

HOUSE SUBSTITUTE FOR
SENATE BILL NO. 1293

A bill to amend 1956 PA 218, entitled
"The insurance code of 1956,"
by amending sections 2213b, 2242, 3426, 3705, 3712, 5008, 5104,
5209, 5800, and 5824 (MCL 500.2213b, 500.2242, 500.3426, 500.3705,
500.3712, 500.5008, 500.5104, 500.5209, 500.5800, and 500.5824),
section 2213b as amended by 1998 PA 457, section 2242 as amended by
1990 PA 305, section 3426 as added by 2006 PA 412, sections 3705
and 3712 as added by 2003 PA 88, section 5008 as amended by 1994 PA
226, section 5104 as amended by 1999 PA 211, and section 5800 as
amended by 2000 PA 8, and by adding sections 3405a, 3407c, 3428,
3472, 3474a, 3612a, 5801, 5805, 5825, and 5826.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

1 Sec. 2213b. (1) Except as **OTHERWISE** provided in this section,
2 an insurer that delivers, issues for delivery, or renews in this

1 state an expense-incurred hospital, medical, or surgical individual
2 policy under chapter 34 shall renew or continue in force the policy
3 at the option of the individual.

4 (2) Except as **OTHERWISE** provided in this section, an insurer
5 that delivers, issues for delivery, or renews in this state an
6 expense-incurred hospital, medical, or surgical group policy or
7 certificate under chapter 36 shall renew or continue in force the
8 policy or certificate at the option of the sponsor of the plan.

9 (3) Guaranteed renewal is not required in cases of fraud,
10 intentional misrepresentation of material fact, lack of payment, if
11 the insurer no longer offers that particular type of coverage in
12 the market, or if the individual or group moves outside the service
13 area.

14 (4) **AN INSURER OR HEALTH MAINTENANCE ORGANIZATION THAT OFFERS**
15 **AN EXPENSE-INCURRED HOSPITAL, MEDICAL, OR SURGICAL POLICY UNDER**
16 **CHAPTER 34 OR 36 SHALL NOT DISCONTINUE OFFERING A PARTICULAR PLAN**
17 **OR PRODUCT IN THE NONGROUP OR GROUP MARKET UNLESS THE INSURER OR**
18 **HEALTH MAINTENANCE ORGANIZATION DOES ALL OF THE FOLLOWING:**

19 (A) **PROVIDES NOTICE TO THE COMMISSIONER AND TO EACH COVERED**
20 **INDIVIDUAL OR GROUP, AS APPLICABLE, PROVIDED COVERAGE UNDER THE**
21 **PLAN OR PRODUCT OF THE DISCONTINUATION AT LEAST 90 DAYS BEFORE THE**
22 **DATE OF THE DISCONTINUATION.**

23 (B) **OFFERS TO EACH COVERED INDIVIDUAL OR GROUP, AS APPLICABLE,**
24 **PROVIDED COVERAGE UNDER THE PLAN OR PRODUCT THE OPTION TO PURCHASE**
25 **ANY OTHER PLAN OR PRODUCT CURRENTLY BEING OFFERED IN THE NONGROUP**
26 **MARKET OR GROUP MARKET, AS APPLICABLE, BY THAT INSURER OR HEALTH**
27 **MAINTENANCE ORGANIZATION WITHOUT EXCLUDING OR LIMITING COVERAGE FOR**

1 A PREEEXISTING CONDITION OR PROVIDING A WAITING PERIOD.

2 (C) ACTS UNIFORMLY WITHOUT REGARD TO ANY HEALTH STATUS FACTOR
3 OF ENROLLED INDIVIDUALS OR INDIVIDUALS WHO MAY BECOME ELIGIBLE FOR
4 COVERAGE IN MAKING THE DETERMINATION TO DISCONTINUE COVERAGE AND IN
5 OFFERING OTHER PLANS OR PRODUCTS.

