and owned by an individual, except to the extent of an annuity benefit guaranteed to an individual by an insurer under the contract or certificate. ~~The term shall also include,~~ **UNALLOCATED ANNUITY CONTRACT INCLUDES,** but is not limited to, **A** guaranteed investment ~~contracts and~~ **CONTRACT OR A** deposit administration ~~contracts.~~**CONTRACT.**

Enacting section 1. Sections 3401, 3406f, 3406g, 3439, 3523, 3527, 3537, 3539, 3541, 3542, 3543, 3549, 3565, 3567, 3580, and 3706 and chapter 36 of the insurance code of 1956, 1956 PA 218, MCL 500.3401, 500.3406f, 500.3406g, 500.3439, 500.3523, 500.3527, 500.3537, 500.3539, 500.3541, 500.3542, 500.3543, 500.3549, 500.3565, 500.3567, 500.3580, 500.3600 to 500.3650, and 500.3706, are repealed.

Enacting section 2. This amendatory act does not take effect unless all of the following bills of the 98th Legislature are enacted into law:

(a) House Bill No. 4933.

(b) House Bill No. 4934.

Enacting section 3. On the effective date of this amendatory act, an insurer may submit to the director of the department of insurance and financial services for approval any modification to policies and certificates that were approved before or on the effective date of this amendatory act, to conform with amendments made to the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302, by this amendatory act. This enacting section does not apply to rates and rating methodologies.