THE INSURANCE CODE OF 1956 (EXCERPT)
Act 218 of 1956

500.2213b Renewal or continuation of policy; modification; guaranteed renewal; discontinuing plan or product in nongroup or group market; short-term or 1-time limited duration policy or certificate; reports.

Sec. 2213b. (1) Except as otherwise provided in this section and section 2213e, an insurer that delivers, issues for delivery, or renews in this state a health insurance policy shall renew the policy or continue the policy in force at the option of the individual or, for a group plan, at the option of the plan sponsor.

(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) 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) An insurer that delivers, issues for delivery, or renews in this state a health insurance policy shall not discontinue offering a particular plan or product in the nongroup or group market unless the insurer 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 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) An insurer shall not discontinue offering all coverage in the nongroup or group market unless the insurer 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 withdrew and does not renew coverage under those plans.

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

(8) Subsections (1) to (7) do not apply to a short-term or 1-time limited duration policy or certificate of not longer than 6 months.

(9) For the purposes of this section, a short-term or 1-time limited duration policy or certificate of not 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) 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 not 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 health insurance policies issued or delivered in this state during the preceding calendar year other than policies or certificates described in subdivision (a).

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

(12) 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 health insurance policies issued or delivered in this state either directly by the insurer or through a person that owns or is owned by the insurer.

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