HOUSE BILL No. 4279

February 25, 2003, Introduced by Reps. O'Neil and Ehardt and referred to the Committee on Health Policy.

A bill to amend 1980 PA 350, entitled

"The nonprofit health care corporation reform act,"

by amending sections 107, 201, 204, 206, 207, 211, 401, 502, 602, 608, 609, 610, 611, 612, 613, and 614 (MCL 550.1107, 550.1201, 550.1204, 550.1206, 550.1207, 550.1211, 550.1401, 550.1502, 550.1602, 550.1608, 550.1609, 550.1610, 550.1611, 550.1612, 550.1613, and 550.1614), section 207 as amended by 1999 PA 210, section 211 as amended by 1993 PA 127, section 401 as amended by 2000 PA 26, section 502 as amended by 1998 PA 446, section 608 as amended by 1991 PA 73, and section 609 as amended by 1991 PA 61, and by adding sections 204a, 205a, 422c, 608a, 608b, 608c, 608d, and 620; and to repeal acts and parts of acts.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Sec. 107. (1) "Participating provider" means a provider that has entered into a participating contract with a health care

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corporation and that meets the standards set by the corporation for that class of providers.

(2) "Participating contract" means an agreement, contract, or other arrangement under which a provider agrees to accept the payment of the health care corporation as payment in full for health care services or parts of health care services covered under a certificate, as provided for in section 502(1).

(3) "Person" means an individual, corporation, partnership, organization, **limited liability company,** or association.

(4) "Personal data" means a document incorporating medical or surgical history, care, treatment, or service; or any similar record, including an automated or computer accessible record, relative to a member, which is maintained or stored by a health care corporation.

(5) "Proposed rate" means any of the following:

(a) A proposed increase or decrease in the rates to be charged to nongroup subscribers.

(b) For group subscribers, any proposed changes in the methodology or definitions of any rating system, formula, component, or factor subject to prior approval by the commissioner.

(c) A proposed increase or decrease in deductible amounts or coinsurance percentages.

(d) A proposed extension of benefits, additional benefits, or a reduction or limitation in benefits.

~~(e) A review pursuant to section 608(2).~~

(6) "Provider class" means classes of providers, as defined

in section 105(4), that have a provider contract or a reimbursement arrangement with a health care corporation to render health care services to subscribers, as those classes are established by the corporation.

(7) "Provider class plan" or "plan" means a document containing a reimbursement arrangement and objectives for a provider class, and, in the case of those providers with which a health care corporation contracts, provisions that are included in that contract.

(8) "Provider contract" or "contract" means an agreement between a provider and a health care corporation that contains provisions to implement the provider class plan.

Sec. 201. (1) A health care corporation shall not be incorporated in this state except under this act.

(2) Not less than 7 persons, all of whom shall be residents of this state, may form a health care corporation under this act for the purpose of providing 1 or more health care benefits at the expense of the corporation to persons or groups of persons who become subscribers to the plan, under certificates ~~which~~ **that** will entitle each subscriber to certain health care services by providers with which the corporation has contracted for that purpose.

(3) A certificate shall not provide for the payment of cash or any other material benefit to a subscriber or the estate of a subscriber on account of death, illness, or injury except where payment is made to a subscriber for health care services by a provider who has not entered into a participating contract with

the corporation or to reimburse a subscriber who has made, or is obligated to make, payment directly to a provider.

(4) A health care corporation ~~shall~~ **is** not ~~be~~ subject to the laws of this state with respect to insurance corporations, except as provided in this act. A health care corporation ~~shall~~ **is** not ~~be~~ subject to the laws of this state with respect to corporations generally.

(5) A health care corporation subject to this act is declared to be a charitable and benevolent institution, and its funds, ~~and~~ property, ~~shall be~~ **and activities are** exempt from taxation by this state or any political subdivision of this state.

(6) A person shall not act as a health care corporation or issue a certificate except as authorized by and pursuant to a certificate of authority granted to the person by the commissioner pursuant to this act.

(7) A health care corporation shall provide only the kinds of health care benefits and certificates authorized by this act. A health care corporation shall not make or issue a certificate relative to health care benefits except as approved or otherwise authorized under this act.

Sec. 204. (1) Before entering into contracts or securing applications of subscribers, the persons incorporating a health care corporation shall file all of the following in the office of the commissioner:

(a) Three copies of the articles of incorporation, with the certificate of the attorney general required under section 202(3)

attached.

(b) A statement showing in full detail the plan upon which the corporation proposes to transact business.

(c) A copy of all certificates to be issued to subscribers.

(d) A copy of the financial statements of the corporation.

(e) Proposed advertising to be used in the solicitation of certificates for subscribers.

(f) A copy of the bylaws.

(g) A copy of all proposed contracts and reimbursement methods.

(2) The commissioner shall examine the statements and documents filed under subsection (1), may conduct any investigation ~~which~~ **that** he or she considers necessary, may request additional oral and written information from the incorporators, and may examine under oath any persons interested in or connected with the proposed health care corporation. The commissioner shall ascertain whether all of the following conditions are met:

(a) The solicitation of certificates will not work a fraud upon the persons solicited by the corporation.

(b) The rates to be charged and the benefits to be provided are adequate, equitable, and not excessive, as defined in section 609.

(c) The amount of money actually available for working capital is sufficient to carry all acquisition costs and operating expenses for a reasonable period of time from the date of issuance of the certificate of authority, and is not less than

$500,000.00 or a greater amount, if the commissioner considers it necessary.

(d) The amounts contributed as the working capital of the corporation are payable only out of amounts in excess of minimum required reserves of the corporation.

(e) Adequate and ~~reasonable reserves are provided, as defined in section 205~~ **unimpaired surplus is provided, as determined under section 204a**.

(3) If the commissioner finds that the conditions prescribed in subsection (2) are met, the commissioner shall do all of the following:

(a) Return to the incorporators 1 copy of the articles of incorporation, certified for filing with the ~~chief officer~~ **director** of the department of ~~commerce~~ **consumer and industry services** or of any other agency or department authorized by law to administer ~~Act No. 284 of the Public Acts of 1972, as amended, being sections 450.1101 to 450.2099 of the Michigan Compiled Laws~~ **the business corporation act, 1972 PA 284, MCL 450.1101 to 450.2098**, or his or her designated representative, and 1 copy of the articles of incorporation certified for the records of the corporation itself.

(b) Retain 1 copy of the articles of incorporation for the commissioner's office files.

(c) Deliver to the corporation a certificate of authority to commence business and to issue certificates ~~which~~ **that** have been approved by the commissioner, or ~~which~~ **that** are exempted from prior approval pursuant to section 607(2) or (7), entitling

subscribers to certain health care benefits.

Sec. 204a. (1) A health care corporation shall possess and maintain unimpaired surplus in an amount determined adequate by the commissioner to comply with section 403 of the insurance code of 1956, 1956 PA 218, MCL 500.403. The commissioner shall follow the risk-based capital requirements as developed by the national association of insurance commissioners in order to determine whether a health care corporation is in adequate compliance with section 403 of the insurance code of 1956, 1956 PA 218, MCL 500.403.

