

SENATE BILL No. 97

February 2, 1989, Introduced by Senators KELLY, MILLER, J. HART,
DINGELL, V. SMITH, SCHWARZ, GEO. HART, POLLACK, HOLMES, VAUGHN
AND MACK and referred to the Committee on Commerce and Technology.

A bill to establish a health benefit plan; to establish a universal health care insurance fund; to provide for employer, employee, and state contributions to the fund; to establish an advisory board; to prescribe the powers and duties of certain state agencies, departments, and persons; to provide standards, requirements, and certification for certain insurers; and to prescribe penalties.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

ARTICLE 1

1

2

Sec. 1. This act shall be known and may be cited as the "universal health care insurance and safety net act".

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Sec. 2. As used in this act:

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(a) "Administrative procedures act of 1969" means the administrative procedures act of 1969, Act No. 306 of the Public

1 Acts of 1969, being sections 24.201 to 24.328 of the Michigan
2 Compiled Laws.

3 (b) "Advisory board" means the board created in section 21.

4 (c) "Child" means an individual less than 18 years of age or
5 if a full-time student, less than 23 years of age.

6 (d) "Commissioner" means the commissioner of insurance.

7 (e) "Director" means the director of the department of
8 public health.

9 (f) "Employee" means an individual employed by an employer
10 for 17-1/2 or more hours per week who is not a temporary
11 employee.

12 (g) "Employee's family" means the spouse and children of an
13 employee.

14 (h) "Employer" means a person who employs in 1989 through
15 1995, an average of 10 or more; in 1996 through 1999, 7 or more;
16 and in 2000 and thereafter 4 or more individuals for 17-1/2 or
17 more hours per week and who is required to pay the individuals it
18 employs the minimum wage prescribed by section 6 of the fair
19 labor standards act of 1938, 29 U.S.C. 206, or would be required
20 to pay the minimum wage but for section 3(s) or section 13(a) of
21 the fair labor standards act of 1938.

22 (i) "General assistance recipient" means an individual who
23 is eligible to receive medical services under section 55 of the
24 social welfare act, Act No. 280 of the Public Acts of 1939, being
25 section 400.55 of the Michigan Compiled Laws.

26 (j) "Health benefit plan" means a plan as described in
27 article 2 that provides medical care to participants or

1 beneficiaries directly or through insurance, reimbursement, or
2 otherwise.

3 (k) "Health insurance zone" means the county or counties
4 participating in a universal health care insurance fund under
5 article 3.

6 (l) "Indemnity plan" means a health benefit plan that makes
7 payment with respect to items and services furnished by a pro-
8 vider with a certificate of authority in this state to provide
9 the items and services if the provider is a type of provider cov-
10 ered under the plan, the provider is not excluded from receiving
11 payment under the plan on the basis of fraud, abuse, or incompe-
12 tence, and the plan does not differentiate in payment to provid-
13 ers under the plan based on a contractual arrangement or lack of
14 a contractual arrangement between the plan and the provider, and
15 under which an individual incurs an obligation or makes payment
16 for a covered item or service and the plan reimburses the indi-
17 vidual or the provider of the services for the amounts payable
18 for the item or service under the plan.

19 (m) "Managed-care plan" means a health maintenance organi-
20 zation, preferred provider, or other health benefit plan under
21 which items or services must generally be furnished either by
22 providers having a contractual relationship with the plan or pro-
23 viders included on a list specified by the plan.

24 (n) "Medicaid recipient" means an individual eligible to
25 receive medical services under the medical assistance program
26 administered under the social welfare act.

1 (o) "Monthly actuarial rate" means, with respect to a health
2 benefit plan in a plan year, the average monthly per enrollee
3 amount that the employer providing the plan estimates, for
4 enrollees under the plan during the year, would be necessary to
5 pay for the total benefits required under the plan during the
6 year, including administrative costs for the provision of the
7 benefits and an appropriate amount for a contingency margin.

8 (p) "Person" means an individual, corporation, partnership,
9 firm, organization, or association.

