

DRAFT 5
**HOUSE SUBSTITUTE FOR SENATE SUBSTITUTE FOR
HOUSE BILL NO. 5283**

A bill to amend 1980 PA 350, entitled
"The nonprofit health care corporation reform act,"
by amending sections 308, 401e, 402b, 608, 609, 610, 612, and 613
(MCL 550.1308, 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 102a, 220, and 613a; and to repeal acts and parts of acts.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

1 **SEC. 102A. (1) A HEALTH CARE CORPORATION SHALL EXPEND ANNUALLY**
2 **AMOUNTS EXCEEDING ITS TAX-EXEMPT VALUE ON ITS CHARITABLE AND SOCIAL**
3 **MISSION OBLIGATIONS. FOR PURPOSES OF THIS SECTION, CHARITABLE AND**
4 **SOCIAL MISSION OBLIGATIONS INCLUDE, BUT ARE NOT LIMITED TO, THE**



1 FOLLOWING:

2 (A) EXPANDING ACCESS TO HEALTH CARE BY PROVIDING SUBSIDIES TO
3 ASSIST WITH THE COST OF INDIVIDUAL HEALTH COVERAGE TO STATE
4 RESIDENTS TO PURCHASE THEIR OWN COVERAGE INCLUDING, BUT NOT LIMITED
5 TO, COST TRANSFERS UNDER SECTION 609(5).

6 (B) EXPANDING AND ENHANCING ACCESS TO HEALTH CARE BY
7 AUGMENTING AND CREATING HEALTH CARE PROGRAMS AND AUGMENTING PUBLIC
8 HEALTH CARE PROGRAMS THAT DELIVER HEALTH SERVICES.

9 (C) SUPPORTING PROGRAMS THAT INFORM AND EDUCATE RESIDENTS OF
10 THIS STATE ABOUT PUBLIC HEALTH ISSUES AND PROGRAMS THAT EMPOWER
11 COMMUNITIES TO ADDRESS PUBLIC HEALTH ISSUES BY BECOMING MORE
12 EFFECTIVE AT IDENTIFYING AND ARTICULATING HEALTH CARE NEEDS AND
13 IMPLEMENTING SOLUTIONS.

14 (D) PROMOTING SAFEGUARDS FOR MAINTAINING APPROPRIATE CAPACITY
15 FOR HEALTH SCIENCE RESEARCH AND HEALTH CARE PROVIDER EDUCATION.

16 (2) BY APRIL 1 OF EACH YEAR, THE HEALTH CARE CORPORATION SHALL
17 FILE WITH THE COMMISSIONER AND WITH THE SENATE AND HOUSE OF
18 REPRESENTATIVES STANDING COMMITTEES ON HEALTH AND INSURANCE ISSUES
19 AN INDEPENDENTLY AUDITED REPORT THAT PROVIDES FOR ALL OF THE
20 FOLLOWING FOR THE IMMEDIATELY PRECEDING CALENDAR YEAR:

21 (A) HOW THE HEALTH CARE CORPORATION MET ITS CHARITABLE AND
22 SOCIAL MISSION OBLIGATIONS.

23 (B) THE AMOUNT SPENT BY THE HEALTH CARE CORPORATION ON ITS
24 CHARITABLE AND SOCIAL MISSION OBLIGATIONS.

25 (C) THE AMOUNT OF TAX EXEMPT BENEFIT OBTAINED BY THE HEALTH
26 CARE CORPORATION.

27 SEC. 220. A NONPROFIT HEALTH CARE CORPORATION IS SUBJECT TO



1 CHAPTER 37A OF THE INSURANCE CODE OF 1956, 1956 PA 218, MCL
2 500.3751 TO 500.3781.

3 Sec. 308. (1) To the extent provided by resolution of the
4 board or in the bylaws or articles, a committee established
5 pursuant to section 307 may exercise the powers and authority of
6 the board in management of the business and affairs of the health
7 care corporation. The board shall review and may modify subject to
8 the rights of third parties any action or decision of a committee.
9 A committee shall not do any of the following:

10 (a) Amend the articles of incorporation.

11 (b) Adopt an agreement of merger or consolidation.

12 (c) Authorize the sale, lease, or exchange of all or
13 substantially all of the corporation's property and assets.

