HOUSE BILL No. 6034

April 13, 2010, Introduced by Reps. Johnson, Corriveau, Ball and Roy Schmidt 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 401e, 402b, 608, 609, 610, 612, and 613 (MCL 550.1401e, 550.1402b, 550.1608, 550.1609, 550.1610, 550.1612, and 550.1613), section 401e as added by 1996 PA 516, section 402b as amended by 1999 PA 7, section 608 as amended by 1991 PA 73, and section 609 as amended by 2003 PA 59, and by adding sections 220, 409b, and 419c.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

SEC. 220. (1) EXCEPT AS OTHERWISE PROVIDED, A HEALTH CARE CORPORATION IS SUBJECT TO CHAPTERS 37A AND 37B OF THE INSURANCE CODE OF 1956, 1956 PA 218, MCL 500.3751 TO 500.3788.

(2) A NONGROUP HEALTH CARE CORPORATION CERTIFICATE INTRODUCED ON OR AFTER APRIL 1, 2009 IS NOT SUBJECT TO SECTION 401(3)(A), (B),

HOUSE BILL No. 6034

AND (C) OR SECTIONS 608 TO 614.

(3) AN INDIVIDUAL ENROLLED IN A HEALTH CARE CORPORATION NONGROUP OR GROUP CONVERSION CERTIFICATE "A" THROUGH "G" OR MEDICARE SUPPLEMENTAL CERTIFICATE ON MARCH 31, 2010 MAY REMAIN ENROLLED IN THAT CERTIFICATE. CERTIFICATES DESCRIBED IN THIS SUBSECTION ARE NOT SUBJECT TO SECTION 3759, 3761(3) OR (4), OR 3762 OF THE INSURANCE CODE OF 1956, 1956 PA 218, MCL 500.3759, 500.3761, AND 500.3762. THE RATES FOR CERTIFICATES DESCRIBED IN THIS SUBSECTION SHALL BE DETERMINED UNDER A SYSTEM OF COMMUNITY RATING.

Sec. 401e. ~~(1) Except as provided in this section, a health care corporation that has issued a nongroup certificate shall renew or continue in force the certificate at the option of the individual.~~

(1) ~~(2)~~ Except as provided in this section, a health care corporation that has issued a group certificate shall renew or continue in force the certificate at the option of the sponsor of the plan.

(2) ~~(3)~~ Guaranteed renewal is not required in cases of fraud, intentional misrepresentation of material fact, lack of payment, if the health care corporation no longer offers that particular type of coverage in the market, or if the individual or group moves outside the service area.

Sec. 402b. ~~(1) For an individual covered under a nongroup certificate or under a certificate not covered under subsection (2), a health care corporation may exclude or limit coverage for a condition only if the exclusion or limitation relates to a condition for which medical advice, diagnosis, care, or treatment~~

~~was recommended or received within 6 months before enrollment and the exclusion or limitation does not extend for more than 6 months after the effective date of the certificate.~~

~~(2)~~ A health care corporation shall not exclude or limit coverage for a preexisting condition for an individual covered under a group certificate.

~~(3) Notwithstanding subsection (1), a health care corporation shall not issue a certificate to a person eligible for nongroup coverage or eligible for a certificate not covered under subsection (2) that excludes or limits coverage for a preexisting condition or provides a waiting period if all of the following apply:~~

~~(a) The person's most recent health coverage prior to applying for coverage with the health care corporation was under a group health plan.~~

~~(b) The person was continuously covered prior to the application for coverage with the health care corporation under 1 or more health plans for an aggregate of at least 18 months with no break in coverage that exceeded 62 days.~~

~~(c) The person is no longer eligible for group coverage and is not eligible for medicare or medicaid.~~

~~(d) The person did not lose eligibility for coverage for failure to pay any required contribution or for an act to defraud a health care corporation, a health insurer, or a health maintenance organization.~~

~~(e) If the person was eligible for continuation of health coverage from that group health plan pursuant to the consolidated omnibus budget reconciliation act of 1985, Public Law 99-272, 100~~

~~Stat. 82, he or she has elected and exhausted that coverage.~~

~~(4)~~ As used in this section, "group" means a group of 2 or more subscribers.