(2) If a health care corporation files a risk-based capital report that indicates that its surplus is less than the amount determined adequate by the commissioner under subsection (1), the health care corporation shall prepare and submit a plan for remedying the deficiency in accordance with risk-based capital requirements adopted by the commissioner. Among the remedies that a health care corporation may employ are planwide viability contributions to surplus by subscribers.

(3) If contributions for planwide viability under subsection (2) are employed, those contributions shall be made in accordance with the following:

(a) If the health care corporation's surplus is less than 200% but more than 150% of the authorized control level under risk-based capital requirements, the maximum contribution rate shall be 0.5% of the rate charged to subscribers for the benefits provided.

(b) If the health care corporation's surplus is 150% or less

than the authorized control level under risk-based capital requirements, the maximum contribution rate shall be 1% of the rate charged to subscribers for the benefits provided.

(c) The actual contribution rate charged is subject to the commissioner's approval.

(4) As used in subsection (3), "authorized control level" means the number determined under the risk-based capital formula in accordance with the instructions developed by the national association of insurance commissioners and adopted by the commissioner.

Sec. 205a. A health care corporation shall report financial information in conformity with sound actuarial practices and statutory accounting principles, including approved permitted practices, in the same manner as designated by the commissioner for other carriers pursuant to section 438(2) of the insurance code of 1956, 1956 PA 218, MCL 500.438.

Sec. 206. (1) The funds and property of a health care corporation shall be acquired, held, and disposed of only for the lawful purposes of the corporation and for the benefit of the subscribers of the corporation as a whole. A health care corporation shall only transact ~~such~~ business, receive, collect, and disburse ~~such~~ money, and acquire, hold, protect, and convey ~~such~~ property, ~~as are~~ **that is** properly within the scope of the purposes of the corporation as specifically set forth in section 202(1)(d), for the benefit of the subscribers of the corporation as a whole, and consistent with this act.

(2) The funds of a health care corporation shall be invested

only in securities permitted by the laws of this state for the investments of assets of life insurance companies, as described in chapter 9 of ~~Act No. 218 of the Public Acts of 1956, as amended, being sections 500.901 to 500.947 of the Michigan Compiled Laws~~ **the insurance code of 1956, 1956 PA 218, MCL 500.901 to 500.947**.

(3) Without regard to the limitation in subsection (2), up to 2% of the assets of the health care corporation may be invested in venture-type investments. For purposes of calculating ~~the contingency reserve pursuant to section 205~~ **adequate and unimpaired surplus under section 204a**, a venture-type investment shall be carried on the books of a health care corporation at the original acquisition cost, and losses may only be realized as an offset against gains from venture-type investments. All venture-type investments under this subsection shall provide employment or capital investment primarily within this state. Each investment under this subsection ~~shall be~~ **is** subject to prior approval by the board of directors. As used in this subsection, "venture-type investments" include:

(a) Common stock, preferred stock, limited partnerships, or similar equity interests acquired from the issuer subject to a provision barring resale without consent of the issuer for 5 years from the date of acquisition by the corporation.

(b) Unsecured debt instruments ~~which~~ **that** are either convertible into equity or have equity acquisition rights. These debt instruments shall be subordinated by their terms to all borrowings of the issuer from other institutional lenders and

shall have no part amortized during the first 5 years.

(4) A health care corporation shall not market or transact, as defined in sections 402a and 402b of ~~Act No. 218 of the Public Acts of 1956, being sections 500.402a and 500.402b of the Michigan Compiled Laws~~ **the insurance code of 1956, 1956 PA 218, MCL 500.402a and 500.402b**, any type of insurance described in chapter 6 of ~~Act No. 218 of the Public Acts of 1956, as amended, being sections 500.600 to 500.644 of the Michigan Compiled Laws~~ **the insurance code of 1956, 1956 PA 218, MCL 500.600 to 500.644**. This subsection shall not be construed to prohibit the provision of prepaid health care benefits.

Sec. 207. (1) A health care corporation, subject to any limitation provided in this act, in any other statute of this state, or in its articles of incorporation, may do any or all of the following:

(a) Contract to provide computer services and other administrative consulting services to 1 or more providers or groups of providers, if the services are primarily designed to result in cost savings to subscribers.

(b) Engage in experimental health care projects to explore more efficient and economical means of implementing the corporation's programs, or the corporation's goals as prescribed in section 504 and the purposes of this act, to develop incentives to promote alternative methods and alternative providers, including nurse midwives, nurse anesthetists, and nurse practitioners, for delivering health care, including preventive care and home health care.

(c) For the purpose of providing health care services to employees of this state, the United States, or an agency, instrumentality, or political subdivision of this state or the United States, or for the purpose of providing all or part of the costs of health care services to disabled, aged, or needy persons, contract with this state, the United States, or an agency, instrumentality, or political subdivision of this state or the United States.

(d) For the purpose of administering any publicly supported health benefit plan, accept and administer funds, directly or indirectly, made available by a contract authorized under subdivision (c), or made available by or received from any private entity.

(e) For the purpose of administering any publicly supported health benefit plan, subcontract with any organization that has contracted with this state, the United States, or an agency, instrumentality, or political subdivision of this state or the United States, for the administration or furnishing of health services or any publicly supported health benefit plan.

(f) Provide administrative services only and cost-plus arrangements for the federal medicare program established by parts A and B of title XVIII of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. ~~1395 to 1395b, 1395b-2, 1395b-6 to 1395b-7,~~ 1395c to 1395i, 1395i-2 to 1395i-5, 1395j to 1395t, 1395u to 1395w, **and** 1395w-2 to 1395w-4**;** ~~, 1395w-21 to 1395w-28, 1395x to 1395yy, and 1395bbb to 1395ggg;~~ for the federal medicaid program established under title XIX of the social

security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1396 to ~~1396f, 1396g-1 to~~ 1396r-6 ~~,~~ and 1396r-8 to 1396v; for title V of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 701 to 704 and 705 to 710; for the program of medical and dental care established by the military medical benefits amendments of 1966, Public Law 85-861, 80 Stat. 862; for the Detroit maternity and infant care--preschool, school, and adolescent project; and for any other health benefit program established under state or federal law.

(g) Provide administrative services only and cost-plus arrangements for any noninsured health benefit plan, subject to the requirements of sections 211 and 211a.

(h) Establish, own, and operate a health maintenance organization, subject to the requirements of the ~~public health code, 1978 PA 368, MCL 333.1101 to 333.25211~~ **insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302**.

(i) Guarantee loans for the education of persons who are planning to enter or have entered a profession that is licensed, certified, or registered under parts 161 to 182 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18237, and has been identified by the commissioner, with the consultation of the office of health and medical affairs in the department of management and budget, as a profession whose practitioners are in insufficient supply in this state or specified areas of this state and who agree, as a condition of receiving a guarantee of a loan, to work in this state, or an area of this state specified in a listing of shortage areas for the profession issued by the

commissioner, for a period of time determined by the commissioner.

(j) Receive donations to assist or enable the corporation to carry out its purposes, as provided in this act.