14 (d) Approve, adopt, or amend provider contracts, provider
15 class plans, OR rates charged to subscribers. ~~, or a certificate.~~

16 (e) Amend the bylaws of the corporation.

17 (f) Fill vacancies on the board.

18 (g) Fix compensation of the directors or officers.

19 (h) Perform other similar acts of a final or binding nature
20 with respect to the business of the corporation.

21 (2) This section ~~shall~~ **DOES** not prohibit emergency actions by
22 the executive committee on behalf of the board, as authorized in
23 the bylaws of the health care corporation.

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



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

5 (2) ~~(3)~~ Guaranteed renewal is not required in cases of fraud,
6 intentional misrepresentation of material fact, lack of payment, if
7 the health care corporation no longer offers that particular type
8 of coverage in the market, or if the individual or group moves
9 outside the service area.

10 Sec. 402b. ~~(1) For an individual covered under a nongroup~~
11 ~~certificate or under a certificate not covered under subsection~~
12 ~~(2), a health care corporation may exclude or limit coverage for a~~
13 ~~condition only if the exclusion or limitation relates to a~~
14 ~~condition for which medical advice, diagnosis, care, or treatment~~
15 ~~was recommended or received within 6 months before enrollment and~~
16 ~~the exclusion or limitation does not extend for more than 6 months~~
17 ~~after the effective date of the certificate.~~

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

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

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



1 ~~health plan.~~

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

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

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

12 ~~—— (e) If the person was eligible for continuation of health~~
 13 ~~coverage from that group health plan pursuant to the consolidated~~
 14 ~~omnibus budget reconciliation act of 1985, Public Law 99 272, 100~~
 15 ~~Stat. 82, he or she has elected and exhausted that coverage.~~

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

18 Sec. 608. (1) The rates charged to nongroup subscribers for
 19 each certificate shall be filed **WITH THE COMMISSIONER AND THE**
 20 **ATTORNEY GENERAL** in accordance with section 610. ~~and shall be~~
 21 ~~subject to the prior approval of the commissioner. Annually, the~~
 22 ~~commissioner shall approve, disapprove, or modify and approve the~~
 23 ~~proposed or existing rates for each certificate subject to the~~
 24 ~~standard that the rates must be determined to be equitable,~~
 25 ~~adequate, and not excessive, as defined in section 609. The burden~~
 26 ~~of proof that rates to be charged meet these standards shall be~~
 27 ~~upon the health care corporation proposing to use the rates. **THE**~~



1 RATE FILING SHALL INCLUDE AN ACTUARIAL CERTIFICATION THAT THE
2 BENEFITS PROVIDED ARE REASONABLE IN RELATION TO THE PREMIUM CHARGED
3 AND ARE ADEQUATE, EQUITABLE, AND NOT EXCESSIVE. THE RATE FILING
4 SHALL SHOW THE ANTICIPATED LOSS RATIO. THE RATE FILING SHALL
5 INCLUDE A COPY OF THE REPORT FILED UNDER SECTION 102A(2) CONCERNING
6 THE HEALTH CARE CORPORATION'S CHARITABLE AND SOCIAL MISSION
7 OBLIGATIONS. A CONTRIBUTION FROM SURPLUS MAY BE CONSIDERED IN THE
8 DETERMINATION OF WHETHER RATES ARE REASONABLE IN RELATION TO THE
9 BENEFITS PROVIDED IF SURPLUS EXCEEDS THE MAXIMUM SURPLUS PERMITTED
10 UNDER SECTION 204A(5). A NONGROUP OR GROUP CONVERSION RATE SHALL BE
11 PRESUMED REASONABLE IN RELATION TO THE PREMIUMS CHARGED AND IS
12 ADEQUATE, EQUITABLE, AND NOT EXCESSIVE IF THE ANTICIPATED LOSS
13 RATIO EQUALS OR EXCEEDS 80%. A MEDICARE SUPPLEMENT RATE SHALL BE
14 PRESUMED REASONABLE IN RELATION TO THE PREMIUMS CHARGED AND IS
15 ADEQUATE, EQUITABLE, AND NOT EXCESSIVE IF THE ANTICIPATED LOSS
16 RATIO EQUALS OR EXCEEDS 90%. SECTION 3765 OF THE INSURANCE CODE OF
17 1956, 1956 PA 218, MCL 500.3765, APPLIES TO ADJUSTING PREMIUMS FOR
18 EACH CERTIFICATE. FOR CERTIFICATES INTRODUCED ON OR AFTER JANUARY
19 1, 2009, ANY PREMIUM DIFFERENCES AMONG THE CERTIFICATES SHALL
20 REFLECT THE ACTUARIAL VALUE OF THE CERTIFICATE DIFFERENCES AND NOT
21 THE UNDERLYING EXPERIENCE OF THE CERTIFICATES.