10 (q) "Taxable income" means that term as defined in
11 section 28 of the income tax act of 1967, Act No. 281 of the
12 Public Acts of 1967, being section 206.28 of the Michigan
13 Compiled Laws.

14 (r) "Temporary employee" means an individual employed by a
15 temporary help services firm who is assigned to perform duties
16 for a person and who is not assigned to perform and complete 300
17 hours or more of service for a temporary help services firm on
18 behalf of 1 or more persons in a period of 6 consecutive months.

19 (s) "Temporary help services firm" means a person engaged in
20 the business of furnishing temporary employees for another
21 person.

22 (t) "Universal health care insurance fund" means a fund
23 established under section 40.

24 Sec. 3. (1) An employer's employee and the employee's
25 family shall be provided with a health benefit plan pursuant to
26 this act.

1 (2) Subsection (1) shall not apply to an employer who
2 provides its employees with a health benefit plan that is
3 actuarially equivalent as determined by the commissioner to the
4 health benefit plan provided for in article 2.

5 Sec. 4. (1) An employer who does not provide a health bene-
6 fit plan that is actuarially equivalent to the health benefit
7 plan provided for in this act shall do all of the following:

8 (a) Contribute to the universal health care insurance fund
9 collected as part of the withholdings of employees for payroll
10 taxes in the insurance zone where the employee is employed an
11 amount equal to 3% of each of its employee's taxable incomes.

12 (b) Contribute to the universal health care insurance fund
13 in the insurance zone where the employee is employed by withhold-
14 ing from each employee who is not a participant in a health bene-
15 fit plan an amount equal to 3% of the employee's taxable income.

16 (2) The amounts paid by the employer and withheld on behalf
17 of an employee under this section shall accrue on the last day of
18 the month in which they are withheld and shall be returned and
19 paid to the universal health care insurance fund by the employer
20 within 15 days after the end of the month in the same manner as
21 other payroll taxes.

22 (3) An employer required by this section to pay an amount
23 and withhold an amount holds the amount withheld as a trustee for
24 the universal health care insurance fund and is liable for the
25 payment thereof to the universal health care insurance fund and
26 is not liable to any individual for the amount of the payment.

1 Sec. 5. For each employee whose employer pays an amount and
2 withholds an amount under section 4, the state shall pay to the
3 universal health care insurance fund in the insurance zone where
4 the employee is employed an amount equal to 3% of the employee's
5 taxable income.

6 Sec. 6. For each medicaid recipient and general assistance
7 recipient who resides in an insurance zone, the state shall pay
8 to the universal health care insurance fund located in that
9 insurance zone an amount equal to 9% of the average taxable
10 income paid for an employee in the county whose employer pays an
11 amount and withholds an amount under section 4.

12 Sec. 7. (1) An employer who violates this act by not con-
13 tributing or by failing to withhold under section 4 is subject to
14 a fine of not more than 10% of the total amount of the employer's
15 expenditures for wages for employees in that year, in addition to
16 an assessment to cover all back contributions of the employee,
17 employer, and the state without a right to contribution.

18 (2) A fine under this section shall be assessed by the
19 director. The director shall not assess a fine on an employer
20 until the employer has been given notice and an opportunity to
21 present its views.

22 (3) In determining the amount of the fine, the director
23 shall consider the gravity of the noncompliance and the demon-
24 strated good faith of the employer charged in attempting to
25 achieve rapid compliance after notification of noncompliance by
26 the director.

1 (4) An employer that knowingly does not comply with
2 section 3 or section 4 shall be liable for damages including
3 health care costs incurred to the employee or the employee's
4 family resulting from the failure to comply.

5 (5) An individual injured or adversely affected or aggrieved
6 by a violation of the requirements of this act may bring an
7 action to enjoin the violation or to compel compliance. In a
8 judicial proceeding under this subsection, the court, in its dis-
9 cretion, may allow the party bringing the action a reasonable
10 attorney's fee as part of costs if the party substantially
11 prevails. At least 15 days before the date a party brings an
12 action under this subsection, the party shall give notice by reg-
13 istered mail to the director and the attorney general. The
14 notice shall state the nature of the alleged violation and the
15 court in which the action will be brought.