(k) Bring an action against an officer or director of the corporation.

(*l*) Designate and maintain a registered office and a resident agent in that office upon whom service of process may be made.

(m) Sue and be sued in all courts and participate in actions and proceedings, judicial, administrative, arbitrative, or otherwise, in the same cases as natural persons.

(n) Have a corporate seal, alter the seal, and use it by causing the seal or a facsimile to be affixed, impressed, or reproduced in any other manner.

(o) Invest and reinvest its funds and ~~, for investment purposes only,~~ purchase, take, receive, subscribe for, or otherwise acquire, own, hold, vote, employ, sell, lend, lease, exchange, transfer, or otherwise dispose of, mortgage, pledge, use, and otherwise deal in and with, bonds and other obligations, shares, or other securities or interests issued by **other** entities ~~other than domestic, foreign, or alien insurers, as defined in sections 106 and 110 of the insurance code of 1956, 1956 PA 218, MCL 500.106 and 500.110,~~ whether engaged in a similar or different business, or governmental or other activity, including banking corporations or trust companies. ~~However, a health care corporation may purchase, take, receive, subscribe for, or otherwise acquire, own, hold, vote, employ, sell, lend, lease,~~

~~exchange, transfer, or otherwise dispose of bonds or other obligations, shares, or other securities or interests issued by a domestic, foreign, or alien insurer, so long as the activity meets all of the following:~~

~~(*i*) Is determined by the attorney general to be lawful under section 202.~~

~~(*ii*) Is approved in writing by the commissioner as being in the best interests of the health care corporation and its subscribers.~~

~~(*iii*) Will not result in the health care corporation owning or controlling 10% or more of the voting securities of the insurer. Nothing in this subdivision shall be interpreted as expanding the lawful purposes of a health care corporation under this act. Except where expressly authorized by statute, a health care corporation shall not indirectly engage in any investment activity that it may not engage in directly. A health care corporation shall not guarantee or become surety upon a bond or other undertaking securing the deposit of public money.~~

(p) Purchase, receive, take by grant, gift, devise, bequest or otherwise, lease, or otherwise acquire, own, hold, improve, employ, use and otherwise deal in and with, real or personal property, or an interest therein, wherever situated.

(q) Sell, convey, lease, exchange, transfer or otherwise dispose of, or mortgage or pledge, or create a security interest in, any of its property, or an interest therein, wherever situated.

(r) Borrow money and issue its promissory note or bond for

the repayment of the borrowed money with interest.

(s) Make donations for the public welfare, including hospital, charitable, or educational contributions that do not significantly affect rates charged to subscribers.

(t) Participate with others in any joint venture with respect to any transaction that the health care corporation would have the power to conduct by itself.

(u) Cease its activities and dissolve, subject to the commissioner's authority under section 606(2).

(v) Make contracts, transact business, carry on its operations, have offices, and ~~exercise the powers granted by this act~~ **engage in any other lawful activity** in any jurisdiction. ~~, to the extent necessary to carry out its purposes under this act.~~

(w) Have and exercise all powers necessary or convenient to effect any purpose for which the corporation was formed.

(x) Notwithstanding subdivision (o) or any other provision of this act, establish, own, and operate a domestic stock insurance company only for the purpose of acquiring, owning, and operating the state accident fund pursuant to chapter 51 of the insurance code of 1956, 1956 PA 218, MCL 500.5100 to 500.5114, so long as all of the following are met:

(*i*) For insurance products and services the insurer whether directly or indirectly only transacts worker's compensation insurance and employer's liability insurance, transacts disability insurance limited to replacement of loss of earnings, and acts as an administrative services organization for an

approved self-insured worker's compensation plan or a disability insurance plan limited to replacement of loss of earnings and does not transact any other type of insurance notwithstanding the authorization in chapter 51 of the insurance code of 1956, 1956 PA 218, MCL 500.5100 to 500.5114. This subparagraph does not preclude the insurer from providing either directly or indirectly noninsurance products and services as otherwise provided by law.

(*ii*) The activity is determined by the attorney general to be lawful under section 202.

(*iii*) The health care corporation does not directly or indirectly subsidize the use of any provider or subscriber information, loss data, contract, agreement, reimbursement mechanism or arrangement, computer system, or health care provider discount to the insurer.

(*iv*) Members of the board of directors, employees, and officers of the health care corporation are not, directly or indirectly, employed by the insurer unless the health care corporation is fairly and reasonably compensated for the services rendered to the insurer if those services were paid for by the health care corporation.

(*v*) Health care corporation and subscriber funds are used only for the acquisition from the state of Michigan of the assets and liabilities of the state accident fund.

(*vi*) Health care corporation and subscriber funds are not used to operate or subsidize in any way the insurer including the use of such funds to subsidize contracts for goods and services. This subparagraph does not prohibit joint undertakings between

the health care corporation and the insurer to take advantage of economies of scale or arm's-length loans or other financial transactions between the health care corporation and the insurer.

(2) In order to ascertain the interests of senior citizens regarding the provision of medicare supplemental coverage, as described in section 202(1)(d)(*v*), and to ascertain the interests of senior citizens regarding the administration of the federal medicare program when acting as fiscal intermediary in this state, as described in section 202(1)(d)(*vi*), a health care corporation shall consult with the office of services to the aging and with senior citizens' organizations in this state.

(3) An act of a health care corporation, otherwise lawful, is not invalid because the corporation was without capacity or power to do the act. However, the lack of capacity or power may be asserted:

(a) In an action by a director or a member of the corporate body against the corporation to enjoin the doing of an act.

(b) In an action by or in the right of the corporation to procure a judgment in its favor against an incumbent or former officer or director of the corporation for loss or damage due to an unauthorized act of that officer or director.

(c) In an action or special proceeding by the attorney general to enjoin the corporation from the transacting of unauthorized business, to set aside an unauthorized transaction, or to obtain other equitable relief.

(4) A health care corporation may engage in any activity not

prohibited by law. The absence of any specific grant of authority in this act shall not be construed to prohibit a health care corporation from engaging in any activity not otherwise prohibited by law.

Sec. 211. (1) Pursuant to section 207(1)(g), a health care corporation may enter into service contracts containing an administrative services only or cost-plus arrangement. Except as otherwise provided in this section, a corporation shall not enter into a service contract containing an administrative services only or cost-plus arrangement for a noninsured benefit plan covering a group of less than 500 individuals, except that a health care corporation may continue an administrative services only or cost-plus arrangement with a group of less than 500, which arrangement is in existence in September of 1980. A corporation may enter into contracts containing an administrative services only or cost-plus arrangement for a noninsured benefit plan covering a group of less than 500 individuals if either the corporation makes arrangements for excess loss coverage or the sponsor of the plan that covers the individuals is liable for the plan's liabilities and is a sponsor of 1 or more plans covering a group of 500 or more individuals in the aggregate. The commissioner, upon obtaining the advice of the corporations subject to this act, shall establish the standards for the manner and amount of the excess loss coverage required by this subsection. It is the intent of the legislature that the excess loss coverage requirements be uniform as between corporations subject to this act and other persons authorized to provide

similar services. The corporation shall offer in connection with a noninsured benefit plan a program of specific or aggregate excess loss coverage.