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



1 the prior approval of the commissioner. The definition of a group,
2 including any clustering principles applied to nongroup subscribers
3 or small group subscribers for the purpose of group formation,
4 ~~shall be~~ **ARE** subject to the prior approval of the commissioner.
5 However, if a Michigan caring program is created under section 436,
6 that program shall be defined as a group program for the purpose of
7 establishing rates. The commissioner shall approve, disapprove, or
8 modify and approve the methodology and definitions of each rating
9 system, formula, component, and factor for each certificate subject
10 to the standard that the resulting rates for group subscribers must
11 be determined to be equitable, adequate, and not excessive, as
12 defined in section 609. In addition, the commissioner may from time
13 to time review the records of the corporation to determine proper
14 application of a rating system, formula, component, or factor with
15 respect to any group. The corporation shall refile for approval
16 under this subsection, every 3 years, the methodology and
17 definitions of each rating system, formula, component, and factor
18 used to calculate rates for group subscribers, including the
19 methodology and definitions used to calculate administrative costs
20 for administrative services only and cost-plus arrangements. **A**
21 **CONTRIBUTION FROM SURPLUS MAY BE CONSIDERED IN THE DETERMINATION OF**
22 **WHETHER RATES ARE ADEQUATE, EQUITABLE, AND NOT EXCESSIVE IF SURPLUS**
23 **EXCEEDS THE MAXIMUM SURPLUS PERMITTED UNDER SECTION 204A(5).** The
24 burden of proof that the resulting rates to be charged meet these
25 standards shall be upon the health care corporation proposing to
26 use the rating system, formula, component, or factor.
27 (3) A proposed rate shall not take effect until a filing has



1 been made with the commissioner and approved under section 607 or
2 this section, as applicable, except as provided in subsections (4)
3 and (5).

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

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

20 (6) FOR RATES SUBMITTED UNDER SUBSECTION (1), NO LATER THAN 4
21 MONTHS AFTER THE END OF A 12-MONTH RATING PERIOD, THE HEALTH CARE
22 CORPORATION SHALL SUBMIT INFORMATION TO THE COMMISSIONER AND THE
23 ATTORNEY GENERAL THAT SHOWS THE ACTUAL LOSS RATIO FOR THE RATING
24 PERIOD FOR ALL CERTIFICATES SUBJECT TO THAT 12-MONTH RATING PERIOD,
25 INCLUDING CERTIFICATES THAT HAVE BEEN OR WILL BE CLOSED TO NEW
26 APPLICANTS. IF THE ACTUAL LOSS RATIO FOR THOSE CERTIFICATES DOES
27 NOT EQUAL OR EXCEED THE APPLICABLE ANTICIPATED LOSS RATIO UNDER



1 SUBSECTION (1), THE COMMISSIONER SHALL ORDER THE CORPORATION TO
2 ISSUE RATE CREDITS OR REFUNDS TO INDIVIDUALS CURRENTLY COVERED
3 UNDER A CERTIFICATE IN THAT LINE OF BUSINESS IN AN AMOUNT THAT WILL
4 RESULT IN A MINIMUM LOSS RATIO FOR THE RATING PERIOD EQUAL TO THE
5 APPLICABLE ANTICIPATED LOSS RATIO FOR THE LINE OF BUSINESS. THE
6 CORPORATION SHALL NOT BE ORDERED TO ISSUE A REFUND IN AN AMOUNT
7 LESS THAN \$25.00 PER INDIVIDUAL APPLICANT. THE RATE CREDITS OR
8 REFUNDS SHALL BE ISSUED NO LATER THAN 90 DAYS AFTER THE
9 COMMISSIONER'S ORDER TO ISSUE RATE CREDITS OR REFUNDS. THE ATTORNEY
10 GENERAL MAY BRING AN ACTION OR APPLY TO THE CIRCUIT COURT FOR A
11 COURT ORDER TO ENFORCE AN ORDER OF THE COMMISSIONER REQUIRING RATE
12 CREDITS UNDER THIS SECTION. AS USED IN THIS SUBSECTION, EACH OF THE
13 FOLLOWING CONSTITUTES A SEPARATE LINE OF BUSINESS:

14 (A) ALL CERTIFICATES THAT ARE MEDICARE SUPPLEMENT
15 CERTIFICATES.

16 (B) ALL CERTIFICATES THAT ARE GROUP CONVERSION CERTIFICATES A
17 CORPORATION IS REQUIRED TO OFFER UNDER SECTION 410A.

18 (C) ALL NONGROUP CERTIFICATES THAT ARE NEITHER MEDICARE
19 SUPPLEMENT NOR GROUP CONVERSION CERTIFICATES.

20 (7) AS USED IN THIS SECTION:

21 (A) "ACTUAL LOSS RATIO" MEANS THE RATIO FOR A 12-MONTH RATING
22 PERIOD OF THE INCURRED CLAIMS TO PREMIUMS. INCURRED CLAIMS MAY
23 INCLUDE REJECTION AND ASSESSMENT FEES LEVIED UNDER SECTION 3774 OF
24 THE INSURANCE CODE OF 1956, 1956 PA 218, MCL 500.3774.

25 (B) "ANTICIPATED LOSS RATIO" MEANS THE RATIO AT THE TIME OF
26 THE RATE FILING, OR AT A TIME OF SUBSEQUENT RATE REVISIONS, OF THE
27 EXPECTED FUTURE INCURRED CLAIMS DURING THE RATING PERIOD DEFINED IN



1 THE RATE FILING TO THE FUTURE PREMIUMS, BASED ON A CREDIBLE PREMIUM
2 VOLUME OVER A REASONABLE PERIOD OF TIME WITH PROPER WEIGHT GIVEN TO
3 RATING TRENDS AND OTHER RELEVANT FACTORS. EXPECTED FUTURE INCURRED
4 CLAIMS MAY INCLUDE ANTICIPATED REJECTION AND ASSESSMENT FEES TO BE
5 LEVIED UNDER SECTION 3774 OF THE INSURANCE CODE OF 1956, 1956 PA
6 218, MCL 500.3774. STATISTICAL DATA RELATING TO EXPECTED FUTURE
7 INCURRED CLAIMS SHALL BE PROVIDED TO THE COMMISSIONER UPON REQUEST.

8 Sec. 609. (1) A rate is not excessive if the rate is not
9 unreasonably high relative to the following elements, individually
10 or collectively; provision for anticipated benefit costs; provision
11 for administrative expense; provision for cost transfers, if any;
12 provision for a contribution to or from surplus that is consistent
13 with the attainment or maintenance of adequate and unimpaired
14 surplus as provided in section 204a; and provision for adjustments
15 due to prior experience of groups, as defined in the group rating
16 system. A determination as to whether a rate is excessive relative
17 to these elements, individually or collectively, shall be based on
18 the following: reasonable evaluations of recent claim experience;
19 projected trends in claim costs; the allocation of administrative
20 expense budgets; and the present and anticipated unimpaired surplus
21 of the health care corporation. To the extent that any of these
22 elements are considered excessive, the provision in the rates for
23 these elements shall be modified accordingly.

24 (2) The administrative expense budget must be reasonable, as
25 determined by the commissioner after examination of material and
26 substantial administrative and acquisition expense items.

27 (3) A rate is equitable if the rate can be compared to any



1 other rate offered by the health care corporation to its
 2 subscribers, and the observed rate differences can be supported by
 3 differences in anticipated benefit costs, administrative expense
 4 cost, differences in risk, or any identified cost transfer
 5 provisions.