6 (5) AN INSURER OR HEALTH MAINTENANCE ORGANIZATION SHALL NOT
7 DISCONTINUE OFFERING ALL COVERAGE IN THE NONGROUP OR GROUP MARKET
8 UNLESS THE INSURER OR HEALTH MAINTENANCE ORGANIZATION DOES ALL OF
9 THE FOLLOWING:

10 (A) PROVIDES NOTICE TO THE COMMISSIONER AND TO EACH COVERED
11 INDIVIDUAL OR GROUP, AS APPLICABLE, OF THE DISCONTINUATION AT LEAST
12 180 DAYS BEFORE THE DATE OF THE EXPIRATION OF COVERAGE.

13 (B) DISCONTINUES ALL HEALTH BENEFIT PLANS ISSUED IN THE
14 NONGROUP OR GROUP MARKET FROM WHICH THE INSURER OR HEALTH
15 MAINTENANCE ORGANIZATION WITHDREW AND DOES NOT RENEW COVERAGE UNDER
16 THOSE PLANS.

17 (6) IF AN INSURER OR HEALTH MAINTENANCE ORGANIZATION
18 DISCONTINUES COVERAGE UNDER SUBSECTION (5), THE INSURER OR HEALTH
19 MAINTENANCE ORGANIZATION SHALL NOT PROVIDE FOR THE ISSUANCE OF ANY
20 HEALTH BENEFIT PLANS IN THE NONGROUP OR GROUP MARKET FROM WHICH THE
21 INSURER OR HEALTH MAINTENANCE ORGANIZATION WITHDREW DURING THE 5-
22 YEAR PERIOD BEGINNING ON THE DATE OF THE DISCONTINUATION OF THE
23 LAST PLAN NOT RENEWED UNDER THAT SUBSECTION.

24 (7) ~~(4)~~ Subsections (1) ~~,~~ ~~(2)~~, ~~and~~ ~~(3)~~ ~~TO~~ (6) do not apply to
25 a short-term or 1-time limited duration policy or certificate of no
26 longer than 6 months.

27 (8) ~~(5)~~ For the purposes of this section and section 3406f, a

1 short-term or 1-time limited duration policy or certificate of no
2 longer than 6 months is an individual health policy that meets all
3 of the following:

4 (a) Is issued to provide coverage for a period of 185 days or
5 less, except that the health policy may permit a limited extension
6 of benefits after the date the policy ended solely for expenses
7 attributable to a condition for which a covered person incurred
8 expenses during the term of the policy.

9 (b) Is nonrenewable, provided that the health insurer may
10 provide coverage for 1 or more subsequent periods that satisfy
11 subdivision (a), if the total of the periods of coverage do not
12 exceed a total of 185 days out of any 365-day period, plus any
13 additional days permitted by the policy for a condition for which a
14 covered person incurred expenses during the term of the policy.

15 (c) Does not cover any preexisting conditions.

16 (d) Is available with an immediate effective date, without
17 underwriting, upon receipt by the insurer of a completed
18 application indicating eligibility under the health insurer's
19 eligibility requirements, except that coverage that includes
20 optional benefits may be offered on a basis that does not meet this
21 requirement.

22 (9) ~~(6) An~~ **BY MARCH 31 EACH YEAR, AN** insurer that delivers,
23 issues for delivery, or renews in this state a short-term or 1-time
24 limited duration policy or certificate of no longer than 6 months
25 shall provide ~~the following~~ to the commissioner +

26 ~~—— (a) By no later than February 1, 1999, a written report that~~
27 ~~discloses both of the following:~~

1 ~~—— (i) The gross written premium for short term or 1 time limited~~
2 ~~duration policies or certificates of no longer than 6 months issued~~
3 ~~in this state during the 1996 calendar year.~~

4 ~~—— (ii) The gross written premium for all individual expense-~~
5 ~~incurred hospital, medical, or surgical policies or certificates~~
6 ~~issued or delivered in this state during the 1996 calendar year~~
7 ~~other than policies or certificates described in subparagraph (i).~~

8 ~~—— (b) By no later than March 31, 1999 and annually thereafter, a~~
9 written annual report that discloses both of the following:

10 (A) ~~(i)~~ The gross written premium for short-term or 1-time
11 limited duration policies or certificates issued in this state
12 during the preceding calendar year.