(2) Relative to actual administrative costs, fees for administrative services only and cost-plus arrangements shall be set in a manner that precludes cost transfers between subscribers subject to either of these arrangements and other subscribers of the health care corporation. Administrative costs for these arrangements shall be determined in accordance with the administrative costs allocation methodology and definitions filed and approved under part 6, and shall be expressed clearly and accurately in the contracts establishing the arrangements, as a percentage of costs rather than charges. This subsection shall not be construed to prohibit the inclusion, in fees charged, of contributions to ~~the contingency reserve of the corporation, consistent with section 205~~ **adequate and unimpaired surplus as provided in section 204a**.

(3) Before a health care corporation may enter into contracts containing administrative services only or cost-plus arrangements pursuant to section 207(1)(g), the board of directors of the corporation shall approve a marketing policy ~~with respect to such~~ **for these** arrangements that is consistent with ~~the provisions of~~ this section. The marketing policy may contain other provisions as the board considers necessary. The marketing policy shall be carried out by the corporation consistent with this act.

(4) A corporation providing services under a contract

containing an administrative services only or cost-plus arrangement in connection with a noninsured benefit plan shall provide in its service contract a provision that the person contracting for the services in connection with a noninsured benefit plan shall notify each covered individual **of** what services are being provided; the fact that individuals are not insured or are not covered by a certificate from the corporation, or are only partially insured or are only partially covered by a certificate from the corporation, as the case may be; which party is liable for payment of benefits; and of future changes in benefits.

(5) A service contract containing an administrative services only arrangement between a corporation and a governmental entity not subject to the employee retirement income security act of 1974, Public Law 93-406, 88 Stat. 829, whose plan provides coverage under a collective bargaining agreement utilizing a policy or certificate issued by a carrier before the signing of the service contract, is void unless the governmental entity has provided the notice described in subsection (4) to the collective bargaining agent and to the members of the collective bargaining unit not less than 30 days before signing the service contract. The voiding of a service contract under this subsection shall not relieve the governmental entity of any obligations to the corporation under the service contract.

(6) Nothing in this section shall be construed to permit an actionable interference by a corporation with the rights and obligations of the parties under a collective bargaining

agreement.

(7) An individual covered under a noninsured benefit plan for which services are provided under a service contract authorized under subsection (1) ~~shall~~ **is** not ~~be~~ liable for that portion of claims incurred and subject to payment under the plan if the service contract is entered into between an employer and a corporation, unless that portion of the claim has been paid directly to the covered individual.

(8) A corporation shall report with its annual statement the amount of business it has conducted as services provided under subsection (1) that are performed in connection with a noninsured benefit plan, and the commissioner shall transmit annually this information to the state ~~commissioner of revenue~~ **treasurer**. The commissioner shall submit to the legislature on April 1, 1994, a report detailing the impact of this section on employers and covered individuals, and similar activities under other provisions of law, and in consultation with the ~~revenue commissioner~~ **state treasurer** the total financial impact on the state for the preceding legislative biennium.

(9) As used in this section, "noninsured benefit plan" or "plan" means a health benefit plan without coverage by a health care corporation, health maintenance organization, or insurer or the portion of a health benefit plan without coverage by a health care corporation, health maintenance organization, or insurer that has a specific or aggregate excess loss coverage.

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) That the group the individual is a member of has failed to enroll enough of its eligible members to meet the minimum participation rules established by the health care corporation pursuant to sound underwriting requirements. A minimum participation rule may require a group to enroll a certain number or percentage of its members with the health care corporation or its subsidiary health maintenance organization as a condition of coverage. A minimum participation rule for groups of 6 or more members shall not require enrollment of more than 75% of the group's members who are receiving health care coverage from the group. A minimum participation rule for groups of fewer than 6 members may require enrollment of up to 100% of the group's members who are receiving health care coverage from the 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) 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.

Sec. 422c. A health care corporation may condition the granting of long-term care coverage based on answers given on an application under section 422a and pursuant to underwriting standards established by the corporation.

Sec. 502. (1) A health care corporation may enter into participating contracts for reimbursement with professional health care providers practicing legally in this state **or with health practitioners practicing legally in any other jurisdiction** for health care services that the professional health care providers **or practitioners** may legally perform. A participating contract may cover all members or may be a separate and individual contract on a per claim basis, as set forth in the provider class plan, if, in entering into a separate and individual contract on a per claim basis, the participating provider certifies to the health care corporation:

(a) That the provider will accept payment from the corporation as payment in full for services rendered for the specified claim for the member indicated.

(b) That the provider will accept payment from the corporation as payment in full for all cases involving the procedure specified, for the duration of the calendar year. As used in this subdivision, provider does not include a person licensed as a dentist under part 166 of the public health code,

1978 PA 368, MCL 333.16601 to 333.16648.

(c) That the provider will not determine whether to participate on a claim on the basis of the race, color, creed, marital status, sex, national origin, residence, age, disability, or lawful occupation of the member entitled to health care benefits.

(2) A contract entered into pursuant to subsection (1) shall provide that the private provider-patient relationship shall be maintained to the extent provided for by law. A health care corporation shall continue to offer a reimbursement arrangement to any class of providers with which it has contracted prior to August 27, 1985 and that continues to meet the standards set by the corporation for that class of providers.

(3) A health care corporation shall not restrict the methods of diagnosis or treatment of professional health care providers who treat members. Except as otherwise provided in section 502a, each member of the health care corporation shall at all times have a choice of professional health care providers. This subsection does not apply to limitations in benefits contained in certificates, to the reimbursement provisions of a provider contract or reimbursement arrangement, or to standards set by the corporation for all contracting providers. A health care corporation may refuse to reimburse a health care provider for health care services that are overutilized, including those services rendered, ordered, or prescribed to an extent that is greater than reasonably necessary.

(4) A health care corporation may provide to a member, upon

request, a list of providers with whom the corporation contracts, for the purpose of assisting a member in obtaining a type of health care service. However, except as otherwise provided in section 502a, an employee, agent, or officer of the corporation, or an individual on the board of directors of the corporation, shall not make recommendations on behalf of the corporation with respect to the choice of a specific health care provider. Except as otherwise provided in section 502a, an employee, agent, or officer of the corporation, or a person on the board of directors of the corporation who influences or attempts to influence a person in the choice or selection of a specific professional health care provider on behalf of the corporation, is guilty of a misdemeanor.

(5) A health care corporation shall provide a symbol of participation, which can be publicly displayed, to providers who participate on all claims for covered health care services rendered to subscribers.

(6) This section does not impede the lawful operation of, or lawful promotion of, a health maintenance organization owned by a health care corporation.

(7) Contracts entered into under this section **with professional health care providers licensed in this state** are subject to the provisions of sections 504 to 518.

(8) A health care corporation shall not deny participation to a freestanding surgical outpatient facility on the basis of ownership if the facility meets the reasonable standards set by the health care corporation for similar facilities, is licensed

under part 208 of the public health code, 1978 PA 368, MCL 333.20801 to 333.20821, and complies with part 222 of the public health code, 1978 PA 368, MCL 333.22201 to 333.22260.