16 Sec. 8. (1) Except as otherwise provided, an employee may
17 not waive his or her enrollment in a health benefit plan or his
18 or her family's enrollment in a health benefit plan under this
19 act.

20 (2) An employee may waive enrollment in a health benefit
21 plan for his or her spouse or child under this act if the spouse
22 or child is covered under a health benefit plan due to the
23 employment of the spouse or the child's other parent.

24 (3) A child employee may waive enrollment in a health bene-
25 fit plan under this act if the child is covered under a health
26 benefit plan due to the employment of the child's parent.

1 (4) An employee who works 17-1/2 hours or more of service
2 per week for 2 employers may waive enrollment in a health benefit
3 plan of 1 of the employers.

4 (5) An employer may not fail or refuse to hire, discharge,
5 or otherwise discriminate against any individual who has a spouse
6 or child because the employer is required to comply with this
7 act.

8 ARTICLE 2

9 Sec. 20. (1) A health benefit plan shall do all of the
10 following:

11 (a) Provide benefits for items and services pursuant to
12 section 22.

13 (b) Provide coverage of employees and employees' families
14 enrolled in the plan pursuant to section 24.

15 (c) Provide for premiums, deductibles, copayments, and coin-
16 surance pursuant to section 27.

17 (2) A health benefit plan meets the requirements of this
18 article notwithstanding that it does not meet 1 or more require-
19 ments of section 22 if the actuarial benefits under the plan are
20 not less than the actuarial benefits that would have applied if
21 the plan met the requirements described in subsection (1).

22 (3) Notwithstanding any other provision of law, a health
23 benefit plan may meet the requirements of section 22(1)(e) by
24 including payment for any combination of benefits specified in
25 section 22(1)(e) if the plan includes payment for benefits that
26 are actuarially equivalent to the benefits for which payment is

1 required and if the plan provides both types of benefits
2 described in section 22(1)(e).

3 Sec. 21. (1) The commissioner shall establish an advisory
4 board to advise the director on the development of actuarial
5 equivalency standards and other matters relating to the adminis-
6 tration of this act.

7 (2) The board shall consist of 10 members appointed by the
8 commissioner as follows:

9 (a) Four members representing employers, who shall be
10 experienced in the administration of and knowledgeable about
11 health insurance and shall be actively engaged in the management
12 or design of health insurance programs.

13 (b) Two members representing labor organizations, who shall
14 be experienced in the administration of and knowledgeable about
15 health insurance and shall be actively engaged in the management
16 or design of health insurance programs.

17 (c) Two members representing the insurance industry, at
18 least 1 of whom shall be knowledgeable about small group
19 policies.

20 (d) Two members who are actuaries, experienced in the admin-
21 istration of and knowledgeable about health insurance programs.

22 (3) Members of the board shall serve for a term of 4 years,
23 except that members first appointed shall serve for staggered
24 terms, as designated by the commissioner. A member may serve on
25 the board after the expiration of the term of the member until a
26 successor has taken office as a member of the board.

1 (4) The members of the board shall receive per diem expenses
2 and compensation as established by the legislature and shall be
3 entitled to receive actual and necessary travel expenses.

4 (5) The board shall develop and transmit to the director all
5 of the following:

6 (a) At least 3 model health plans that are actuarially
7 equivalent to the minimum health benefit plan required under this
8 act.

9 (b) A table of actuarial equivalency describing permitted
10 variations in covered services, copayments, deductibles, limits
11 on out-of-pocket expenses, and an employer's share of the premium
12 or premiums under an optional, enhanced health benefit plan as a
13 percentage increase or decrease in the minimum plan, with the
14 table describing as many variations as possible in order to
15 facilitate compliance with this act.

16 (c) Recommendations for procedures to facilitate the process
17 by which an employer may certify actuarial equivalency for plan
18 variations not provided in the model health benefit plans or the
19 table of actuarial equivalency and for certification of multiple
20 plans offered by the same employer.

