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

500.3701 Definitions.

Sec. 3701. As used in this chapter:

(a) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or another individual acceptable to the director that a small employer carrier is in compliance with section 3705, based on the 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 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.

(f) "Commercial carrier" means a small employer carrier other than a 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 subchapter XVIII of the social security act, 42 USC 1395c to 1395w-6.

(*iv*) Subchapter XIX of the social security act, 42 USC 1396 to 1396w-5, other than coverage consisting solely of benefits under 42 USC 1396t.

(*v*) Chapter 55 of title 10 of the United States Code, 10 USC 1071 to 1110b. For purposes of coverage under chapter 55 of title 10 of the United States Code, 10 USC 1071 to 1110b, "uniformed services" means the armed forces and the commissioned corps of the National Oceanic and Atmospheric Administration and of the Public Health Service.

(*vi*) A medical care program of the Indian Health Service or of a tribal organization.

(*vii*) A state health benefits risk pool.

(*viii*) A health plan offered under chapter 89 of title 5 of the United States Code, 5 USC 8901 to 8914.

(*ix*) A public health plan.

(*x*) A health benefit plan under section 5(e) of title I of the peace corps act, 22 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) "Geographic area" means an area in this state that includes not less than 1 entire county, is established by a carrier 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) "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 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 42 USC 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, is, subject to subparagraph (*ii*), 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*) "Health benefit plan" or "plan" means an expense-incurred hospital, medical, or surgical policy or 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) "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.

(n) "Premium" means all money paid by a small employer, 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) "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) "Small employer" means any person actively engaged in business that, on at least 50% of its working days during the preceding and current calendar years, employed not fewer than 2 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 full-time equivalent employees, persons that are affiliated with each other or that are eligible to file a combined tax return for state taxation purposes are considered 1 employer.

(r) "Small employer carrier" means a carrier that offers health benefit plans covering the employees of a small employer.

(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 is not considered as a gap in coverage.

History: Add. 2003, Act 88, Eff. Jan. 23, 2004;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: Former Chapter 37 and its contents, MCL 500.3701-500.3728, were repealed by Act 271 of 2001, Imd. Eff. Jan. 11, 2002.

Former Chapter 37 was entitled “GROUP HEALTH INSURANCE FOR PERSONS 65 OR OLDER.” Former MCL 500.3701 pertained to purpose of chapter.

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