13 (B) ~~(ii)~~ The gross written premium for all individual expense-
14 incurred hospital, medical, or surgical policies or certificates
15 issued or delivered in this state during the preceding calendar
16 year other than policies or certificates described in ~~subparagraph~~
17 ~~(i)~~. **SUBDIVISION (A) .**

18 (10) ~~(7)~~ The commissioner shall maintain copies of reports
19 prepared pursuant to subsection ~~(6)~~ **(9)** on file with the annual
20 statement of each reporting insurer. The commissioner shall
21 annually compile the reports received under subsection ~~(6)~~ **(9)**. The
22 commissioner shall provide this annual compilation to the senate
23 and house of representatives standing committees on insurance
24 issues no later than the June 1 immediately following the ~~February~~
25 ~~1 or~~ March 31 date for which the reports under subsection ~~(6)~~ **(9)**
26 are provided.

27 (11) ~~(8)~~ In each calendar year, a health insurer shall not

1 continue to issue short-term or 1-time limited duration policies or
2 certificates if to do so the collective gross written premiums on
3 those policies or certificates would total more than 10% of the
4 collective gross written premiums for all individual expense-
5 incurred hospital, medical, or surgical policies or certificates
6 issued or delivered in this state either directly by that insurer
7 or through a corporation that owns or is owned by that insurer.

8 Sec. 2242. (1) Except as otherwise provided in section
9 2236(8)(d), a group disability policy shall not be issued or
10 delivered in this state unless a copy of the form has been filed
11 with the commissioner and approved by him or her.

12 (2) ~~The~~**SUBJECT TO SUBSECTION (3), THE** commissioner may within
13 30 days after the filing of a disability insurance policy form
14 applicable to individual or family expense coverage, disapprove the
15 form for any of the following, subject to the requirements as to
16 notice, hearing, and appeal set forth in sections 244 and 2236:

17 (a) The benefits provided ~~therein~~**UNDER THE POLICY** are
18 unreasonable in relation to the premium charged.

19 (b) ~~It~~**THE POLICY** contains a provision ~~or provisions which are~~
20 **THAT IS** unjust, unfair, inequitable, misleading, **OR** deceptive ~~—or~~
21 ~~encourage~~**THAT ENCOURAGES** misrepresentation of the policy.

22 (c) ~~It~~**THE POLICY** does not comply with other provisions of
23 law.

24 (3) **THE COMMISSIONER MAY EXTEND THE TIME PERIOD IN**
25 **SUBSECTION (2) FOR AN ADDITIONAL PERIOD NOT TO EXCEED 30 DAYS IF**
26 **WRITTEN NOTICE TO THE INSURER IS PROVIDED WITHIN 30 DAYS AFTER**
27 **THE FILING UNDER SUBSECTION (2).**

1 (4) ~~(3)~~—The commissioner may at any time withdraw his or her
2 approval of an individual or family expense policy form on any of
3 the grounds stated in subsection (2), subject to the requirements
4 as to notice, hearing, and appeal set forth in sections 244 and
5 2236. An insurer shall not issue the form after the effective date
6 of the withdrawal of approval.

7 SEC. 3405A. (1) NOTWITHSTANDING ANY PROVISION OF THIS ACT TO
8 THE CONTRARY, THIS SECTION APPLIES TO THE USE OF A MOST FAVORED
9 NATION CLAUSE IN A PROVIDER CONTRACT ON AND AFTER FEBRUARY 1, 2013.

