THE NONPROFIT HEALTH CARE CORPORATION REFORM ACT (EXCERPT)
Act 350 of 1980

550.1401 Offering of health care benefits; limiting benefits; division of benefits into classes or kinds; prohibited conduct; grounds for denial of coverage; coordination of benefits, subrogation, and nonduplication of benefits; health care corporation as party in interest; limiting or denying coverage or participation status; requirements for participation and reimbursement; determination by commissioner; definitions.

Sec. 401. (1) A health care corporation established, maintained, or operating in this state shall offer health care benefits to all residents of this state, and may offer other health care benefits as the corporation specifies with the approval of the commissioner.

(2) A health care corporation may limit the health care benefits that it will furnish, except as provided in this act, and may divide the health care benefits that it elects to furnish into classes or kinds.

(3) A health care corporation shall not do any of the following:

(a) Refuse to issue or continue a certificate to 1 or more residents of this state, except while the individual, based on a transaction or occurrence involving a health care corporation, is serving a sentence arising out of a charge of fraud, is satisfying a civil judgment, or is making restitution pursuant to a voluntary payment agreement between the corporation and the individual.

(b) Refuse to continue in effect a certificate with 1 or more residents of this state, other than for failure to pay amounts due for a certificate, except as allowed for refusal to issue a certificate under subdivision (a).

(c) Limit the coverage available under a certificate, without the prior approval of the commissioner, unless the limitation is as a result of: an agreement with the person paying for the coverage; an agreement with the individual designated by the persons paying for or contracting for the coverage; or a collective bargaining agreement.

(d) Rate, cancel benefits on, refuse to provide benefits for, or refuse to issue or continue a certificate solely because a subscriber or applicant is or has been a victim of domestic violence. A health care corporation shall not be held civilly liable for any cause of action that may result from compliance with this subdivision. This subdivision applies to all health care corporation certificates issued or renewed on or after June 1, 1998. As used in this subdivision, "domestic violence" means inflicting bodily injury, causing serious emotional injury or psychological trauma, 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.

(e) Require a member or his or her dependent or an applicant for coverage or his or her dependent to do either of the following:

(*i*) Undergo genetic testing before issuing, renewing, or continuing a health care corporation certificate.

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

(4) Subsection (3) does not prevent a health care corporation from denying to a resident of this state coverage under a certificate for any of the following grounds:

(a) That the individual was not a member of a group that had contracted for coverage under this certificate.

(b) That the individual is not a member of a group with a size greater than a minimum size established for a certificate pursuant to sound underwriting requirements.

(c) That the individual does not meet requirements for coverage contained in a certificate.

(d) For groups of under 100 subscribers and except as otherwise provided in section 3709 of the insurance code of 1956, 1956 PA 218, MCL 500.3709, that the group that the individual is a member of has failed to enroll enough of its eligible members with the health care corporation. A denial under this subdivision shall be made only if the health care corporation determines that the cost for the portion of the group applying for coverage would be at least 50% more on a per subscriber basis than the per subscriber cost for the whole group. A denial under this subdivision shall not be based on the health status of any individual in the group or his or her dependent. A denial under this subdivision shall be based on sound actuarial principles and may be based on 1 or more of the following:

(*i*) That the contract holder for the group applying for coverage is also offering a self-funded health benefit plan.

(*ii*) That the group applying for coverage is composed entirely of the contract holder's retiree business segment.

(*iii*) That the average individual age of the members of the group applying for coverage is either 50% higher or 10 years higher than the average individual age for the whole group.

(5) A certificate may provide for the coordination of benefits, subrogation, and the nonduplication of

benefits. Savings realized by the coordination of benefits, subrogation, and nonduplication of benefits shall be reflected in the rates for those certificates. If a group certificate issued by the corporation contains a coordination of benefits provision, the benefits shall be payable pursuant to the coordination of benefits act, 1984 PA 64, MCL 550.251 to 550.255.

(6) A health care corporation shall have the right to status as a party in interest, whether by intervention or otherwise, in any judicial, quasi-judicial, or administrative agency proceeding in this state for the purpose of enforcing any rights it may have for reimbursement of payments made or advanced for health care services on behalf of 1 or more of its subscribers or members.

(7) A health care corporation shall not directly reimburse a provider in this state who has not entered into a participating contract with the corporation.

(8) A health care corporation shall not limit or deny coverage to a subscriber or limit or deny reimbursement to a provider on the ground that services were rendered while the subscriber was in a health care facility operated by this state or a political subdivision of this state. A health care corporation shall not limit or deny participation status to a health care facility on the ground that the health care facility is operated by this state or a political subdivision of this state, if the facility meets the standards set by the corporation for all other facilities of that type, government-operated or otherwise. To qualify for participation and reimbursement, a facility shall, at a minimum, meet all of the following requirements, which shall apply to all similar facilities:

(a) Be accredited by the joint commission on accreditation of hospitals.

(b) Meet the certification standards of the medicare program and the medicaid program.

(c) Meet all statutory requirements for certificate of need.

(d) Follow generally accepted accounting principles and practices.

(e) Have a community advisory board.

(f) Have a program of utilization and peer review to assure that patient care is appropriate and at an acute level.

(g) Designate that portion of the facility that is to be used for acute care.

(9) Not later than the close of business on the seventh business day after denying coverage under subsection (4)(d), the health care corporation shall notify the commissioner of this denial and shall supply the commissioner with the information used in determining the denial. The commissioner shall determine whether he or she will approve or disapprove the health care corporation denial not later than the close of business on the seventh business day after receipt of the notice and shall promptly notify the health care corporation of his or her determination. The commissioner shall base his or her determination under this subsection on whether the health care corporation met the standards in subsection (4)(d). The health care corporation or the denied contract holder may appeal the commissioner's decision in circuit court. The commissioner shall report to the senate and house of representatives standing committees on insurance issues by May 15, 2005 and biennially thereafter all of the following:

(a) The number of denials made each calendar year by a health care corporation under subsection (4)(d).

(b) The number of denials under subdivision (a) that were approved by the commissioner under this subsection and a summary of the type of group approved.

(c) The number of denials under subdivision (a) that were disapproved by the commissioner under this subsection and a summary of the type of group disapproved.

(d) The number of decisions by the commissioner under this subsection that have been appealed and the results of the appeals.

(10) As used in this section:

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

(*i*) Predicted 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 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 if their 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.

History: 1980, Act 350, Eff. Apr. 3, 1981;—Am. 1984, Act 66, Imd. Eff. Apr. 18, 1984;—Am. 1998, Act 135, Imd. Eff. June 24, 1998;—Am. 2000, Act 26, Imd. Eff. Mar. 15, 2000;—Am. 2003, Act 59, Eff. July 23, 2003.

Popular name: Blue Cross-Blue Shield

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