

SENATE BILL No. 1243

March 25, 2010, Introduced by Senators GEORGE, GLEASON, BIRKHOLZ and ALLEN 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:

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

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

1 AND (C) OR SECTIONS 608 TO 614.

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

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

14 (1) ~~(2)~~ Except as provided in this section, a health care
15 corporation that has issued a group certificate shall renew or
16 continue in force the certificate at the option of the sponsor of
17 the plan.

18 (2) ~~(3)~~ Guaranteed renewal is not required in cases of fraud,
19 intentional misrepresentation of material fact, lack of payment, if
20 the health care corporation no longer offers that particular type
21 of coverage in the market, or if the individual or group moves
22 outside the service area.

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

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

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

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

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

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

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

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

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

1 ~~Stat. 82, he or she has elected and exhausted that coverage.~~
2 ~~——(4) As used in this section, "group" means a group of 2 or~~
3 ~~more subscribers.~~

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

10 (A) IS UNMARRIED.

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

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

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

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

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

21 (G) WAS CONTINUOUSLY COVERED PRIOR TO THE APPLICATION FOR
22 CONTINUATION COVERAGE UNDER 1 OR MORE INDIVIDUAL OR GROUP HEALTH
23 BENEFITS OR COVERAGE PLANS WITH NO BREAK IN COVERAGE THAT EXCEEDED
24 62 DAYS.

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

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

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

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

20 SEC. 419C. (1) IF THE MI-HEALTH BOARD DETERMINES THAT SECTION
21 401B, 401F, 401G, 414A, 415, 416, 416A, 416B, 416C, 416D, OR 417
22 SHOULD BE WAIVED AS PROVIDED IN SECTION 3783 OF THE INSURANCE CODE
23 OF 1956, 1956 PA 218, MCL 500.3783, THEN THE SECTIONS SO IDENTIFIED
24 BY THE MI-HEALTH BOARD ARE NOT REQUIRED TO BE PROVIDED OR OFFERED
25 IN A STANDARD GUARANTEED ISSUE HEALTH PLAN OR AN ENHANCED
26 GUARANTEED ISSUE HEALTH PLAN.

27 (2) AS USED IN THIS SECTION:

1 (A) "MI-HEALTH BOARD" MEANS THE MI-HEALTH BOARD CREATED IN
2 SECTION 3782 OF THE INSURANCE CODE OF 1956, 1956 PA 218, MCL
3 500.3782.

4 (B) "STANDARD GUARANTEED ISSUE HEALTH PLAN" AND "ENHANCED
5 GUARANTEED ISSUE HEALTH PLAN" MEAN THOSE PLANS AS REGULATED UNDER
6 CHAPTER 37B OF THE INSURANCE CODE OF 1956, 1956 PA 218, MCL
7 500.3780 TO 500.3788.

8 Sec. 608. (1) The rates charged to nongroup subscribers for
9 each **NONGROUP OR GROUP CONVERSION CERTIFICATE "A" THROUGH "G" OR**
10 **MEDICARE SUPPLEMENT** certificate shall be filed in accordance with
11 section 610 and shall be subject to the prior approval of the
12 commissioner. ~~Annually, the~~ **THE** commissioner shall approve,
13 disapprove, or modify and approve the proposed or existing rates
14 for each certificate subject to the standard that the rates must be
15 determined to be equitable, adequate, and not excessive, as defined
16 in section 609. The burden of proof that rates to be charged meet
17 these standards shall be upon the health care corporation proposing
18 to use the rates.

19 (2) The methodology and definitions of each rating system,
20 formula, component, and factor used to calculate rates for group
21 subscribers for each certificate, including the methodology and
22 definitions used to calculate administrative costs for
23 administrative services only and cost-plus arrangements, shall be
24 filed in accordance with section 610 and ~~shall be~~ **ARE** subject to
25 the prior approval of the commissioner. The definition of a group,
26 including any clustering principles applied to nongroup subscribers
27 or small group subscribers for the purpose of group formation,