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

12 (5) Except for identified cost transfers, each line of
 13 business, over time, shall be self-sustaining. However, there may
 14 be cost transfers for the benefit of senior citizens and group
 15 conversion subscribers. Cost transfers for the benefit of senior
 16 citizens, in the aggregate, annually shall not exceed 1% of the
 17 earned subscription income of the health care corporation as
 18 reported in the most recent annual statement of the corporation.
 19 Group conversion subscribers are those who have maintained coverage
 20 with the health care corporation on an individual basis after
 21 leaving a subscriber group.

22 (6) **SUBSECTIONS (1) TO (4) APPLY ONLY TO RATE FILINGS**
 23 **SUBMITTED PURSUANT TO SECTION 608(2).**

24 Sec. 610. (1) Except as provided under section 608(4) or (5),
 25 a filing of information and materials relative to a proposed rate
 26 **UNDER SECTION 608(1) OR (2)** shall be made not less than ~~120~~60 days
 27 before the proposed effective date of the proposed rate. A filing



1 shall not be considered to have been received until there has been
2 substantial and material compliance with the requirements
3 prescribed in ~~subsections (6) and (8)~~ **THIS SECTION**.

4 (2) Within ~~30~~15 days after a filing is made of information
5 and materials relative to a proposed rate, the commissioner shall
6 do either of the following:

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

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

22 (3) Within ~~10~~8 days after the filing of notice pursuant to
23 subsection (2)(b), the corporation shall submit to the commissioner
24 such additional information and materials, as requested by the
25 commissioner. Within ~~10~~8 days after receipt of the additional
26 information and materials, the commissioner shall determine whether
27 the filing is in material and substantial compliance with



1 subsections ~~(6) and (8)~~ **THIS SECTION**. If the commissioner
2 determines that the filing does not yet materially and
3 substantially meet the requirements of subsections ~~(6) and (8)~~ **THIS**
4 **SECTION**, the commissioner shall give notice to the corporation
5 pursuant to subsection (2)(b) or use visitation of the
6 corporation's facilities and examination of the corporation's
7 records to obtain the necessary information described in the notice
8 issued pursuant to subsection (2)(b). The commissioner shall use
9 either procedure previously mentioned, or a combination of both
10 procedures, in order to obtain the necessary information as
11 expeditiously as possible. The per diem, traveling, reproduction,
12 and other necessary expenses in connection with visitation and
13 examination shall be paid by the corporation, and shall be credited
14 to the general fund of the state.

15 ~~—— (4) If a filing is approved, approved with modifications, or~~
16 ~~disapproved under subsection (2)(a), the commissioner shall issue a~~
17 ~~written order of the approval, approval with modifications, or~~
18 ~~disapproval. If the filing was approved with modifications or~~
19 ~~disapproved, the order shall state specifically in what respects~~
20 ~~the filing fails to meet the requirements of this act and, if~~
21 ~~applicable, what modifications are required for approval under this~~
22 ~~act. If the filing was approved with modifications, the order shall~~
23 ~~state that the filing shall take effect after the modifications are~~
24 ~~made and approved by the commissioner. If the filing was~~
25 ~~disapproved, the order shall state that the filing shall not take~~
26 ~~effect.~~

27 ~~—— (5) The inability to approve 1 or more rating classes of~~



1 ~~business within a line of business because of a requirement to~~
2 ~~submit further data or because a request for a hearing under~~
3 ~~section 613 has been granted shall not delay the approval of rates~~
4 ~~by the commissioner which could otherwise be approved or the~~
5 ~~implementation of rates already approved, unless the approval or~~
6 ~~implementation would affect the consideration of the unapproved~~
7 ~~classes of business.~~

8 (4) THIRTY DAYS AFTER THE COMMISSIONER'S WRITTEN NOTICE TO THE
9 HEALTH CARE CORPORATION THAT THE FILING IS IN MATERIAL AND
10 SUBSTANTIAL COMPLIANCE WITH THIS SECTION AND IS COMPLETE, THE RATES
11 SHALL BE CONSIDERED APPROVED AND BECOME EFFECTIVE.