10 (2) SUBJECT TO SUBSECTION (3), BEGINNING FEBRUARY 1, 2013, AN
11 INSURER OR A HEALTH MAINTENANCE ORGANIZATION SHALL NOT USE A MOST
12 FAVORED NATION CLAUSE IN ANY PROVIDER CONTRACT, INCLUDING A
13 PROVIDER CONTRACT IN EFFECT ON FEBRUARY 1, 2013, UNLESS THE MOST
14 FAVORED NATION CLAUSE HAS BEEN FILED WITH AND APPROVED BY THE
15 COMMISSIONER. SUBJECT TO SUBSECTION (3), BEGINNING FEBRUARY 1,
16 2013, AN INSURER OR A HEALTH MAINTENANCE ORGANIZATION SHALL NOT
17 ENFORCE A MOST FAVORED NATION CLAUSE IN ANY PROVIDER CONTRACT
18 WITHOUT THE PRIOR APPROVAL OF THE COMMISSIONER.

19 (3) BEGINNING JANUARY 1, 2014, AN INSURER OR A HEALTH
20 MAINTENANCE ORGANIZATION SHALL NOT USE A MOST FAVORED NATION CLAUSE
21 IN ANY PROVIDER CONTRACT, INCLUDING A PROVIDER CONTRACT IN EFFECT
22 ON JANUARY 1, 2014.

23 (4) AS USED IN THIS SECTION, "MOST FAVORED NATION CLAUSE"
24 MEANS A CLAUSE THAT DOES ANY OF THE FOLLOWING:

25 (A) PROHIBITS, OR GRANTS A CONTRACTING INSURER OR HEALTH
26 MAINTENANCE ORGANIZATION AN OPTION TO PROHIBIT, A PROVIDER FROM
27 CONTRACTING WITH ANOTHER PARTY TO PROVIDE HEALTH CARE SERVICES AT A

1 LOWER RATE THAN THE PAYMENT OR REIMBURSEMENT RATE SPECIFIED IN THE
2 CONTRACT WITH THE INSURER OR HEALTH MAINTENANCE ORGANIZATION.

3 (B) REQUIRES, OR GRANTS A CONTRACTING INSURER OR HEALTH
4 MAINTENANCE ORGANIZATION AN OPTION TO REQUIRE, A PROVIDER TO ACCEPT
5 A LOWER PAYMENT OR REIMBURSEMENT RATE IF THE PROVIDER AGREES TO
6 PROVIDE HEALTH CARE SERVICES TO ANY OTHER PARTY AT A LOWER RATE
7 THAN THE PAYMENT OR REIMBURSEMENT RATE SPECIFIED IN THE CONTRACT
8 WITH THE INSURER OR HEALTH MAINTENANCE ORGANIZATION.

9 (C) REQUIRES, OR GRANTS A CONTRACTING INSURER OR HEALTH
10 MAINTENANCE ORGANIZATION AN OPTION TO REQUIRE, TERMINATION OR
11 RENEGOTIATION OF AN EXISTING PROVIDER CONTRACT IF A PROVIDER AGREES
12 TO PROVIDE HEALTH CARE SERVICES TO ANY OTHER PARTY AT A LOWER RATE
13 THAN THE PAYMENT OR REIMBURSEMENT RATE SPECIFIED IN THE CONTRACT
14 WITH THE INSURER OR HEALTH MAINTENANCE ORGANIZATION.

15 (D) REQUIRES A PROVIDER TO DISCLOSE, TO THE INSURER OR HEALTH
16 MAINTENANCE ORGANIZATION OR THE INSURER'S OR HEALTH MAINTENANCE
17 ORGANIZATION'S DESIGNEE, THE PROVIDER'S CONTRACTUAL PAYMENT OR
18 REIMBURSEMENT RATES WITH OTHER PARTIES.