21 (6) The board shall review proposed changes and options to
22 the health benefit package required in the minimum plan and
23 options such as vision, dental, and prescriptions and transmit a
24 cost benefit analysis of the changes or options, along with rec-
25 ommendations, to the director and to the legislature.

26 (7) The director shall publish a table that describes
27 variations in covered services, copayments, deductibles, limits

1 on out-of-pocket expenses, and an employer's share of the premium
2 or premiums under an optional, enhanced health benefit plan as a
3 percentage increase or decrease in the minimum plan. The table
4 shall describe as many variations as feasible. In developing the
5 table, the director shall consider the recommendations of the
6 board.

7 (8) If a health benefit plan provides variations not
8 expressly provided for in the table or if the 1 or more elements
9 of covered services, copayments, deductibles, and limits on
10 out-of-pocket services are given a different relative value by a
11 health benefit plan administrator than is provided by the table,
12 the plan shall not be considered out of compliance with this act
13 if the plan has established actuarial equivalency by a good faith
14 process and has been certified as actuarially equivalent by an
15 actuary meeting credentials established by the American academy
16 of actuaries or by the director.

17 (9) A health benefit plan shall be considered out of compli-
18 ance with this act if the director has found the plan not to be
19 in compliance. If the plan is found not to be in compliance, a
20 penalty shall not be levied against the plan for the prior period
21 of noncompliance if the plan complies with subsection (8).

22 (10) The director shall establish rules pursuant to the
23 administrative procedures act of 1969 that provide for a stream-
24 lined procedure for an employer that has multiple health plans,
25 at least 1 of which has been certified as at least actuarially
26 equivalent, for the approval of an additional health plan that is
27 at least actuarially equivalent to the certified plan.

1 (11) For purposes of this section, "actuarial benefits"
2 means the amount by which the total of the amounts payable as
3 benefits under a health benefit plan exceed the amount of the
4 premiums, deductibles, copayments, and coinsurance payable by the
5 employee under the plan, as determined on an actuarial basis per
6 enrollee for a plan year.

7 Sec. 22. (1) A health benefit plan shall include payment
8 for all of the following:

9 (a) Inpatient and outpatient hospital care.

10 (b) Inpatient and outpatient physician services.

11 (c) Diagnostic and screening tests.

12 (d) Prenatal care and well-baby care provided to children
13 who are 1-year old or younger.

14 (e) Optional mental health care if elected as follows:

15 (i) Inpatient hospital care for a mental disorder for not
16 less than 45 days per year except that days of inpatient care may
17 be substituted for days of partial hospitalization according to a
18 ratio established by the director.

19 (ii) Outpatient psychotherapy and counseling for a mental
20 disorder for not less than 20 visits per year provided by a phy-
21 sician, a licensed or certified clinical psychologist, a certi-
22 fied social worker, or other licensed or certified mental health
23 professional or licensed or certified clinic or center providing
24 mental health services.

25 (2) A health benefit plan is not required to provide payment
26 for items and services that are not medically necessary or that
27 are experimental services and procedures.

1 Sec. 23. The director shall prescribe and annually revise a
2 schedule specifying the amount, duration, and scope of well-baby
3 care required under section 22(1)(d).

4 Sec. 24. Coverage for an employee and the employee's family
5 enrolled under a health benefit plan provided by an employer
6 under this act shall begin not later than the latest of the
7 following:

8 (a) Thirty days after the day on which the employee first
9 performs an hour of service as an employee of that employer.

10 (b) The first day on which the employer is required to meet
11 the requirements of this act.

12 Sec. 25. A health benefit plan under this act may not
13 exclude or otherwise limit an individual from coverage under the
14 plan on the basis that the individual has, or at any time has
15 had, any disease, disorder, or condition; however, a preexisting
16 condition of 6 months or more shall be eligible only according to
17 the standards and guidelines of the medicaid program reinsurance
18 fund.

19 Sec. 26. A temporary employee shall become eligible for
20 coverage under a health benefit plan of a temporary services firm
21 on the first day of the first calendar month following the com-
22 pletion of 320 hours of service during a period of 6 consecutive
23 months if employed by the employer on the eligibility date and
24 shall be eligible for continued coverage under this act in each
25 calendar month following the month of initial coverage, if the
26 employee has completed at least 70 hours of service in the

1 immediately preceding calendar month and has not been terminated
2 before the first day of the calendar month.