12 (5) THE COMMISSIONER OR THE ATTORNEY GENERAL MAY REQUEST AN
13 ACTUARIAL REVIEW UNDER SECTION 613A OF A FILING APPROVED UNDER
14 SUBSECTION (4) IF THE COMMISSIONER OR ATTORNEY GENERAL HAS
15 REASONABLE CAUSE TO BELIEVE 1 OR MORE OF THE FOLLOWING:

16 (A) THE ANTICIPATED LOSS RATIO FOR THE PROPOSED RATE WILL NOT
17 EQUAL OR EXCEED THE ANTICIPATED LOSS RATIO APPLICABLE TO THE
18 PROPOSED RATE UNDER SECTION 608(1).

19 (B) THE HEALTH CARE CORPORATION'S SURPLUS EXCEEDS THE MAXIMUM
20 SURPLUS PERMITTED UNDER SECTION 204A(5).

21 (C) THE HEALTH CARE CORPORATION HAS NOT SATISFIED ITS
22 CHARITABLE OR SOCIAL MISSION OBLIGATIONS BASED ON THE MOST RECENT
23 REPORT FILED WITH THE COMMISSIONER UNDER SECTION 102A(2).

24 (6) RATES CONSIDERED APPROVED AND EFFECTIVE UNDER SUBSECTION
25 (4) SHALL REMAIN IN EFFECT DURING THE PENDENCY OF AN ACTUARIAL
26 REVIEW.

27 (7) ~~(6)~~ Information furnished under subsection (1) in support



1 of a nongroup rate filing shall include the following:

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

4 (b) Actual prior trend experience.

5 (c) Actual prior administrative expenses.

6 (d) Projected trend factors.

7 (e) Projected administrative expenses.

8 (f) Contributions for risk and ~~contingency reserve~~ **SURPLUS**
9 factors.

10 (g) Actual health care corporation ~~contingency reserve~~ **SURPLUS**
11 position.

12 (h) Projected health care corporation ~~contingency reserve~~
13 **SURPLUS** position.

14 (i) Other information which the corporation considers
15 pertinent to evaluating the risks to be rated, or relevant to the
16 determination to be made under this section.

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

20 (8) ~~(7)~~—A copy of the filing, and all supporting information,
21 except for the information which may not be disclosed under section
22 604, shall be open to public inspection as of the date filed with
23 the commissioner.

24 (9) ~~(8)~~—The commissioner shall make available forms and
25 instructions for filing for proposed rates under sections 608(1)
26 and 608(2). The forms with instructions shall be available not less
27 than 180 days before the proposed effective date of the filing.



1 Sec. 612. (1) Upon receipt of a rate filing under section 610,
2 the commissioner immediately shall notify each person who has
3 requested in writing notice of those filings within the previous 2
4 years, specifying the nature and extent of the proposed rate
5 revision and identifying the location, time, and place where the
6 copy of the rate filing described in section ~~610(7)~~—610(8) shall be
7 open to public inspection and copying. ~~The~~ **FOR A RATE FILING MADE**
8 **UNDER SECTION 608(2) ONLY, THE** notice shall also state that if the
9 person has standing, the person shall have, upon making a written
10 request for a hearing within 60 days after receiving notice of the
11 rate filing, an opportunity for an evidentiary hearing under
12 section 613 to determine whether the proposed rates meet the
13 requirements of this act. The request shall identify the issues
14 which the requesting party asserts are involved, what portion of
15 the rate filing is requested to be heard, and how the party has
16 standing. The corporation shall place advertisements giving notice,
17 containing the information specified above, in at least 1 newspaper
18 which serves each geographic area in which significant numbers of
19 subscribers reside.

20 (2) The commissioner may charge a fee for providing, pursuant
21 to subsection (1), a copy of the rate filing described in section
22 ~~610(7)~~—610(8). The commissioner may charge a fee for providing a
23 copy of the entire filing to a person whose request for a hearing
24 has been granted by the commissioner pursuant to section 613. The
25 fee shall be limited to actual mailing costs and to the actual
26 incremental cost of duplication, including labor and the cost of
27 deletion and separation of information as provided in section 14 of



1 ~~Act No. 442 of the Public Acts of 1976, being section 15.244 of the~~
2 ~~Michigan Compiled Laws~~ **THE FREEDOM OF INFORMATION ACT, 1976 PA 442,**
3 **MCL 15.244.** Copies of the filing may be provided free of charge or
4 at a reduced charge if the commissioner determines that a waiver or
5 reduction of the fee is in the public interest because the
6 furnishing of a copy of the filing will primarily benefit the
7 general public. In calculating the costs under this subsection, the
8 commissioner shall not attribute more than the hourly wage of the
9 lowest paid, full-time clerical employee of the ~~insurance bureau~~
10 **OFFICE OF FINANCIAL AND INSURANCE REGULATION** to the cost of labor
11 incurred in duplication and mailing and to the cost of separation
12 and deletion. The commissioner shall use the most economical means
13 available to provide copies of a rate filing.