SEC. 409B. (1) ANY CERTIFICATE DELIVERED, ISSUED FOR DELIVERY, OR RENEWED IN THIS STATE THAT PROVIDES FOR HOSPITAL OR MEDICAL CARE COVERAGE FOR DEPENDENT CHILDREN SHALL PERMIT CONTINUATION OF THAT COVERAGE FOR A CHILD UNTIL THAT CHILD ATTAINS AGE 26 EVEN IF THE CHILD IS NO LONGER CONSIDERED A DEPENDENT IF THE CHILD MEETS ALL OF THE FOLLOWING:

(A) IS UNMARRIED.

(B) HAS NO DEPENDENTS OF HIS OR HER OWN.

(C) IS A RESIDENT OF THIS STATE OR RESIDES SOMEWHERE ELSE TEMPORARILY.

(D) IS NOT ELIGIBLE FOR A GROUP HEALTH BENEFITS OR COVERAGE PLAN FROM HIS OR HER EMPLOYER.

(E) IS NOT PROVIDED COVERAGE UNDER ANY OTHER GROUP OR INDIVIDUAL HEALTH BENEFITS OR COVERAGE PLAN.

(F) HAS NOT ACCEPTED A FINANCIAL INCENTIVE FROM HIS OR HER EMPLOYER OR OTHER SOURCE TO DECLINE ANY OTHER GROUP OR INDIVIDUAL HEALTH BENEFITS OR COVERAGE PLAN.

(G) WAS CONTINUOUSLY COVERED PRIOR TO THE APPLICATION FOR CONTINUATION COVERAGE UNDER 1 OR MORE INDIVIDUAL OR GROUP HEALTH BENEFITS OR COVERAGE PLANS WITH NO BREAK IN COVERAGE THAT EXCEEDED 62 DAYS.

(2) IF A CERTIFICATE PROVIDES CONTINUATION COVERAGE UNDER SUBSECTION (1) AND THE CHILD FOR WHICH THE CONTINUATION COVERAGE IS PROVIDED ATTAINS AGE 27 DURING THE CERTIFICATE YEAR, COVERAGE FOR

THAT CHILD SHALL CONTINUE THROUGH THE END OF THE CERTIFICATE YEAR.

(3) A COVERED PERSON'S CERTIFICATE MAY REQUIRE PAYMENT OF A PREMIUM BY THE COVERED PERSON OR CHILD, SUBJECT TO THE COMMISSIONER'S APPROVAL, FOR ANY PERIOD OF CONTINUATION COVERAGE ELECTED UNDER SUBSECTION (1). THE PREMIUM SHALL NOT EXCEED 102% OF THE APPLICABLE PORTION OF THE PREMIUM PREVIOUSLY PAID FOR THAT DEPENDENT'S COVERAGE UNDER THE CERTIFICATE BEFORE THE TERMINATION OF COVERAGE AT THE SPECIFIC AGE PROVIDED FOR IN THE CERTIFICATE. THE APPLICABLE PORTION OF THE PREMIUM PREVIOUSLY PAID FOR THAT DEPENDENT'S COVERAGE SHALL BE DETERMINED PURSUANT TO RULES ADOPTED BY THE COMMISSIONER UNDER THE ADMINISTRATIVE PROCEDURES ACT, BASED UPON THE DIFFERENCE BETWEEN THE CERTIFICATE'S RATING TIERS FOR ADULT AND DEPENDENT COVERAGE OR FAMILY COVERAGE, AS APPROPRIATE, AND SINGLE COVERAGE, OR BASED UPON ANY OTHER FORMULA OR DEPENDENT RATING TIER THAT THE COMMISSIONER CONSIDERS APPROPRIATE AND THAT PROVIDES A SUBSTANTIALLY SIMILAR RESULT.