1 ~~shall be~~ IS subject to the prior approval of the commissioner.
2 However, if a Michigan caring program is created under section 436,
3 that program shall be defined as a group program for the purpose of
4 establishing rates. The commissioner shall approve, disapprove, or
5 modify and approve the methodology and definitions of each rating
6 system, formula, component, and factor for each certificate subject
7 to the standard that the resulting rates for group subscribers must
8 be determined to be equitable, adequate, and not excessive, as
9 defined in section 609. In addition, the commissioner may from time
10 to time review the records of the corporation to determine proper
11 application of a rating system, formula, component, or factor with
12 respect to any group. The corporation shall refile for approval
13 under this subsection, every 3 years, the methodology and
14 definitions of each rating system, formula, component, and factor
15 used to calculate rates for group subscribers, including the
16 methodology and definitions used to calculate administrative costs
17 for administrative services only and cost-plus arrangements. The
18 burden of proof that the resulting rates to be charged meet these
19 standards shall be upon the health care corporation proposing to
20 use the rating system, formula, component, or factor.

21 (3) A proposed rate shall not take effect until a filing has
22 been made with the commissioner and approved under section 607 or
23 this section, as applicable, except as provided in subsections (4)
24 and (5).

25 (4) Upon request by a health care corporation, the
26 commissioner may allow rate adjustments to become effective prior
27 to approval, for federal or state mandated benefit changes.

1 However, a filing for these adjustments shall be submitted before
2 the effective date of the mandated benefit changes. If the
3 commissioner disapproves or modifies and approves the rates, an
4 adjustment shall be made retroactive to the effective date of the
5 mandated benefit changes or additions.

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

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

1 elements are considered excessive, the provision in the rates for
2 these elements shall be modified accordingly.

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

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

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

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

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

11 (6) ~~(5)~~—Except for identified cost transfers, each line of
12 business, over time, shall be self-sustaining. However, there may
13 be cost transfers for the benefit of senior citizens **WHO ARE**
14 **RESIDENTS OF THIS STATE** and group conversion subscribers. Cost
15 transfers for the benefit of senior citizens, in the aggregate,
16 annually shall not exceed 1% of the earned subscription income of
17 the health care corporation as reported in the most recent annual
18 statement of the corporation. Group conversion subscribers are
19 those who have maintained coverage with the health care corporation
20 on an individual basis after leaving a subscriber group. **AS USED IN**
21 **THIS SUBSECTION, EARNED SUBSCRIPTION INCOME IS THE SUM OF THE GROUP**
22 **AND NONGROUP PREMIUM AND THE CLAIM AND ADMINISTRATIVE EXPENSE**
23 **REIMBURSEMENTS FOR ADMINISTRATIVE SERVICES CONTRACTS, LESS THE**
24 **INCOME FROM THE FEDERAL EMPLOYEE HEALTH BENEFIT PROGRAM, MEDICARE**
25 **SUPPLEMENT POLICIES, MEDICARE ADVANTAGE PLANS, AND MICHILD**
26 **POLICIES. COST TRANSFERS FOR THE BENEFIT OF RESIDENT SENIOR**
27 **CITIZENS SHALL BE EXPENDED AS DETERMINED BY THE COMMISSIONER SO**

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

7 Sec. 610. (1) Except as provided under section 608(4) or (5),
8 a filing of information and materials relative to a proposed rate
9 shall be made not less than ~~120-60~~ days before the proposed
10 effective date of the proposed rate. A filing shall not be
11 considered to have been received until there has been substantial
12 and material compliance with the requirements prescribed in
13 subsections (6) and (8).

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

17 (a) Give written notice to the corporation, and to each person
18 described under section 612(1), that the filing is in material and
19 substantial compliance with ~~subsections (6) and (8)~~ **THIS SECTION**
20 and that the filing is complete. The commissioner shall then
21 proceed to approve, approve with modifications, or disapprove the
22 rate filing ~~60-30~~ days after receipt of the filing, based upon
23 whether the filing meets the requirements of this act. However, if
24 a hearing has been requested under section 613, the commissioner
25 shall not approve, approve with modifications, or disapprove a
26 filing until the hearing has been completed and an order issued.

27 (b) Give written notice to the corporation that the

1 corporation has not yet complied with ~~subsections (6) and (8)~~ **THIS**
2 **SECTION**. The notice shall state specifically in what respects the
3 filing fails to meet the requirements of ~~subsections (6) and (8)~~
4 **THIS SECTION**.

