Act No. 110
Public Act of 1989
June 27, 1989
Filed by the Secretary of State
June 27, 1989

STATE OF MICHIGAN
85TH LEGISLATURE
REGULAR SESSION OF 1989

Introduced by Reps. DeLange, Brown, Runco, Middaugh, Krause, Hoffman, Stacey, Gilmer, Van Singel, Camp and Weeks

ENROLLED HOUSE BILL No. 4391

AN ACT to amend Act No. 350 of the Public Acts of 1980, entitled "An act to provide for the incorporation of nonprofit health care corporations; to provide their rights, powers, and immunities; to prescribe the powers and duties of certain state officers relative to the exercise of those rights, powers, and immunities; to prescribe certain conditions for the transaction of business by those corporations in this state; to define the relationship of health care providers to nonprofit health care corporations and to specify their rights, powers, and immunities with respect thereto; to provide for the regulation and supervision of nonprofit health care corporations by the commissioner of insurance; to prescribe powers and duties of certain other state officers with respect to the regulation and supervision of nonprofit health care corporations; to regulate the merger or consolidation of certain corporations; to prescribe an expeditious and effective procedure for the maintenance and conduct of certain administrative appeals relative to provider class plans; to provide for certain administrative hearings relative to rates for health care benefits; to provide for certain causes of action; to prescribe penalties and to provide civil fines for violations of this act; and to repeal certain acts and parts of acts," as amended, being sections 550.1101 to 550.1704 of the Michigan Compiled Laws, by adding sections 420, 421, 422, 423, 424, 425, 426, and 430.

The People of the State of Michigan enact:

Section 1. Act No. 350 of the Public Acts of 1980, as amended, being sections 550.1101 to 550.1704 of the Michigan Compiled Laws, is amended by adding sections 420, 421, 422, 423, 424, 425, 426, and 430 to read as follows:

Sec. 420. As used in this section and sections 421 to 430:

(a) "Applicant" means:

(*i*) For an individual long-term care certificate, the person who seeks to contract for long-term care benefits.

(*ii*) For a group long-term care certificate, the proposed member.

(b) "Group long-term care coverage" means a long-term care certificate that is delivered or issued for delivery in this state and issued to any of the following:

(*i*) One or more employers, or labor organizations, or to a trust or the trustees of a fund established by 1 or more employers or labor organizations for employees or former employees or members or former members of the labor organization.

(*ii*) A professional, trade, or occupational association for its members or former or retired members if the association is composed of individuals who were all actively engaged in the same profession, trade, or occupation and the association has been maintained in good faith for purposes other than obtaining coverage unless waived by the commissioner.

(*iii*) Subject to section 421(2), an association or to a trust or to the trustees of a fund established, created, or maintained for the benefit of members of 1 or more associations.

(*iv*) A group other than that described in subparagraphs (*i*), (*ii*), or (*iii*) if the commissioner determines all of the following:

(A) The issuance of the group certificate is not contrary to the best interests of the public.

(B) The issuance of the group certificate would result in economies of acquisition or administration.

(C) The benefits are reasonable in relation to the premiums charged.

(c) "Home care services" means 1 or more of the following medically prescribed services or assessment team recommended services for the long-term care and treatment of a member that are to be provided by 1 or more home health or care agencies in a noninstitutional setting according to a written diagnosis and plan of care or individual assessment and plan of care:

(*i*) Nursing services under the direction of a registered nurse, including the service of a home health aide.

(*ii*) Physical therapy.

(*iii*) Speech therapy.

(*iv*) Respiratory therapy.

(*v*) Occupational therapy.

(*vi*) Nutritional services provided by a registered dietitian.

(*vii*) Personal care services, homemaker services, adult day care, and similar nonmedical services.

(*viii*) Medical social services.

(*ix*) Other similar medical services and health-related support services.

(d) "Home health or care agency" means a person certified by medicare whose business is to provide to individuals in their places of residence other than in a hospital, nursing home, or county medical care facility, 1 or more of the following services: nursing services, therapeutic services, social work services, homemaker services, home health aide services, or other related services.

(e) "Intermediate care facility" means a facility, or distinct part of a facility, certified by the department of public health to provide intermediate care, custodial care, or basic care that is less than skilled nursing care but more than room and board.

(f) "Long-term care coverage" means an individual or group certificate or rider advertised, marketed, offered, or designed to provide coverage for at least 12 consecutive months for each covered person on an expense-incurred, indemnity, prepaid, or other basis for 1 or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, personal, or custodial care services provided in a setting other than an acute care unit of a hospital. Long-term care coverage does not include a certificate which is offered primarily to provide coverage for rehabilitative and convalescent care and is not offered, advertised, or marketed as a long-term care certificate, or that is offered primarily to provide basic medicare supplemental coverage, hospital confinement indemnity coverage, basic hospital expense coverage, basic medical surgical expense coverage, major medical expense coverage, disability income protection coverage, catastrophic coverage, comprehensive coverage, accident only coverage, specific disease or specified accident coverage, or limited benefit health coverage.

(g) "Preexisting condition" means a condition for which medical advice or treatment was recommended by, or received from, a provider of health care services within 6 months preceding the effective date of coverage of a member.

(h) "Skilled nursing facility" means a facility, or a distinct part of a facility, certified by the department of public health to provide skilled nursing care.