(9) Notwithstanding any other provision of this act, if a certificate provides for benefits for services that are within the scope of practice of optometry, a health care corporation is not required to provide benefits or reimburse for a practice of optometric service unless that service was included in the definition of practice of optometry under section 17401 of the public health code, 1978 PA 368, MCL 333.17401, as of May 20, 1992.

(10) Notwithstanding any other provision of this act, a health care corporation is not required to reimburse for services otherwise covered under a certificate if the services were performed by a member of a health care profession, which health care profession was not licensed or registered by this state on or before January 1, 1998 but that becomes a health care profession licensed or registered by this state after January 1, 1998. This subsection does not change the status of a health care profession that was licensed or registered by this state on or before January 1, 1998.

Sec. 602. (1) Not later than March 1 each year, subject to a 30-day extension ~~which~~ **that** may be granted by the commissioner, a health care corporation shall file in the office of the commissioner a sworn statement verified by at least 2 of the principal officers of the corporation showing its condition as of the preceding December 31. The statement shall be in a

form ~~,~~ and contain those matters ~~, which~~ **that** the commissioner prescribes for a health care corporation, including those matters contained in section ~~205~~ **204a**. The statement shall include the number of members and the number of subscribers' certificates issued by the corporation and outstanding.

(2) The commissioner, by order, may require a health care corporation to submit statistical, financial, and other reports for the purpose of monitoring compliance with this act.

Sec. 608. (1) The rates charged to nongroup **medicare supplemental** subscribers for each certificate shall be filed in accordance with section 610 and shall be subject to the prior approval of the commissioner. Annually, the commissioner shall approve, disapprove, or modify and approve the proposed or existing rates for each certificate subject to the standard that the rates must be determined to be equitable, adequate, and not excessive, as defined in section 609. **The rates charged to nongroup medicare supplemental subscribers shall not include rate differentials based on age or residence.** The burden of proof that rates to be charged meet these standards shall be upon the health care corporation proposing to use the rates.

~~(2) The methodology and definitions of each rating system, formula, component, and factor used to calculate rates for group subscribers for each certificate, including the methodology and definitions used to calculate administrative costs for administrative services only and cost-plus arrangements, shall be filed in accordance with section 610 and shall be subject to the~~

~~prior approval of the commissioner. The definition of a group, including any clustering principles applied to nongroup subscribers or small group subscribers for the purpose of group formation, shall be subject to the prior approval of the commissioner. However, if a Michigan caring program is created under section 436, that program shall be defined as a group program for the purpose of establishing rates. The commissioner shall approve, disapprove, or modify and approve the methodology and definitions of each rating system, formula, component, and factor for each certificate subject to the standard that the resulting rates for group subscribers must be determined to be equitable, adequate, and not excessive, as defined in section 609. In addition, the commissioner may from time to time review the records of the corporation to determine proper application of a rating system, formula, component, or factor with respect to any group. The corporation shall refile for approval under this subsection, every 3 years, the methodology and definitions of each rating system, formula, component, and factor used to calculate rates for group subscribers, including the methodology and definitions used to calculate administrative costs for administrative services only and cost-plus arrangements. The burden of proof that the resulting rates to be charged meet these standards shall be upon the health care corporation proposing to use the rating system, formula, component, or factor.~~

(2) ~~(3)~~ A proposed rate **filed under subsection (1)** shall not take effect until a filing has been made with the commissioner and approved under section 607 or this section, as

applicable, except as provided in ~~subsections (4) and (5)~~ **subsection (3)**.

(3) ~~(4)~~ Upon request by a health care corporation, the commissioner may allow rate adjustments to become effective prior to approval, for federal or state mandated benefit changes. However, a filing for these adjustments shall be submitted before the effective date of the mandated benefit changes. If the commissioner disapproves or modifies and approves the rates, an adjustment shall be made retroactive to the effective date of the mandated benefit changes or additions.

~~(5) Implementation prior to approval may be allowed if the health care corporation is participating with 1 or more health care corporations to underwrite a group whose employees are located in several states. Upon request from the commissioner, the corporation shall file with the commissioner, and the commissioner shall examine, the financial arrangement, formulae, and factors. If any are determined to be unacceptable, the commissioner shall take appropriate action.~~

Sec. 608a. (1) The rates for nongroup and group conversion subscribers shall be filed with and approved by the commissioner. The rates under this section shall not be filed more frequently than annually. The rates shall be reasonable in relation to the benefits provided. The rates shall be considered reasonable if the filing includes an actuarial certification that the anticipated loss ratio will not be less than 70%. The rates shall be considered approved and effective 30 days after filing with the commissioner.

(2) Not later than 180 days after every 2 years after a rate approved under subsection (1) has been in effect, the health care corporation shall determine if the minimum loss ratio has been met for nongroup and group conversion subscribers. This determination shall be based on the actual experience of the nongroup and group conversion lines of business over the 2-year period under review. The results of this determination shall be filed with the commissioner.

(3) If the actual loss ratio is less than the minimum loss ratio under subsection (1) for nongroup or group conversion subscribers, the health care corporation shall give a pro rata rate credit or credits to current subscribers. The rate credits shall be determined separately for nongroup subscribers and group conversion subscribers. In the aggregate, the rate credits shall be in an amount equal to the difference between the actual loss ratio and the minimum loss ratio. The rate credits shall begin no later than 180 days after there has been a determination that the minimum loss ratio was not met. The rate credits shall be filed with the commissioner.

(4) The rates charged to nongroup and group conversion subscribers may include rate differentials based on age and residence if the differentials are supported by sound actuarial principles and a reasonable classification system and are related to actual and credible loss statistics or, for new coverages, reasonably anticipated experience.

Sec. 608b. (1) The rates for group subscribers, other than those covered under the small employer health market reform act,

shall be filed with and approved by the commissioner. The rates under this section shall not be filed more frequently than annually. The rates shall be reasonable in relation to the benefits provided. The rates shall be considered reasonable if the filing includes an actuarial certification that the anticipated loss ratio will not be less than 70%. The rates shall be considered approved and effective 30 days after filing with the commissioner.

(2) Not later than 180 days after every 2 years after a rate approved under subsection (1) has been in effect, the health care corporation shall determine if the minimum loss ratio has been met for each of the group lines of business. This determination shall be based on the actual experience of each group line of business over the 2-year period under review. The results of this determination shall be filed with the commissioner.

(3) If the actual loss ratio is less than the anticipated minimum loss ratio under subsection (1) for group subscribers, the health care corporation shall give a pro rata rate credit or credits to current group subscribers. The rate credits shall be determined separately for each group line of business. In the aggregate, the rate credits shall be in an amount equal to the difference between the actual loss ratio and the minimum loss ratio. The rate credits shall begin no later than 180 days after there has been a determination that the anticipated minimum loss ratio was not met. The rate credits shall be filed with the commissioner.

Sec. 608c. (1) If the commissioner disapproves the rates

filed under section 608a or 608b, the commissioner shall issue a written order of disapproval. The order shall state specifically the reasons the rates fail to achieve the minimum loss ratio and what modifications are required to meet the minimum loss ratio.