5 (3) Within ~~10-8~~ days after the filing of notice pursuant to
6 subsection (2)(b), the corporation shall submit to the commissioner
7 such additional information and materials, as requested by the
8 commissioner. Within ~~10-8~~ days after receipt of the additional
9 information and materials, the commissioner shall determine whether
10 the filing is in material and substantial compliance with
11 ~~subsections (6) and (8)~~ **THIS SECTION**. If the commissioner
12 determines that the filing does not yet materially and
13 substantially meet the requirements of ~~subsections (6) and (8)~~ **THIS**
14 **SECTION**, the commissioner shall give notice to the corporation
15 pursuant to subsection (2)(b) or use visitation of the
16 corporation's facilities and examination of the corporation's
17 records to obtain the necessary information described in the notice
18 issued pursuant to subsection (2)(b). The commissioner shall use
19 either procedure previously mentioned, or a combination of both
20 procedures, in order to obtain the necessary information as
21 expeditiously as possible. The per diem, traveling, reproduction,
22 and other necessary expenses in connection with visitation and
23 examination shall be paid by the corporation, and shall be credited
24 to the general fund of the state.

25 (4) If a filing is approved, approved with modifications, or
26 disapproved under subsection (2)(a), the commissioner shall issue a
27 written order of the approval, approval with modifications, or

1 disapproval. If the filing was approved with modifications or
2 disapproved, the order shall state specifically in what respects
3 the filing fails to meet the requirements of this act and, if
4 applicable, what modifications are required for approval under this
5 act. If the filing was approved with modifications, the order shall
6 state that the filing shall take effect after the modifications are
7 made and approved by the commissioner. If the filing was
8 disapproved, the order shall state that the filing shall not take
9 effect.

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

18 (6) Information furnished under subsection (1) in support of a
19 nongroup **OR GROUP CONVERSION CERTIFICATE "A" THROUGH "G" OR**
20 **MEDICARE SUPPLEMENT CERTIFICATE** rate filing shall include the
21 following:

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

24 (b) Actual prior trend experience.

25 (c) Actual prior administrative expenses.

26 (d) Projected trend factors.

27 (e) Projected administrative expenses.

1 (f) Contributions for risk and contingency reserve factors.

2 (g) Actual health care corporation contingency reserve
3 position.

4 (h) Projected health care corporation contingency reserve
5 position.

6 (i) Other information ~~which~~**THAT** the corporation considers
7 pertinent to evaluating the risks to be rated, or relevant to the
8 determination to be made under this section.

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

12 (7) A copy of the filing, and all supporting information,
13 except for the information which may not be disclosed under section
14 604, shall be open to public inspection as of the date filed with
15 the commissioner.

16 (8) The commissioner shall make available forms and
17 instructions for filing for proposed rates under ~~sections~~**SECTION**
18 608(1) and ~~608(2)~~**(2)**. The forms with instructions shall be
19 available not less than ~~180~~**90** days before the proposed effective
20 date of the filing.

21 Sec. 612. (1) Upon receipt of a rate filing under section 610,
22 the commissioner immediately shall notify each person who has
23 requested in writing notice of those filings within the previous 2
24 years, specifying the nature and extent of the proposed rate
25 revision and identifying the location, time, and place where the
26 copy of the rate filing described in section 610(7) shall be open
27 to public inspection and copying. The notice shall also state that

1 if the person has standing, the person shall have, upon making a
2 written request for a hearing within ~~60~~30 days after receiving
3 notice of the rate filing, an opportunity for an evidentiary
4 hearing under section 613 to determine whether the proposed rates
5 meet the requirements of this act. The request shall identify the
6 issues which the requesting party asserts are involved, what
7 portion of the rate filing is requested to be heard, and how the
8 party has standing. The corporation shall place advertisements
9 giving notice, containing the information specified above, in at
10 least 1 newspaper which serves each geographic area in which
11 significant numbers of subscribers reside.