Sec. 421. (1) Group long-term care coverage shall not be offered to a resident of this state under a group certificate issued in another state to a group described in section 420(b)(*iv*), unless the commissioner of this state has made a determination that those requirements have been met.

(2) Before advertising, marketing, or offering a group long-term care certificate within this state to a group described in section 420(b)(*iii*), the group or the corporation shall file evidence with the commissioner that the group meets all of the following requirements:

(a) Consists of at least 100 members.

(b) Has been in active existence for at least 1 year.

(c) Holds regular meetings at least annually.

(d) Except for credit unions, the group collects dues or solicits contributions from members.

(e) The members have voting privileges and representation on the governing board and committees.

(f) Has been organized and maintained in good faith for purposes other than obtaining coverage. The commissioner may waive the requirement provided in this subdivision.

(3) Thirty days after making the filing under this section, the group described in section 420(b)(*iii*) shall be considered to satisfy such organizational requirements, unless the commissioner makes a finding that the group does not satisfy those organizational requirements.

Sec. 422. The commissioner may promulgate rules including the following:

Rules establishing standards for the sale of long-term care certificates; terms of renewability; initial and subsequent conditions of eligibility; nonduplication of coverage provisions; coverage of dependents if provided in the certificate; preexisting conditions; termination of coverage; continuation or conversion; probationary periods; limitations; exceptions; reductions; elimination periods; requirements for replacement; recurrent conditions; definitions of terms; and for full and fair disclosure setting forth the manner, content, and required disclosures.

Sec. 423. (1) Each individual long-term care certificate shall contain a guaranteed renewable provision. A health care corporation shall not cancel or otherwise terminate a long-term care certificate on the grounds of the age or the deterioration of the mental or physical health of the member.

(2) Each group long-term care certificate shall contain a conversion provision permitting an individual entitled to benefits under the group certificate to elect to convert from the group certificate to an individual long-term care certificate with the option of receiving benefits substantially similar to the prior coverage.

(3) If existing coverage is converted to or replaced by a long-term care certificate with the same health care corporation, the long-term care certificate shall not contain a provision establishing a new limitation period except with respect to an increase in benefits voluntarily selected by the member.

(4) A long-term care certificate that provides coverage for care in an intermediate care facility or a skilled nursing facility shall also provide coverage for home care services.

(5) Notwithstanding any other provision of this act, if a health care corporation established, maintained, or operating in this state offers long-term care coverage, it is not required to offer long-term care coverage to a state resident who is hospitalized or institutionalized, or who has been informed by a physician that he or she will require hospitalization or institutionalization within 30 days after the time of application for long-term care coverage, until the day after the date of discharge from the facility.

Sec. 424. (1) A preexisting condition limitation period in a long-term care certificate, other than a group long-term care certificate described in section 420(b)(*i*), shall not exceed 1 of the following:

(a) Six months after the effective date of coverage.

(b) A period of time set by the commissioner if the commissioner has found that a longer limitation period than provided for in subdivision (a) is justified because the group is specially limited by age, group categories, or other specific certificate provisions and that the longer limitation period will be in the best interest of the public.

(2) A long-term care certificate, other than a group long-term care certificate described in section 420(b)(*i*), shall not use a definition of preexisting condition which is more restrictive than the definition in section 420.

(3) The definition of preexisting condition does not prohibit a health care corporation from using an application form designed to elicit the complete health history of an applicant.

(4) Unless otherwise provided in the certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until after the limitation period. A long-term care certificate shall not exclude or use waivers or riders of any kind to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting conditions beyond the limitation period.

Sec. 425. A long-term care insurance certificate shall not condition benefits on the prior institutionalization of the member.

Sec. 426. (1) Except as otherwise provided in subsection (2), individual long-term care subscribers shall have the right to return the certificate within 30 days after its delivery and to have the entire premium refunded if, after examination of the certificate, the subscriber is not satisfied for any reason and benefits have not been incurred under the certificate. Long-term care certificates shall have a notice prominently printed on the first page of the certificate and the outline of coverage stating in substance that the subscriber shall have the right to return the certificate within 30 days after its delivery and to have the entire premium refunded if, after examination of the certificate, the subscriber is not satisfied for any reason.

(2) A subscriber covered under a long-term care certificate issued pursuant to a direct response solicitation shall have the right to return the certificate within 30 days after its delivery and to have the entire premium

refunded if, after examination, the subscriber is not satisfied for any reason. Long-term care certificates issued pursuant to a direct response solicitation shall have a notice prominently printed on the first page of the certificate and the outline of coverage stating in substance that the subscriber shall have the right to return the certificate within 30 days after its delivery and to have the entire premium refunded if, after examination, the subscriber is not satisfied for any reason. As used in this section, "direct response solicitation" means solicitation in which a representative of the health care corporation does not contact the applicant in person and explain the coverage available, such as, but not limited to, solicitation through direct mail or through advertisements in periodicals and other media.

Sec. 430. Each certificate that is advertised, marketed, or offered as long-term care coverage or nursing home coverage shall comply with sections 420 to 429 and the other applicable provisions of this act.

Section 2. This amendatory act shall not take effect unless Senate Bill No. 250 of the 85th Legislature is enacted into law.

Section 3. This amendatory act shall take effect January 1, 1990.

This act is ordered to take immediate effect.

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Clerk of the House of Representatives.

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Secretary of the Senate.

Approved.....

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Governor.