19 SEC. 3407C. (1) A QUALIFIED HEALTH PLAN OFFERED THROUGH AN
20 AMERICAN HEALTH BENEFIT EXCHANGE IN THIS STATE PURSUANT TO THE
21 PATIENT PROTECTION AND AFFORDABLE CARE ACT, PUBLIC LAW 111-148, AS
22 AMENDED BY THE HEALTH CARE AND EDUCATION RECONCILIATION ACT OF
23 2010, PUBLIC LAW 111-152, SHALL NOT PROVIDE COVERAGE FOR ELECTIVE
24 ABORTION. THIS SECTION DOES NOT PROHIBIT AN INDIVIDUAL,
25 ORGANIZATION, OR EMPLOYER PARTICIPATING IN A QUALIFIED HEALTH PLAN
26 OFFERED THROUGH AN AMERICAN HEALTH BENEFIT EXCHANGE IN THIS STATE
27 FROM PURCHASING OPTIONAL SUPPLEMENTAL COVERAGE FOR ELECTIVE

1 ABORTION OUTSIDE OF THE EXCHANGE AS PROVIDED IN SUBSECTION (2).

2 (2) AN EXPENSE-INCURRED HOSPITAL, MEDICAL, OR SURGICAL POLICY
3 OR CERTIFICATE DELIVERED, ISSUED FOR DELIVERY, OR RENEWED IN THIS
4 STATE AND A HEALTH MAINTENANCE ORGANIZATION GROUP OR INDIVIDUAL
5 CONTRACT OFFERED OUTSIDE OF AN AMERICAN HEALTH BENEFIT EXCHANGE
6 SHALL NOT PROVIDE COVERAGE FOR ELECTIVE ABORTIONS EXCEPT BY AN
7 OPTIONAL RIDER FOR WHICH AN ADDITIONAL PREMIUM HAS BEEN PAID BY THE
8 PURCHASER.

9 (3) AN EMPLOYER MAY PURCHASE AN OPTIONAL RIDER TO PROVIDE
10 COVERAGE FOR AN ELECTIVE ABORTION IF THE EMPLOYER PROVIDES NOTICE
11 TO EACH EMPLOYEE THAT ELECTIVE ABORTION WILL BE INCLUDED AS A RIDER
12 TO HIS OR HER HEALTH COVERAGE AND THAT THE COVERAGE MAY BE USED BY
13 A COVERED DEPENDENT WITHOUT NOTICE TO THE EMPLOYEE.

14 (4) THIS SECTION DOES NOT REQUIRE AN INSURER, HEALTH
15 MAINTENANCE ORGANIZATION, OR EMPLOYER TO PROVIDE OR OFFER TO
16 PROVIDE AN OPTIONAL RIDER FOR ELECTIVE ABORTION COVERAGE.

17 (5) THIS SECTION DOES NOT APPLY TO BENEFITS PROVIDED UNDER
18 TITLE XIX OF THE SOCIAL SECURITY ACT, 42 USC 1396 TO 1396W-5.

19 (6) THIS SECTION DOES NOT CREATE A RIGHT TO ABORTION.

20 (7) NOTWITHSTANDING ANY OTHER PROVISION OF THIS SECTION, A
21 PERSON SHALL NOT PERFORM AN ABORTION THAT IS PROHIBITED BY LAW.

22 (8) THIS SECTION APPLIES TO POLICIES, CERTIFICATES, OR
23 CONTRACTS DELIVERED, ISSUED FOR DELIVERY, OR RENEWED IN THIS STATE
24 ON AND AFTER THE EFFECTIVE DATE OF THIS SECTION.

25 (9) AS USED IN THIS SECTION:

26 (A) "ELECTIVE ABORTION" MEANS THE INTENTIONAL USE OF AN
27 INSTRUMENT, DRUG, OR OTHER SUBSTANCE OR DEVICE TO TERMINATE A

1 WOMAN'S PREGNANCY FOR A PURPOSE OTHER THAN TO INCREASE THE
2 PROBABILITY OF A LIVE BIRTH, TO PRESERVE THE LIFE OR HEALTH OF THE
3 CHILD AFTER LIVE BIRTH, OR TO REMOVE A DEAD FETUS. ELECTIVE
4 ABORTION DOES NOT INCLUDE EITHER OF THE FOLLOWING:

5 (i) THE PRESCRIPTION OF OR USE OF A DRUG OR DEVICE INTENDED AS
6 A CONTRACEPTIVE.