(2) If the commissioner disapproves the rates filed under section 608a or 608b, the health care corporation may request a contested case hearing contesting the disapproval under the administrative procedures act. The hearing shall be conducted by an independent hearing officer appointed by the commissioner. The person appointed as the independent hearing officer shall meet the qualifications and conditions listed under section 613(1). The hearing shall be conducted under the time frames and guidelines established under section 613(2).

Sec. 608d. (1) For purposes of sections 608a to 608c, the premium income used to calculate the anticipated and actual loss ratio shall include any cost transfer received by the line of business pursuant to section 609(5), but shall not include any cost transfer paid by the line of business pursuant to section 609(5). In addition, the premium income used to calculate the anticipated and actual loss ratio for group business shall not include the reserve for the prior experience of the group.

(2) As used in this section and sections 608a to 608c:

(a) "Loss ratio" means incurred claims as a percentage of earned subscription income, where incurred claims are the amount paid for health care services during the applicable period plus the reserve for claims incurred but not paid as of the end of the applicable period minus the reserve for claims incurred but not

paid as of the beginning of the applicable period.

(b) "Rate" includes any rating methodology or formula used by the health care corporation to develop rates for group, nongroup, or group conversion business.

Sec. 609. (1) A rate is not excessive if the rate is not unreasonably high relative to the following elements, individually or collectively; provision for anticipated benefit costs; provision for administrative expense; provision for cost transfers, if any; provision for a contribution to or from ~~the corporate contingency reserve that is consistent with the attainment or maintenance of the target contingency reserve level prescribed in section 205~~ **surplus that is consistent with the attainment or maintenance of adequate and unimpaired surplus as provided in section 204a**; and provision for adjustments due to prior experience of groups, as defined in the group rating system. A determination as to whether a rate is excessive relative to ~~the~~ **these** elements**,** ~~listed above,~~ individually or collectively, shall be based on the following: reasonable evaluations of recent claim experience; projected trends in claim costs; the allocation of administrative expense budgets; and the present and anticipated ~~contingency reserve positions~~ **unimpaired surplus** of the health care corporation. To the extent that any of these elements are considered excessive, the provision in the rates for these elements shall be modified accordingly.

(2) The administrative expense budget must be reasonable, as determined by the commissioner after examination of material and

substantial administrative and acquisition expense items.

(3) A rate is equitable if the rate can be compared to any other rate offered by the health care corporation to its subscribers, and the observed rate differences can be supported by differences in anticipated benefit costs, administrative expense cost, differences in risk, or any identified cost transfer provisions.

(4) A rate is adequate if the rate is not unreasonably low relative to the elements prescribed in subsection (1), individually or collectively, based on reasonable evaluations of recent claim experience, projected trends in claim costs, the allocation of administrative expense budgets, and the present and anticipated ~~contingency reserve positions~~ **unimpaired surplus** of the health care corporation.

(5) Except for identified cost transfers, each line of business, over time, shall be self-sustaining. However, there may be cost transfers for the benefit of senior citizens and group conversion subscribers. Cost transfers for the benefit of senior citizens, in the aggregate, annually shall not exceed 1% of the earned subscription income of the health care corporation as reported in the most recent annual statement of the corporation. Group conversion subscribers are those who have maintained coverage with the health care corporation on an individual basis after leaving a subscriber group. ~~The Michigan caring program created in section 436 is not subject to any assessment or surcharge for cost transfer under this subsection.~~

Sec. 610. (1) Except as provided under section ~~608(4) or~~

~~(5)~~ **608(3)**, a filing of information and materials relative to a proposed **nongroup medicare supplemental** rate shall be made not less than ~~120~~ **90** days before the proposed effective date of the proposed rate. A filing shall not be considered to have been received until there has been substantial and material compliance with the requirements prescribed in subsections (6) and (8).

(2) Within 30 days after a filing is made of information and materials relative to a proposed **nongroup medicare supplemental** rate, the commissioner shall do either of the following:

(a) Give written notice to the corporation, and to each person described under section 612(1), that the filing is in material and substantial compliance with subsections (6) and (8) and that the filing is complete. The commissioner shall then proceed to approve, approve with modifications, or disapprove the rate filing 60 days after receipt of the filing, based upon whether the filing meets the requirements of this act. However, if a hearing has been requested under section 613, the commissioner shall not approve, approve with modifications, or disapprove a filing until the hearing has been completed and an order issued.

(b) Give written notice to the corporation that the corporation has not yet complied with subsections (6) and (8). The notice shall state specifically ~~in what respects~~ **the reasons** the filing fails to meet the requirements of subsections (6) and (8).

(3) Within 10 days after the filing of notice pursuant to subsection (2)(b), the corporation shall submit to the

commissioner ~~such~~ additional information and materials ~~, as~~ requested by the commissioner. Within 10 days after receipt of the additional information and materials, the commissioner shall determine whether the filing is in material and substantial compliance with subsections (6) and (8). If the commissioner determines that the filing does not yet materially and substantially meet the requirements of subsections (6) and (8), the commissioner shall give notice to the corporation pursuant to subsection (2)(b) or use visitation of the corporation's facilities and examination of the corporation's records to obtain the necessary information described in the notice issued pursuant to subsection (2)(b). The commissioner shall use either procedure previously mentioned, or a combination of both procedures, in order to obtain the necessary information as expeditiously as possible. The per diem, traveling, reproduction, and other necessary expenses in connection with visitation and examination shall be paid by the corporation, and shall be credited to the general fund of the state.

(4) If a filing is approved, approved with modifications, or disapproved under subsection (2)(a), the commissioner shall issue a written order of the approval, approval with modifications, or disapproval. If the filing was approved with modifications or disapproved, the order shall state specifically ~~in what respects~~ **the reasons** the filing fails to meet the requirements of this act and, if applicable, what modifications are required for approval under this act. If the filing was approved with modifications, the order shall state that the filing shall take

effect after the modifications are made and approved by the commissioner. If the filing was disapproved, the order shall state that the filing shall not take effect.

(5) The inability to approve 1 or more rating classes of business within a line of business because of a requirement to submit further data or because a request for a hearing under section 613 has been granted shall not delay the approval of rates by the commissioner ~~which~~ **that** could otherwise be approved or the implementation of rates already approved, unless the approval or implementation would affect the consideration of the unapproved classes of business.

(6) Information furnished under subsection (1) in support of a nongroup **medicare supplemental** rate filing shall include the following:

(a) Recent claim experience on the benefits or comparable benefits for which the rate filing applies.

(b) Actual prior trend experience.

(c) Actual prior administrative expenses.

(d) Projected trend factors.

(e) Projected administrative expenses.

(f) Contributions for risk and contingency reserve factors.

(g) Actual health care corporation contingency reserve position.

(h) Projected health care corporation contingency reserve position.

(i) Other information ~~which~~ the corporation considers pertinent to evaluating the risks to be rated, or relevant to the

determination to be made under this section.

