Act No. 173
Public Act of 1989
July 11, 1989
Filed by the Secretary of State
July 11, 1989

STATE OF MICHIGAN
85TH LEGISLATURE
REGULAR SESSION OF 1989

Introduced by Reps. Brown, DeLange, Bartnik, Dutko, Middaugh, Krause, Stabenow, Palamara, Barns, Runco, Varga, Stallworth, Gire, Webb, Pitoniak, Weeks, Clack, Rocca, Gilmer, Van Singel, Stupak, Bandstra, Fitzgerald, Strand, Dunaskiss, Honigman, Munsell, Emmons, Miller, Alley, Mathieu, Berman, Johnson, Hollister, Porreca, Hoekman, Camp and Saunders

ENROLLED HOUSE BILL No. 4396

AN ACT to amend sections 3405, 3631, and 3709 of Act No. 218 of the Public Acts of 1956, entitled as amended "An act to revise, consolidate, and classify the laws relating to the insurance and surety business; to regulate the incorporation or formation of domestic insurance and surety companies and associations and the admission of foreign and alien companies and associations; to provide their rights, powers, and immunities and to prescribe the conditions on which companies and associations organized, existing, or authorized under this act may exercise their powers; to provide the rights, powers, and immunities and to prescribe the conditions on which other persons, firms, corporations, and associations engaged in an insurance or surety business may exercise their powers; to provide for the imposition of a privilege fee on domestic insurance companies and associations and the state accident fund; to provide for the imposition of a tax on the business of foreign and alien companies and associations; to provide for the imposition of a tax on the business of surplus line agents; to modify tort liability arising out of certain accidents; to provide for limited actions with respect to that modified tort liability, and to prescribe certain procedures for maintaining those actions; to require security for losses arising out of certain accidents; to provide for the continued availability and affordability of automobile insurance and homeowners insurance in this state, and to facilitate the purchase of that insurance by all residents of this state at fair and reasonable rates; to provide for certain reporting with respect to insurance, and with respect to certain claims against uninsured or self-insured persons; and to prescribe duties for certain state departments and officers with respect to that reporting; to provide for certain assessments; to establish and continue certain state insurance funds; to modify and clarify the status, rights, powers, duties, and operations of the nonprofit malpractice insurance fund; to provide for the departmental supervision and regulation of the insurance and surety business within this state; to provide for the conservation, rehabilitation, or liquidation of unsound or insolvent insurers; to provide for the protection of policyholders, claimants, and creditors of unsound or insolvent insurers; to provide for associations of insurers to protect policyholders and claimants in the event of insurer insolvencies; to prescribe educational requirements for insurance agents and solicitors; to provide for the regulation of multiple employer welfare arrangements; to create an automobile theft prevention authority to reduce the number of automobile thefts in this state; to prescribe the powers and duties of the automobile theft prevention authority; to provide certain powers and duties upon certain officials, departments, and authorities of this state; to repeal certain acts and parts of acts; to repeal certain acts and parts of acts on specific dates; and to provide penalties for the violation of this act," as added by Act No. 280 of the Public Acts of 1984, being sections 500.3405, 500.3631, and 500.3709 of the Michigan Compiled Laws; and to add sections 2280, 2281, 2282, 2283, 2284, 2285, 2286, and 2290.

The People of the State of Michigan enact:

Section 1. Sections 3405, 3631, and 3709 of Act No. 218 of the Public Acts of 1956, as added by Act No. 280 of the Public Acts of 1984, being sections 500.3405, 500.3631, and 500.3709 of the Michigan Compiled Laws, are amended and sections 2280, 2281, 2282, 2283, 2284, 2285, 2286, and 2290 are added to read as follows:

Sec. 2280. As used in this section and sections 2281 to 2290:

(a) "Applicant" means:

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

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

(b) "Group long-term care insurance" means a long-term care insurance policy 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 insurance unless waived by the commissioner.

(*iii*) Subject to section 2281(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 policy is not contrary to the best interests of the public.

(B) The issuance of the group policy 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 an insured 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 insurance" means an individual or group insurance policy 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 insurance does not include an insurance policy which is offered primarily to provide coverage for rehabilitative and convalescent care and is not offered, advertised, or marketed as a long-term care policy, or which 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 an insured person.

(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. 2281. (1) Group long-term care insurance coverage shall not be offered to a resident of this state under a group policy issued in another state to a group described in section 2280(b)(*iv*), unless this state or another state having statutory and regulatory long-term care insurance requirements substantially similar to those adopted in this state has made a determination that those requirements have been met.

(2) Before advertising, marketing, or offering a group long-term care insurance policy within this state to a group described in section 2280(b)(*iii*), the group or the insurer 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 insurance. 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 2280(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. 2282. The commissioner may promulgate rules including the following:

(a) Rules establishing standards for the sale of long-term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents if provided in the policy, preexisting conditions, termination of insurance, 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.