14 Sec. 613. (1) If the request for a hearing under this section
15 is with regard to a rate filing **UNDER SECTION 608(2)** not yet acted
16 upon under section 610(2)(a), no such action shall be taken by the
17 commissioner until after the hearing has been completed. However,
18 the commissioner shall proceed to act upon those portions of a rate
19 filing upon which no hearing has been requested. Within 15 days
20 after receipt of a request for a hearing, the commissioner shall
21 determine if the person has standing. If the commissioner
22 determines that the person has standing, the person may have access
23 to the entire filing subject to the same confidentiality
24 requirements as the commissioner under section 604, and shall be
25 subject to the penalty provision of section 604(5). Upon
26 determining that the person has standing, the commissioner shall
27 immediately appoint an independent hearing officer before whom the



1 hearing shall be held. In appointing an independent hearing
2 officer, the commissioner shall select a person qualified to
3 conduct hearings, who has experience or education in the area of
4 health care corporation or insurance rate determination and
5 finance, and who is not otherwise associated financially with a
6 health care corporation or a health care provider. The person
7 selected shall not be currently or actively employed by this state.
8 For purposes of this subsection, an employee of an educational
9 institution shall not be considered to be employed by this state.
10 For purposes of this section, a person has "standing" if any of the
11 following circumstances exist:

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

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

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

18 (2) Not more than 30 days after receipt of a request for a
19 hearing, and upon not less than 15 days' notice to all parties, the
20 hearing shall be commenced. Each party to the hearing shall be
21 given a reasonable opportunity for discovery before and throughout
22 the course of the hearing. However, the hearing officer may
23 terminate discovery at any time, for good cause shown. The hearing
24 officer shall conduct the hearing pursuant to the administrative
25 procedures act. The hearing shall be conducted in an expeditious
26 manner. At the hearing, the burden of proving compliance with this
27 act shall be upon the health care corporation.



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

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

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

9 **SEC. 613A. BY NOT LATER THAN 30 DAYS AFTER RATES ARE**
10 **CONSIDERED APPROVED AND EFFECTIVE UNDER SECTION 610(4), THE**
11 **ATTORNEY GENERAL MAY FILE WITH THE COMMISSIONER, OR THE**
12 **COMMISSIONER MAY FILE ON HIS OR HER OWN MOTION, A NOTICE OF REQUEST**
13 **FOR REVIEW BY AN ACTUARIAL PANEL UNDER THIS SECTION. BY NOT LATER**
14 **THAN 15 DAYS AFTER THIS FILING, THE COMMISSIONER AND THE HEALTH**
15 **CARE CORPORATION SHALL EACH SELECT AN ACTUARY TO REVIEW THE FILING.**
16 **BY NOT LATER THAN 7 DAYS AFTER THESE 2 ACTUARIES ARE SELECTED, THE**
17 **2 ACTUARIES SHALL SELECT A THIRD ACTUARY. EACH ACTUARY APPOINTED TO**
18 **THE PANEL SHALL MEET ALL OF THE FOLLOWING:**

19 (A) BE A FELLOW IN THE SOCIETY OF ACTUARIES.

20 (B) HAVE AT LEAST 10 YEARS' EXPERIENCE DEVELOPING OR REVIEWING
21 NONGROUP HEALTH INSURANCE RATES.

22 (C) NOT BE AN EMPLOYEE OF A HEALTH INSURER, HEALTH MAINTENANCE
23 ORGANIZATION, THIRD PARTY ADMINISTRATOR, HEALTH CARE CORPORATION,
24 OR THIS STATE.