(j) Other information ~~which~~ the commissioner considers pertinent to evaluating the risks to be rated, or relevant to the determination to be made under this section.

(7) A copy of the filing, and all supporting information, except for the information ~~which~~ **that** may not be disclosed under section 604, shall be open to public inspection as of the date filed with the commissioner.

(8) The commissioner shall make available forms and instructions for filing for proposed rates under ~~sections~~ **section** 608(1). ~~and 608(2).~~ The forms with instructions shall be available not less than 180 days before the proposed effective date of the filing.

Sec. 611. It is the intent of the legislature to promote uniformity of rates among subscribers to the greatest extent practicable. **This section does not prohibit the use of rate differentials as permitted by sections 608a and 608b.**

Sec. 612. (1) Upon receipt of a **nongroup medicare supplemental** rate filing under section 610, the commissioner immediately shall notify each person who has requested in writing notice of those filings within the previous 2 years, specifying the nature and extent of the proposed rate revision and identifying the location, time, and place where the copy of the rate filing described in section 610(7) shall be open to public inspection and copying. The notice shall also state that if the person has standing, the person shall have, upon making a written request for a hearing within ~~60~~ **30** days after receiving notice

of the rate filing, an opportunity for an evidentiary hearing under section 613 to determine whether the proposed rates meet the requirements of this act. The request shall identify the issues ~~which~~ **that** the requesting party asserts are involved, what portion of the rate filing is requested to be heard, and how the party has standing. The corporation shall place advertisements giving notice, containing the information specified above, in at least 1 newspaper ~~which serves~~ **serving** each geographic area in which significant numbers of subscribers reside.

(2) The commissioner may charge a fee for providing, pursuant to subsection (1), a copy of the rate filing described in section 610(7). The commissioner may charge a fee for providing a copy of the entire filing to a person whose request for a hearing has been granted by the commissioner pursuant to section 613. The fee shall be limited to actual mailing costs and to the actual incremental cost of duplication, including labor and the cost of deletion and separation of information as provided in section 14 of ~~Act No. 442 of the Public Acts of 1976, being section 15.244 of the Michigan Compiled Laws~~ **the freedom of information act, 1976 PA 442, MCL 15.244**. Copies of the filing may be provided free of charge or at a reduced charge if the commissioner determines that a waiver or reduction of the fee is in the public interest because the furnishing of a copy of the filing will primarily benefit the general public. In calculating the costs under this subsection, the commissioner shall not attribute more than the hourly wage of the lowest paid, full-time clerical

employee of the ~~insurance bureau~~ **office of financial and insurance services** to the cost of labor incurred in duplication and mailing and to the cost of separation and deletion. The commissioner shall use the most economical means available to provide copies of a rate filing.

Sec. 613. (1) If the request for a hearing under this section is with regard to a rate filing not yet acted upon under section 610(2)(a), no such action shall be taken by the commissioner until after the hearing has been completed. However, the commissioner shall proceed to act upon those portions of a rate filing upon which no hearing has been requested. Within 15 days after receipt of a request for a hearing, the commissioner shall determine if the person has standing. If the commissioner determines that the person has standing, the person may have access to the entire filing subject to the same confidentiality requirements as the commissioner under section 604, and shall be subject to the penalty provision of section 604(5). Upon determining that the person has standing, the commissioner shall immediately appoint an independent hearing officer before whom the hearing shall be held. In appointing an independent hearing officer, the commissioner shall select a person qualified to conduct hearings, who has experience or education in the area of health care corporation or insurance rate determination and finance, and who is not otherwise associated financially with a health care corporation or a health care provider. The person selected shall not be currently or actively employed by this state. For

purposes of this subsection, an employee of an educational institution shall not be considered to be employed by this state. For purposes of this section, a person has "standing" if any of the following circumstances exist:

(a) The person is, or there are reasonable grounds to believe that the person could be, aggrieved by the proposed rate.

(b) The person is acting on behalf of 1 or more named persons described in subdivision (a).

(c) The person is the commissioner, the attorney general, or the health care corporation.

(2) ~~Not more than 30 days after receipt of a request for a hearing, and upon not less than 15 days' notice to all parties, the hearing shall be commenced.~~ **A hearing shall be held not later than 45 days after receipt of a request for a hearing. A pretrial conference may be held prior to the start of a hearing but cannot delay the start of a hearing.** Each party to the hearing shall be given a reasonable opportunity for discovery before and throughout the course of the hearing. However, the hearing officer may terminate discovery at any time, for good cause shown**, and discovery cannot delay the start of a hearing**. The hearing officer shall conduct the hearing pursuant to the administrative procedures act. The hearing shall be conducted in an expeditious manner. At the hearing, the burden of proving compliance with this act shall be upon the health care corporation.

(3) In rendering a proposal for a decision, the hearing officer shall consider the factors prescribed in section 609.

(4) Within 30 days after receipt of the hearing officer's proposal for decision, the commissioner shall by order render a decision ~~which~~ **that** shall include a statement of findings.

(5) The commissioner shall withdraw an order of approval or approval with modifications if the commissioner finds that the filing no longer meets the requirements of this act.

Sec. 614. (1) Not less than ~~75~~ **45** days after a **nongroup medicare supplemental rate** filing is received, as provided in section 610, the health care corporation may petition the commissioner, who shall make a determination with respect to interim rates and shall order interim rates in the amount prescribed in subsection (2). Interim rates shall not be implemented if the commissioner finds that the health care corporation has substantially contributed to the delay or that the health care corporation has not provided information requested by the commissioner relative to a determination under this section. The interim rate determination shall not be a contested case under chapter 4 of the administrative procedures act**, MCL 24.271 to 24.287**.

(2) ~~The~~ **Within 15 days after receiving the petition for interim rates, the** commissioner shall grant an interim rate, in an amount as determined by the commissioner, if the commissioner makes a finding that the corporation has ~~made a convincing showing that there is~~ **shown** probable cause to believe that the failure to grant the interim rate will result in an underwriting loss for that line of business for the period for which rates are being requested. As used in this subsection, "underwriting loss"

means the difference between income from current rates plus investment income, and projected claims plus projected administrative expenses.

(3) If the final rate determination results in approval of a lower rate, appropriate refunds or adjustments, as determined by the commissioner, shall be made to reflect payments made in excess of the approved rate.

(4) The order establishing an interim rate adjustment made pursuant to this section ~~shall be~~ **is** limited to adjusting rates for certificates then in effect, and shall not be used to alter certificates or implement new certificates.

(5) This section shall apply only to rates subject to section 608(1) for which a hearing has been requested.

Sec. 620. (1) Except as otherwise provided in this section, a health care corporation compliance self-evaluative audit document is privileged information and is not discoverable or admissible as evidence in any civil, criminal, or administrative proceeding.

(2) Except as otherwise provided in this section, a person involved in preparing a compliance self-evaluative audit or compliance self-evaluative audit document is not subject to examination concerning that audit or audit document in any civil, criminal, or administrative proceeding. However, if the compliance self-evaluative audit, compliance self-evaluative audit document, or any portion of the audit or audit document is not privileged, the individual involved in the preparation of the audit or audit document may be examined concerning the portion of

the audit or audit document that is not privileged. A person involved in preparing a compliance self-evaluative audit or compliance self-evaluative audit document who becomes aware of any alleged criminal violation of this act shall report that act to the health care corporation. Within 30 days after receiving the report, the health care corporation shall provide the information to the commissioner.