(b) Rules establishing loss ratio standards for long-term care insurance policies.

Sec. 2283. (1) Each individual long-term care policy shall contain a guaranteed renewable provision. An insurer shall not cancel or otherwise terminate a long-term care insurance policy on the grounds of the age or the deterioration of the mental or physical health of the insured.

(2) Each group long-term care policy shall contain a conversion provision permitting an individual entitled to benefits under the group policy to elect to convert from the group policy to an individual long-term care policy 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 insurance policy with the same insurer, the long-term care insurance policy shall not contain a provision establishing a new limitation period except with respect to an increase in benefits voluntarily selected by the insured.

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

Sec. 2284. (1) A preexisting condition limitation period in a long-term care insurance policy, other than a group long-term care policy described in section 2280(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 policy provisions and that the longer limitation period will be in the best interest of the public.

(2) A long-term care insurance policy, other than a group long-term care policy described in section 2280(b)(*i*), shall not use a definition of preexisting condition which is more restrictive than the definition in section 2280.

(3) The definition of preexisting condition does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant and, on the basis of the answers on that application, underwrite in accordance with that insurer's established underwriting standards.

(4) Unless otherwise provided in the policy, 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 insurance policy 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. 2285. A long-term care insurance policy shall not condition benefits on the prior institutionalization of the insured.

Sec. 2286. (1) Except as otherwise provided in subsection (2), individual long-term care insurance policyholders shall have the right to return the policy within 30 days after its delivery and to have the entire premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason and benefits have not been incurred under the policy. Long-term care insurance policies shall have a notice prominently printed on the first page of the policy and the outline of coverage stating in substance that the policyholder shall have the right to return the policy within 30 days after its delivery and to have the entire premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason.

(2) A person insured under a long-term care insurance policy issued pursuant to a direct response solicitation shall have the right to return the policy within 30 days after its delivery and to have the entire premium refunded if, after examination, the insured person is not satisfied for any reason. Long-term care insurance policies issued pursuant to a direct response solicitation shall have a notice prominently printed on the first page of the policy and the outline of coverage stating in substance that the insured person shall have the right to return the policy within 30 days after its delivery and to have the entire premium refunded if, after examination, the insured person is not satisfied for any reason. As used in this section, "direct response solicitation" means solicitation in which a representative of the insurer 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. 2290. Each insurance policy that is advertised, marketed, or offered as long-term care insurance or nursing home insurance shall comply with sections 2280 to 2289 and the other applicable provisions of this act.

Sec. 3405. (1) For the purpose of doing business as an organization under the prudent purchaser act, Act No. 233 of the Public Acts of 1984, being sections 550.51 to 550.63 of the Michigan Compiled Laws, an insurer authorized in this state to write disability insurance which 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 Act No. 233 of the Public Acts of 1984.

(2) An insurer may offer disability insurance policies under which the insured persons shall be required, as a condition of coverage, 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 such a policy is offered shall also be offered a policy which:

(a) Does not, as a condition of coverage, require insured persons to obtain services exclusively from health care providers who have entered into prudent purchaser agreements.

(b) Does not 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 insurance policies under which insured persons who elect to obtain hospital, nursing, medical, surgical, or sick-care services from health care providers who have entered into prudent purchaser agreements shall realize a financial advantage or other advantage by selecting such providers. Policies offered pursuant to this subsection shall not, as a condition of coverage, require insured persons to obtain such services exclusively from health care providers who have entered into prudent purchaser agreements. A person to whom such a policy is offered shall also be offered a policy which:

(a) Does not, as a condition of coverage, require insured persons to obtain services exclusively from health care providers who have entered into prudent purchaser agreements.

(b) Does not 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) The rates charged by an insurer for coverage under policies issued under this section shall not be unreasonably lower than what is necessary to meet the expenses of the insurer 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.

(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 shall not be construed to:

(a) Prohibit the formation of a provider panel consisting of a single class of providers when 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 which conforms to the specifications of a purchaser of the coverage authorized by this section so long as 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 which has uniformly applied the standards filed pursuant to section 3(3) of Act No. 233 of the Public Acts of 1984, being section 550.53 of the Michigan Compiled Laws, to contract with any individual provider.

(6) Nothing in this 1984 amendatory act shall apply to any contract which is in existence before December 20, 1984, or the renewal of such contract.

Sec. 3631. (1) For the purpose of doing business as an organization under the prudent purchaser act, Act No. 233 of the Public Acts of 1984, being sections 550.51 to 550.63 of the Michigan Compiled Laws, an insurer authorized to write group disability insurance or family expense insurance which 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 Act No. 233 of the Public Acts of 1984.