3 Sec. 27. (1) A health benefit plan may require an employee
4 enrollee to pay for premiums, deductibles, and coinsurance
5 amounts for coverage under the plan, but only if the premiums,
6 deductibles, copayments, and coinsurance do not exceed the limi-
7 tations imposed under this section.

8 (2) A health benefit plan may not require an employee to pay
9 a premium for coverage for a period of longer than 1 month or to
10 pay a premium the amount of which on a monthly basis exceeds 3%
11 of the employee's hourly wage.

12 Sec. 28. A health benefit plan may provide for the optional
13 premiums to be applied and the monthly actuarial rate to be com-
14 puted separately for employees without a family and for employees
15 with a family, and with respect to employees with a family, to be
16 computed separately for employees who have a spouse and children,
17 for employees who have a spouse but no children, and for employ-
18 ees who do not have a spouse but have children. However, the
19 basic insurance program shall be extended to every child of an
20 employee, and no employer shall discriminate against any individ-
21 ual who has dependents from participating in the program or
22 employment.

23 Sec. 29. (1) Except as permitted under subsection (3), a
24 health benefit plan may not provide, for benefits provided in any
25 plan year, for a deductible amount that exceeds the following:

26 (a) For benefits payable for items and services furnished to
27 an employee with no family member enrolled under the plan, for a

1 plan year beginning in the first calendar year that begins more
2 than 1 year after the date of the enactment of this act, \$150.00,
3 or for a subsequent calendar year, the limitation of deductions
4 specified in this subdivision for the previous calendar year
5 increased by the percentage increase in the Detroit consumer
6 price index for the 12-month period ending on September 30 of the
7 preceding calendar year.

8 (b) For benefits payable for items and services furnished to
9 an employee with a family member enrolled under the plan, for a
10 plan year beginning in the first calendar year that begins more
11 than 1 year after the date of the enactment of this act, \$250.00,
12 or for a subsequent calendar year, the limitation of deductions
13 specified in this subdivision for the previous calendar year
14 increased by the percentage increase in the Detroit consumer
15 price index for the 12-month period ending on September 30 of the
16 preceding calendar year.

17 (2) A health benefit plan may not provide, for benefits pro-
18 vided in any plan year, for a deductible amount for prenatal care
19 or well-baby care described in section 22(1)(d).

20 (3) A health benefit plan may provide for another deductible
21 amount instead of the limitations under subsection (1)(a) if the
22 amount does not exceed, on an annualized basis, 1% of the total
23 wages paid to the employee in the plan year, or for another
24 deductible amount instead of the limitations under subsection
25 (1)(b) if the amount does not exceed, on an annualized basis, 2%
26 of the total wages paid to the employee in the plan year.

1 Sec. 30. (1) Except as otherwise provided in this section,
2 a health benefit plan shall not require payment of any copayment
3 or coinsurance for an item or service for which coverage is
4 required by this act in an amount that exceeds 10% of the cost of
5 the item or service, require payment of any copayment or coinsur-
6 ance for prenatal care or well-baby care described in
7 section 22(1)(d), or require payment of any copayment or coinsur-
8 ance for items and services required under section 22 furnished
9 in a plan year for an employee after the employee has incurred
10 out-of-pocket expenses under the plan that are equal to the
11 out-of-pocket limit.

12 (2) If a health benefit plan establishes reasonable classi-
13 fications of participating and nonparticipating providers of
14 items and services, the plan may require payments in excess of
15 the amount permitted under subsection (1) for items and services
16 furnished by nonparticipating providers.

17 (3) A health benefit plan may provide for copayment or coin-
18 surance in excess of the amount permitted under subsection (1)
19 for any item or service that an individual obtains without com-
20 plying with any reasonable procedures established by the plan to
21 ensure the efficient and appropriate utilization of covered
22 services.