12 (2) The commissioner may charge a fee for providing, pursuant
13 to subsection (1), a copy of the rate filing described in section
14 610(7). The commissioner may charge a fee for providing a copy of
15 the entire filing to a person whose request for a hearing has been
16 granted by the commissioner pursuant to section 613. The fee shall
17 be limited to actual mailing costs and to the actual incremental
18 cost of duplication, including labor and the cost of deletion and
19 separation of information as provided in section 14 of ~~Act No. 442~~
20 ~~of the Public Acts of 1976, being section 15.244 of the Michigan~~
21 ~~Compiled Laws~~ **THE FREEDOM OF INFORMATION ACT, 1976 PA 442, MCL**
22 **15.244**. Copies of the filing may be provided free of charge or at a
23 reduced charge if the commissioner determines that a waiver or
24 reduction of the fee is in the public interest because the
25 furnishing of a copy of the filing will primarily benefit the
26 general public. In calculating the costs under this subsection, the
27 commissioner shall not attribute more than the hourly wage of the

1 lowest paid, full-time clerical employee of the ~~insurance bureau~~
2 **OFFICE OF FINANCIAL AND INSURANCE REGULATION** to the cost of labor
3 incurred in duplication and mailing and to the cost of separation
4 and deletion. The commissioner shall use the most economical means
5 available to provide copies of a rate filing.

6 Sec. 613. (1) If the request for a hearing under this section
7 is with regard to a rate filing not yet acted upon under section
8 610(2)(a), no such action shall be taken by the commissioner until
9 after the hearing has been completed. However, the commissioner
10 shall proceed to act upon those portions of a rate filing upon
11 which no hearing has been requested. Within ~~15~~8 days after receipt
12 of a request for a hearing, the commissioner shall determine if the
13 person has standing. If the commissioner determines that the person
14 has standing, the person may have access to the entire filing
15 subject to the same confidentiality requirements as the
16 commissioner under section 604, and shall be subject to the penalty
17 provision of section 604(5). Upon determining that the person has
18 standing, the commissioner shall immediately appoint an independent
19 hearing officer before whom the hearing shall be held. In
20 appointing an independent hearing officer, the commissioner shall
21 select a person qualified to conduct hearings, who has experience
22 or education in the area of health care corporation or insurance
23 rate determination and finance, and who is not otherwise associated
24 financially with a health care corporation or a health care
25 provider. The person selected shall not be currently or actively
26 employed by this state. For purposes of this subsection, an
27 employee of an educational institution shall not be considered to

1 be employed by this state. For purposes of this section, a person
2 has "standing" if any of the following circumstances exist:

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

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

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

9 (2) Not more than ~~30~~15 days after receipt of a request for a
10 hearing, and upon not less than ~~15~~8 days' notice to all parties,
11 the hearing shall be commenced. Each party to the hearing shall be
12 given a reasonable opportunity for discovery before and throughout
13 the course of the hearing. However, the hearing officer may
14 terminate discovery at any time, for good cause shown. The hearing
15 officer shall conduct the hearing pursuant to the administrative
16 procedures act. The hearing shall be conducted in an expeditious
17 manner **AND THE HEARING OFFICER SHALL RENDER A PROPOSAL FOR DECISION**
18 **NOT LATER THAN 30 DAYS AFTER THE START OF THE HEARING.** At the
19 hearing, the burden of proving compliance with this act shall be
20 upon the health care corporation.

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

23 (4) Within ~~30~~8 days after receipt of the hearing officer's
24 proposal for decision, the commissioner shall by order render a
25 decision which shall include a statement of findings.

26 (5) The commissioner shall withdraw an order of approval or
27 approval with modifications if the commissioner finds that the

1 filing no longer meets the requirements of this act.

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

5 (a) Senate Bill No. 1244.

6

7 (b) Senate Bill No. _____ or House Bill No. _____ (request no.
8 H00083'09 *).

9 (c) Senate Bill No. _____ or House Bill No. _____ (request no.
10 06174'10).

11 (d) Senate Bill No. 1245.

12

13 (e) Senate Bill No. _____ or House Bill No. _____ (request no.
14 H06472'10 *).

15 (f) Senate Bill No. _____ or House Bill No. _____ (request no.
16 06473'10).

17 (g) Senate Bill No. 1242.

18