(2) An insurer may offer group disability insurance policies or family expense policies under which the insured persons shall be required, as a condition of coverage, to obtain hospital, nursing, medical, surgical, or sick-care services exclusively from health care providers who have entered into prudent purchaser agreements.

(3) An individual who is a member of a group who is offered the option of being under a policy pursuant to subsection (2) shall also be offered the option of being insured under a policy pursuant to subsection (4). This subsection shall only apply if the group to which the individual is a member has 25 or more members or if the provider panel which is providing the services under the group policy is limited by the organization to a specific number pursuant to section 3(1) of the prudent purchaser act.

(4) An insurer may offer group disability insurance policies or family expense policies under which insured persons who elect to obtain hospital, nursing, medical, surgical, or sick-care services from health care providers who have entered into prudent purchaser agreements shall realize a financial advantage or other advantage by selecting such a provider. Policies offered pursuant to this subsection shall not, as a condition of coverage, require insured persons to obtain such services exclusively from health care providers who have entered into prudent purchaser agreements.

(5) An individual who is a member of a group who is offered the option of being insured under a policy pursuant to subsection (2) or (4) shall also be offered the option of being insured under a policy which:

(a) Does not, as a condition of coverage, require insured persons to obtain services exclusively from health care providers who have entered into prudent purchaser agreements.

(b) Does not 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.

(6) Subsection (5) shall only apply if the group to which the individual is a member has 25 or more members and if the group on the effective date of this section had health care coverage through the group sponsor.

(7) The rates charged by an insurer for coverage under policies issued under this section shall not be unreasonably lower than what is necessary to meet the expenses of the insurer 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.

(8) 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 shall not be construed to:

(a) Prohibit the formation of a provider panel consisting of a single class of providers when 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 which conforms to the specifications of a purchaser of the coverage authorized by this section so long as 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 which has uniformly applied the standards filed pursuant to section 3(3) of Act No. 233 of the Public Acts of 1984, being section 550.53 of the Michigan Compiled Laws, to contract with any individual provider.

(9) Nothing in this 1984 amendatory act shall apply to any contract which is in existence before December 20, 1984, or the renewal of such contract.

Sec. 3709. (1) For the purpose of doing business as an organization under the prudent purchaser act, Act No. 233 of the Public Acts of 1984, being sections 550.51 to 550.63 of the Michigan Compiled Laws, an insurer authorized under this chapter to write health insurance which 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 Act No. 233 of the Public Acts of 1984.

(2) An insurer may offer health insurance policies or family expense policies under which the insured persons shall be required, as a condition of coverage, to obtain hospital, nursing, medical, surgical, or sick-care services exclusively from health care providers who have entered into prudent purchaser agreements.

(3) An individual who is a member of a group who is offered the option of being insured under a policy pursuant to subsection (2) shall also be offered the option of being insured under a policy pursuant to subsection (4). This subsection shall only apply if the group to which the individual is a member has 25 or more members or if the provider panel which is providing the services under the group policy is limited by the organization to a specific number pursuant to section 3(1) of Act No. 233 of the Public Acts of 1984, being section 550.53 of the Michigan Compiled Laws.

(4) An insurer may offer health insurance policies under which insured persons who elect to obtain hospital, nursing, medical, surgical, or sick-care services from health care providers who have entered into prudent purchaser agreements shall realize a financial advantage or other advantage by selecting such providers. Policies offered pursuant to this subsection shall not, as a condition of coverage, require insured persons to obtain services exclusively from health care providers who have entered into prudent purchaser agreements.

(5) An individual who is a member of a group who is offered the option of being insured under a policy pursuant to subsection (2) or (4) shall also be offered the option of being insured under a policy which:

(a) Does not, as a condition of coverage, require insured persons to obtain services exclusively from health care providers who have entered into prudent purchaser agreements.

(b) Does not 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.

(6) Subsection (5) shall only apply if the group to which the individual is a member has 25 or more members and if the group on December 20, 1984 had health care coverage through the group sponsor.

(7) The rates charged by an insurer for coverage under policies issued under this section shall not be unreasonably lower than what is necessary to meet the expenses of the insurer 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.

(8) 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 shall not be construed to:

(a) Prohibit the formation of a provider panel consisting of a single class of providers when 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 which conforms to the specifications of a purchaser of the coverage authorized by this section so long as 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 which has uniformly applied the standards filed pursuant to section 3(3) of Act No. 233 of the Public Acts of 1984, being section 550.53 of the Michigan Compiled Laws, to contract with any individual provider.

(9) Nothing in this 1984 amendatory act shall apply to any contract which is in existence before December 20, 1984, or the renewal of such contract.

Section 2. This amendatory act shall not take effect unless Senate Bill No. 311 of the 85th Legislature is enacted into law.

Section 3. Sections 2280, 2281, 2282, 2283, 2284, 2285, 2286, and 2290 of Act No. 218 of the Public Acts of 1956, as added by 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.