23 (4) For care provided under section 22(1)(e)(ii), a health
24 benefit plan may not require payment of any copayment or coinsur-
25 ance for an item or service for which coverage is required by
26 this act in an amount that exceeds 50% of the cost of the item or
27 service.

1 (5) A health benefit plan under this act may provide for an
2 out-of-pocket limit other than that defined in subsection (6)(b)
3 if, for a plan year with respect to an employee and the
4 employee's family, the limit does not exceed, on an annualized
5 basis, 10% of the total wages paid to the employee in the plan
6 year.

7 (6) As used in this section:

8 (a) "Out-of-pocket expenses" means, with respect to an
9 employee in a plan year, amounts payable under the plan as
10 deductibles and coinsurance with respect to items and services
11 provided under the plan and furnished in the plan year on behalf
12 of the employee and the employee's family covered under the
13 plan.

14 (b) "Out-of-pocket limit" means for a plan year beginning in
15 the first calendar year that begins more than 1 year after the
16 effective date of this act, \$1,000.00, or for a subsequent calen-
17 dar year, the out-of-pocket limit of \$1,000.00 for the previous
18 calendar year increased by the percentage increase in the Detroit
19 consumer price index for the 12-month period ending on
20 September 30 of the preceding calendar year.

21 ARTICLE 3

22 Sec. 40. There is created within each health insurance zone
23 a universal health care insurance fund. The universal health
24 care insurance fund shall receive the amounts described in
25 section 4(1) and sections 5 and 6 and may accept other grants,
26 gifts, and funds.

1 Sec. 41. The universal health care insurance fund shall be
2 operated by a board of directors in each insurance zone composed
3 of the following 9 members:

4 (a) Three members elected by employers contributing to the
5 fund under section 4(1)(a).

6 (b) Three members elected by employees contributing to the
7 fund under section 4(1)(b) and by the medicaid recipients and the
8 general assistance recipients benefited by the universal health
9 care insurance fund in the insurance zone.

10 (c) Two members appointed by the county board of commission-
11 ers, or if a charter county, by the county executive in the
12 county or counties in the health insurance zone.

13 (d) One member who shall serve as chair of the board of
14 directors selected by the director of the department of public
15 health, and appointed by the governor with the advice and consent
16 of the senate.

17 Sec. 43. A county with a population of less than 500,000
18 residents may agree to form a universal health care insurance
19 fund in an insurance zone with another county or counties. A
20 universal health care insurance fund in an insurance zone that
21 consists of more than 1 county shall be operated by a board of
22 directors composed of the members listed in section 41, except
23 that if 2 counties participate, each county shall have a total of
24 6 members with 2 members elected under section 41(a), 2 members
25 elected under section 41(b), and 2 members appointed under
26 section 41(c), and if 3 or more counties participate, each county
27 shall have a total of 3 members with 1 member elected under

1 section 41(a), 1 member elected under section 41(b), and 1 member
2 appointed under section 41(c).

3 Sec. 44. The board of directors of the universal health
4 care insurance fund shall do all of the following:

5 (a) Select, monitor, and oversee the insurance providers
6 participating in providing service for the universal health care
7 insurance fund in the insurance zone.

8 (b) Designate hospitals, clinics, and providers eligible to
9 participate in providing services for the universal health care
10 insurance fund in the insurance zone.

11 (c) Evaluate and make recommendations concerning coverage
12 and programs being offered by the universal health care insurance
13 fund in the insurance zone.

14 Sec. 45. The commissioner shall establish procedures for
15 the periodic certification of participating insurers in a univer-
16 sal health care insurance fund. To be certified as an insurer
17 under this article, the applicant shall do all of the following:

18 (a) Meet standards of financial stability established by the
19 commissioner.

20 (b) Meet standards for quality and type of services estab-
21 lished by the commissioner.

22 (c) Meet the requirements of section 47.

23 (d) Agree to enroll any group in the state applying for
24 enrollment that is eligible to enroll with a participating
25 insurer.

1 (e) Agree to offer only plans and plan options approved by
2 the commissioner to organizations required to enroll with a
3 participating insurer.