(4) THIS SECTION DOES NOT PROHIBIT AN EMPLOYER FROM REQUIRING AN EMPLOYEE TO PAY ALL OR PART OF THE COST OF COVERAGE PROVIDED FOR THAT EMPLOYEE'S CHILD UNDER THIS SECTION.

SEC. 419C. (1) IF THE MI-HEALTH BOARD DETERMINES THAT SECTION 401B, 401F, 401G, 414A, 415, 416, 416A, 416B, 416C, 416D, OR 417 SHOULD BE WAIVED AS PROVIDED IN SECTION 3783 OF THE INSURANCE CODE OF 1956, 1956 PA 218, MCL 500.3783, THEN THE SECTIONS SO IDENTIFIED BY THE MI-HEALTH BOARD ARE NOT REQUIRED TO BE PROVIDED OR OFFERED IN A STANDARD GUARANTEED ISSUE HEALTH PLAN OR AN ENHANCED GUARANTEED ISSUE HEALTH PLAN.

(2) AS USED IN THIS SECTION:

(A) "MI-HEALTH BOARD" MEANS THE MI-HEALTH BOARD CREATED IN SECTION 3782 OF THE INSURANCE CODE OF 1956, 1956 PA 218, MCL 500.3782.

(B) "STANDARD GUARANTEED ISSUE HEALTH PLAN" AND "ENHANCED GUARANTEED ISSUE HEALTH PLAN" MEAN THOSE PLANS AS REGULATED UNDER CHAPTER 37B OF THE INSURANCE CODE OF 1956, 1956 PA 218, MCL 500.3780 TO 500.3788.

Sec. 608. (1) The rates charged to nongroup subscribers for each **NONGROUP OR GROUP CONVERSION CERTIFICATE "A" THROUGH "G" OR MEDICARE SUPPLEMENT** certificate shall be filed in accordance with section 610 and shall be subject to the prior approval of the commissioner. ~~Annually, the~~ **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 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~~ **ARE** 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~~ **IS** 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.

(3) A proposed rate 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).

(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. 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 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 these elements, 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 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 unimpaired surplus of the health care corporation.

(5) FOR A NONGROUP CERTIFICATE "A" THROUGH "G", A RATE SHALL BE PRESUMED ADEQUATE, EQUITABLE, AND NOT EXCESSIVE IF THE HEALTH CARE CORPORATION ACTUARIALLY CERTIFIES THAT THE RATE DOES NOT EXCEED THE PROJECTED TREND IN CLAIM COSTS. FOR A GROUP CONVERSION CERTIFICATE "A" THOUGH "G", A RATE SHALL BE PRESUMED ADEQUATE, EQUITABLE, AND NOT EXCESSIVE IF THE HEALTH CARE CORPORATION ACTUARIALLY CERTIFIES THAT THE RATE CHANGE DOES NOT EXCEED THE PROJECTED TREND IN CLAIM COSTS. FOR A MEDICARE SUPPLEMENT CERTIFICATE, A RATE SHALL BE PRESUMED ADEQUATE, EQUITABLE, AND NOT EXCESSIVE IF THE HEALTH CARE CORPORATION ACTUARIALLY CERTIFIES THAT

THE RATE DOES NOT EXCEED THE PROJECTED TREND IN CLAIM COSTS. AS USED IN THIS SUBSECTION, PROJECTED TREND IN CLAIM COSTS SHALL BE DETERMINED BY DIVIDING THE PER MEMBER PER MONTH COST FOR THE 12-MONTH PERIOD ENDING 6 MONTHS PRIOR TO THE FILING BY THE PER MEMBER PER MONTH COST FOR THE 12-MONTH PERIOD ENDING 18 MONTHS PRIOR TO THE FILING. IF SURPLUS EXCEEDS THE MAXIMUM SURPLUS PERMITTED UNDER SECTION 204A(5), A CONTRIBUTION FROM SURPLUS MAY BE CONSIDERED IN DETERMINING WHETHER RATES ARE ADEQUATE, EQUITABLE, AND NOT EXCESSIVE, AND PROMOTE THE HEALTH CARE CORPORATION'S CHARITABLE AND SOCIAL MISSION OBLIGATIONS.