25 (2) BY NOT LATER THAN 3 DAYS AFTER THE ACTUARIAL PANEL HAS
26 BEEN APPOINTED, THE COMMISSIONER SHALL FORWARD THE RATE FILING AND
27 ANY ADDITIONAL SUPPORTING INFORMATION TO THE PANEL. AFTER RECEIPT



1 OF THE RATE FILING AND ANY SUPPORTING INFORMATION, THE MEMBERS OF
2 THE ACTUARIAL PANEL SHALL HAVE 10 DAYS TO REQUEST ADDITIONAL
3 INFORMATION RELATED TO THE RATE FILING FROM THE HEALTH CARE
4 CORPORATION. ANY REQUEST FOR ADDITIONAL INFORMATION SHALL BE
5 SUPPORTED BY AT LEAST 2 MEMBERS OF THE PANEL. BY NOT LATER THAN 10
6 DAYS AFTER A REQUEST FOR ADDITIONAL INFORMATION IS RECEIVED, THE
7 HEALTH CARE CORPORATION SHALL PROVIDE THE INFORMATION TO THE PANEL.

8 (3) BY NOT LATER THAN 21 DAYS AFTER THE APPOINTMENT OF THE
9 ACTUARIAL PANEL OR THE PANEL'S RECEIPT OF ADDITIONAL INFORMATION
10 FROM THE HEALTH CARE CORPORATION, WHICHEVER IS LATER, THE PANEL
11 SHALL SUBMIT WRITTEN RECOMMENDATIONS TO THE COMMISSIONER REGARDING
12 WHETHER THE HEALTH CARE CORPORATION HAS COMPLIED WITH THE PROVISION
13 OR PROVISIONS OF SECTION 610(5) FOR WHICH A REVIEW WAS REQUESTED.
14 THE RECOMMENDATIONS OF THE PANEL SHALL BE SUPPORTED BY AT LEAST 2
15 MEMBERS OF THE PANEL.

16 (4) BY NOT LATER THAN 15 DAYS AFTER RECEIPT OF THE PANEL'S
17 RECOMMENDATIONS, THE COMMISSIONER SHALL BY ORDER RENDER A DECISION
18 THAT INCLUDES A STATEMENT OF FINDINGS.

19 (5) THE COMMISSIONER'S ORDER UNDER SUBSECTION (4) SHALL BE
20 ISSUED NO LATER THAN 180 DAYS AFTER THE PROPOSED RATES ARE FILED
21 UNDER SECTION 608(1). IF THE COMMISSIONER DOES NOT ISSUE AN ORDER
22 WITHIN 180 DAYS OF FILING, THE RATES CONSIDERED APPROVED AND
23 EFFECTIVE UNDER SECTION 610(4) SHALL REMAIN IN EFFECT AND THE RATES
24 SHALL NOT BE SUBJECT TO FURTHER CHALLENGE BY THE COMMISSIONER OR
25 ATTORNEY GENERAL. THE 180-DAY PERIOD, HOWEVER, SHALL BE TOLLED FOR
26 ANY PERIOD OF TIME THE HEALTH CARE CORPORATION TAKES TO SUBMIT
27 ADDITIONAL INFORMATION TO THE COMMISSIONER UNDER SECTION 610(3) OR



1 TO THE ACTUARIAL PANEL UNDER SUBSECTION (2) THAT IS BEYOND THE TIME
2 THE HEALTH CARE CORPORATION IS PERMITTED TO TAKE UNDER THOSE
3 SECTIONS.

4 (6) IF THE COMMISSIONER'S ORDER UNDER SUBSECTION (4) RESULTS
5 IN APPROVAL OF A LOWER RATE, APPROPRIATE REFUNDS OR ADJUSTMENTS, AS
6 DETERMINED BY THE COMMISSIONER, SHALL BE MADE TO REFLECT PAYMENTS
7 IN EXCESS OF THE APPROVED RATE.

8 Enacting section 1. Section 614 of the nonprofit health care
9 corporation reform act, 1980 PA 350, MCL 550.1614, is repealed.

10 Enacting section 2. This amendatory act takes effect January
11 1, 2009.

12 Enacting section 3. This amendatory act does not take effect
13 unless House Bill No. 5282 of the 94th Legislature is enacted into
14 law.