4 (f) Agree that if it offers a managed care program to an
5 organization within the state, it will also make that managed
6 care program, with benefits packages meeting the requirements of
7 section 47, available in its capacity as participating insurer.

8 (g) Agree to allow its offerings to be listed in material
9 distributed by the commissioner, described in a form as the com-
10 missioner may prescribe, and to enroll persons who wish to enroll
11 by mail by accepting a completed form to be contained in the
12 material.

13 Sec. 46. (1) To be certified as a participating insurer in
14 a universal health care insurance fund, the insurer shall submit
15 to the commissioner an application for certification. The appli-
16 cation shall include the following:

17 (a) Specific descriptions of each of the health benefit
18 plans the insurer proposes to offer under section 47 as a partic-
19 ipating insurer.

20 (b) Information as is needed for the commissioner to con-
21 sider the items described in subsection (2).

22 (2) In reviewing applications for certification as partici-
23 pating insurers, the commissioner shall consider all of the
24 following:

25 (a) The price of health benefit plans proposed to be offered
26 by the applicant.

1 (b) The quality and types of services to be provided under
2 the plans.

3 (c) The experience of the applicant in providing and manag-
4 ing health benefit plans.

5 (d) The financial stability of the applicant.

6 (3) Not later than 1 year after the effective date of this
7 act, the commissioner shall certify participating insurers for
8 each universal health care insurance fund. The commissioner
9 shall publish in the Michigan register a list of the participat-
10 ing insurers certified under this section.

11 (4) The commissioner shall periodically evaluate the per-
12 formance of participating insurers under this act. If the com-
13 missioner finds that a participating insurer is not substantially
14 meeting the requirements of this act, the commissioner, after
15 notice and opportunity for a hearing, may terminate the certifi-
16 cation of the insurer.

17 Sec. 47. (1) A participating insurer shall offer to employ-
18 ers located in its health insurance zone either of the
19 following:

20 (a) Two indemnity plans, 1 of which provides only the mini-
21 mum benefits required of a health benefit plan under this act and
22 the other which provides benefits typical of the benefits offered
23 under comprehensive health benefit plans offered in the health
24 insurance zone.

25 (b) Two managed-care plans, 1 of which provides only the
26 minimum benefits required of a health benefit plan under this act
27 and the other of which provides benefits typical of the benefits

1 offered under comprehensive health benefit plans offered in the
2 health insurance zone.

3 (2) For a plan described in subsection (1)(a) or (b), a par-
4 ticipating insurer shall provide optional, additional benefits
5 for an additional premium. The options shall include variations
6 in copayments, deductibles, and the catastrophic cap, and addi-
7 tional services and categories of providers including dental,
8 vision, and hearing. The benefits shall be subject to approval
9 by the commissioner and, to the maximum extent feasible, shall be
10 standard across carriers within a zone of the state.

11 Sec. 48. Each participating insurer shall fix optional pre-
12 miums for the plans required under section 47 under a community
13 rating system for all employers. An insurer may not set or
14 adjust these premiums based on the age or gender of employees or
15 employees' families, on other factors relating to the projected
16 or actual use of health services under the plan, or on geograph-
17 ical location within the health insurance zone.

18 Sec. 49. (1) Each participating insurer in a universal
19 health care insurance fund may enter into subcontracts with other
20 entities in carrying out this act. The commissioner shall
21 encourage participating insurers to enter into appropriate
22 arrangements with entities representing business groups for the
23 provision of administrative services with respect to businesses
24 enrolled in plans offered by the insurers. Each such insurer
25 shall reduce the premiums otherwise charged for the health bene-
26 fit plans to such businesses by an amount that reflects the value
27 of the administrative services.

1 (2) The commissioner shall provide technical assistance and
2 enrollment forms to employers required under this act to provide
3 health benefit plans. In carrying out this subsection, the com-
4 missioner shall, to the maximum extent feasible, enter into con-
5 tracts with business service bureaus, chambers of commerce, and
6 other entities with experience in providing health insurance
7 services to businesses.

8 Sec. 50. This act shall take effect January 1, 1990.