(6) ~~(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 **WHO ARE RESIDENTS OF THIS STATE** 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. **AS USED IN THIS SUBSECTION, EARNED SUBSCRIPTION INCOME IS THE SUM OF THE GROUP AND NONGROUP PREMIUM AND THE CLAIM AND ADMINISTRATIVE EXPENSE REIMBURSEMENTS FOR ADMINISTRATIVE SERVICES CONTRACTS, LESS THE INCOME FROM THE FEDERAL EMPLOYEE HEALTH BENEFIT PROGRAM, MEDICARE SUPPLEMENT POLICIES, MEDICARE ADVANTAGE PLANS, AND MICHILD POLICIES. COST TRANSFERS FOR THE BENEFIT OF RESIDENT SENIOR CITIZENS SHALL BE EXPENDED AS DETERMINED BY THE COMMISSIONER SO**

THAT NOT LESS THAN 66-2/3% OF THE COST TRANSFER SHALL BE USED TO PROVIDE A SUBSIDY FOR SENIORS WITH A HOUSEHOLD INCOME OF NOT MORE THAN 300% OF THE FEDERAL POVERTY LEVEL AS DEFINED IN THE POVERTY GUIDELINES PUBLISHED PERIODICALLY IN THE FEDERAL REGISTER BY THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES UNDER ITS AUTHORITY TO REVISE THE POVERTY LINE UNDER 42 USC 9902.

Sec. 610. (1) Except as provided under section 608(4) or (5), a filing of information and materials relative to a proposed rate shall be made not less than ~~120~~ **60** 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~~ **15** days after a filing is made of information and materials relative to a proposed 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)~~ **THIS SECTION** and that the filing is complete. The commissioner shall then proceed to approve, approve with modifications, or disapprove the rate filing ~~60~~ **30** 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)~~ **THIS SECTION**. The notice shall state specifically in what respects the filing fails to meet the requirements of ~~subsections (6) and (8)~~ **THIS SECTION**.

(3) Within ~~10~~ **8** 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~~ **8** 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)~~ **THIS SECTION**. If the commissioner determines that the filing does not yet materially and substantially meet the requirements of ~~subsections (6) and (8)~~ **THIS SECTION**, 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 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 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 **OR GROUP CONVERSION CERTIFICATE "A" THROUGH "G" OR MEDICARE SUPPLEMENT CERTIFICATE** 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~~ **THAT** 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~~ **THAT** 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 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)~~ **(2)**. The forms with instructions shall be available not less than ~~180~~ **90** days before the proposed effective date of the filing.

Sec. 612. (1) Upon receipt of a 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 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 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 REGULATION** 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~~ **8** 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~~ **15** days after receipt of a request for a hearing, and upon not less than ~~15~~ **8** days' notice to all parties, the hearing shall be commenced. 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. The hearing officer shall conduct the hearing pursuant to the administrative procedures act. The hearing shall be conducted in an expeditious manner **AND THE HEARING OFFICER SHALL RENDER A PROPOSAL FOR DECISION NOT LATER THAN 30 DAYS AFTER THE START OF THE HEARING**. 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~~ **8** days after receipt of the hearing officer's proposal for decision, the commissioner shall by order render a decision which 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.

Enacting section 1. This amendatory act does not take effect unless all of the following bills of the 95th Legislature are enacted into law:

(a) Senate Bill No. 1244 or House Bill No. (request no. 00083'09).

(b) Senate Bill No.____ or House Bill No. 6036(request no. H00083'09 *).

(c) Senate Bill No.____ or House Bill No. 6037(request no. 06174'10).

(d) Senate Bill No. 1245 or House Bill No. (request no. S06174'10 *).

(e) Senate Bill No. 1243 or House Bill No.____(request no. 06472'10).

(f) Senate Bill No.____ or House Bill No. 6035(request no. 06473'10).

(g) Senate Bill No. 1242 or House Bill No.____(request no. S06473'10 *).