(3) A compliance self-evaluative audit document furnished to the commissioner voluntarily or as a result of a request of the commissioner under a claim of authority to compel disclosure under subsection (7) shall not be provided by the commissioner to any other person and shall be accorded the same confidentiality and other protections provided under this act without waiving the privileges in subsections (1) and (2). Any use of a compliance self-evaluative audit document furnished voluntarily or as a result of a request of the commissioner under a claim of authority to compel disclosure under subsection (7) is limited to determining whether or not any disclosed defects in a health care corporation's policies and procedures or inappropriate treatment of customers has been remedied or that an appropriate plan for remedy is in place.

(4) A compliance self-evaluative audit document submitted to the commissioner remains subject to all applicable statutory or common law privileges including, but not limited to, the work product doctrine, attorney-client privilege, or the subsequent remedial measures exclusion. A compliance self-evaluative audit document submitted to the commissioner remains the property of

the health care corporation and is not subject to disclosure under the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246.

(5) Disclosure of a compliance self-evaluative audit document to a governmental agency, whether voluntary or pursuant to compulsion of law, does not constitute a waiver of the privileges under subsections (1) and (2) with respect to any other person or other governmental agency.

(6) The privileges under subsections (1) and (2) do not apply to the extent that they are expressly waived by the health care corporation that prepared or caused to be prepared the compliance self-evaluative audit document.

(7) The privileges in subsections (1) and (2) do not apply as follows:

(a) If a court, after an in camera review, requires disclosure in a civil or administrative proceeding after determining 1 or more of the following:

(*i*) The privilege is asserted for a fraudulent purpose.

(*ii*) The material is not subject to the privilege as provided under subsection (13).

(b) If a court, after an in camera review, requires disclosure in a criminal proceeding after determining 1 or more of the following:

(*i*) The privilege is asserted for a fraudulent purpose.

(*ii*) The material is not subject to the privilege as provided under subsection (13).

(*iii*) The material contains evidence relevant to the

commission of a criminal offense under this act.

(8) Within 14 days after the commissioner or the attorney general makes a written request by certified mail for disclosure of a compliance self-evaluative audit document, the health care corporation that prepared the document or caused the document to be prepared may file with the Ingham county circuit court a petition requesting an in camera hearing on whether the compliance self-evaluative audit document or portions of the audit document are subject to disclosure. Failure by the health care corporation to file a petition waives the privilege provided by this section for that request. A health care corporation asserting the compliance self-evaluative privilege in response to a request for disclosure under this subsection shall include in its request for an in camera hearing all of the information listed in subsection (10). Within 30 days after the filing of the petition, the court shall issue an order scheduling an in camera hearing to determine whether the compliance self-evaluative audit document or portions of the audit document are privileged or are subject to disclosure.

(9) If the court requires disclosure under subsections (7) and (8), the court may compel the disclosure of only those portions of a compliance self-evaluative audit document relevant to issues in dispute in the underlying proceeding. Information required to be disclosed shall not be considered a public document and shall not be considered to be a waiver of the privilege for any other civil, criminal, or administrative proceeding.

(10) A health care corporation asserting the privilege under this section in response to a request for disclosure under subsection (8) shall provide to the commissioner or the attorney general, at the time of filing any objection to the disclosure, all of the following information:

(a) The date of the compliance self-evaluative audit document.

(b) The identity of the entity or individual conducting the audit.

(c) The general nature of the activities covered by the compliance self-evaluative audit.

(d) An identification of the portions of the compliance self-evaluative audit document for which the privilege is being asserted.

(11) A health care corporation asserting the privilege under this section has the burden of demonstrating the applicability of the privilege. Once a health care corporation has established the applicability of the privilege, a party seeking disclosure under subsection (7)(a)(*i*) has the burden of proving that the privilege is asserted for a fraudulent purpose. The commissioner or attorney general seeking disclosure under subsection (7)(b)(*iii*) has the burden of proving the elements listed in subsection (7)(b)(*iii*).

(12) The parties may at any time stipulate in proceedings under this section to entry of an order directing that specific information contained in a compliance self-evaluative audit document is or is not subject to the privileges provided under

subsections (1) and (2). Any such stipulation may be limited to the instant proceeding and, absent specific language to the contrary, is not applicable to any other proceeding.

(13) The privileges provided under subsections (1) and (2) do not extend to any of the following:

(a) Documents, communications, data, reports, or other information expressly required to be collected, developed, maintained, or reported to a regulatory agency under this act or other federal or state law.

(b) Information obtained by observation or monitoring by any regulatory agency.

(c) Information obtained from a source independent of the compliance audit.

(d) Documents, communication, data, reports, memoranda, drawings, photographs, exhibits, computer records, maps, charts, graphs, and surveys kept or prepared in the ordinary course of business.

(14) This section does not limit, waive, or abrogate the scope or nature of any other statutory or common law privilege.

(15) As used in this section:

(a) "Compliance self-evaluative audit" means a voluntary, internal evaluation, review, assessment, audit, or investigation for the purpose of identifying or preventing noncompliance with or promoting compliance with laws, regulations, orders, or industry or professional standards, conducted by or on behalf of a health care corporation licensed or regulated under this act or which involves an activity regulated under this act.

(b) "Compliance self-evaluative audit document" means a document prepared as a result of or in connection with a compliance audit. A compliance self-evaluative audit document may include a written response to the findings of a compliance self-evaluative audit. A compliance self-evaluative audit document may include, but is not limited to, field notes and records of observations, findings, opinions, suggestions, conclusions, drafts, memoranda, drawings, photographs, exhibits, computer-generated or electronically recorded information, telephone records, maps, charts, graphs, and surveys, if this supporting information is collected or prepared in the course of a compliance self-evaluative audit or attached as an exhibit to the audit. A compliance self-evaluative audit document also includes, but is not limited to, any of the following:

(*i*) A compliance self-evaluative audit report prepared by an auditor, who may be an employee of the health care corporation or an independent contractor, which may include the scope of the audit, the information gained in the audit, and conclusions and recommendations, with exhibits and appendices.

(*ii*) Memoranda and documents analyzing portions or all of the compliance self-evaluative audit report and discussing potential implementation issues.

(*iii*) An implementation plan that addresses correcting past noncompliance, improving current compliance, and preventing future noncompliance.

(*iv*) Analytic data generated in the course of conducting the compliance self-evaluative audit.

Enacting section 1. To the extent that a provision of this act concerning health coverage, including, but not limited to, premiums, rates, filings, and coverages, conflicts with the small employer health market reform act, the small employer health market reform act supersedes this act.

Enacting section 2. This amendatory act does not take effect unless Senate Bill No. _____ or House Bill No. 4278 (request no. 01709'03) of the 92nd Legislature is enacted into law.

Enacting section 3. Section 205 of the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1205, is repealed.