7 (ii) THE INTENTIONAL USE OF AN INSTRUMENT, DRUG, OR OTHER
8 SUBSTANCE OR DEVICE BY A PHYSICIAN TO TERMINATE A WOMAN'S PREGNANCY
9 IF THE WOMAN'S PHYSICAL CONDITION, IN THE PHYSICIAN'S REASONABLE
10 MEDICAL JUDGMENT, NECESSITATES THE TERMINATION OF THE WOMAN'S
11 PREGNANCY TO AVERT HER DEATH.

12 (B) "QUALIFIED HEALTH PLAN" MEANS THAT TERM AS DEFINED IN
13 SECTION 1301 OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT,
14 PUBLIC LAW 111-148.

15 (C) "PHYSICIAN" MEANS AN INDIVIDUAL LICENSED OR OTHERWISE
16 AUTHORIZED TO ENGAGE IN THE PRACTICE OF MEDICINE OR THE PRACTICE OF
17 OSTEOPATHIC MEDICINE AND SURGERY UNDER ARTICLE 15 OF THE PUBLIC
18 HEALTH CODE, 1978 PA 368, MCL 333.16101 TO 333.18838.

19 Sec. 3426. (1) Each insurer providing a group expense-incurred
20 hospital, medical, or surgical certificate delivered, issued for
21 delivery, or renewed in this state and each health maintenance
22 organization may offer group wellness coverage. Wellness coverage
23 may provide for an appropriate rebate or reduction in premiums or
24 for reduced copayments, coinsurance, or deductibles, or a
25 combination of these incentives, for participation in any health
26 behavior wellness, maintenance, or improvement program offered by
27 the employer. The employer shall provide evidence of demonstrative

1 maintenance or improvement of the insureds' or enrollees' health
2 behaviors as determined by assessments of agreed-upon health status
3 indicators between the employer and the ~~health~~-insurer or health
4 maintenance organization. Any rebate of premium provided by the
5 ~~health~~-insurer or health maintenance organization is presumed to be
6 appropriate unless credible data demonstrate otherwise, but shall
7 not exceed ~~10%~~30% of paid premiums, **UNLESS OTHERWISE APPROVED BY**
8 **THE COMMISSIONER**. Each insurer and each health maintenance
9 organization shall make available to employers all wellness
10 coverage plans that the insurer or health maintenance organization
11 markets to employers in this state.

12 (2) Each insurer providing an individual or family expense-
13 incurred hospital, medical, or surgical policy delivered, issued
14 for delivery, or renewed in this state and each health maintenance
15 organization may offer individual and family wellness coverage.
16 Wellness coverage may provide for an appropriate rebate or
17 reduction in premiums or for reduced copayments, coinsurance, or
18 deductibles, or a combination of these incentives, for
19 participation in any health behavior wellness, maintenance, or
20 improvement program approved by the insurer or health maintenance
21 organization. The insured or enrollee shall provide evidence of
22 demonstrative maintenance or improvement of the individual's or
23 family's health behaviors as determined by assessments of agreed-
24 upon health status indicators between the insured or enrollee and
25 the ~~health~~-insurer or health maintenance organization. Any rebate
26 of premium provided by the ~~health~~-insurer or health maintenance
27 organization is presumed to be appropriate unless credible data

1 demonstrate otherwise, but shall not exceed ~~10%~~30% of paid
2 premiums, **UNLESS OTHERWISE APPROVED BY THE COMMISSIONER**. Each
3 insurer and each health maintenance organization shall make
4 available to individuals and families all wellness coverage plans
5 that the insurer or health maintenance organization markets to
6 individuals and families in this state.

7 (3) An insurer and a health maintenance organization are not
8 required to continue any health behavior wellness, maintenance, or
9 improvement program or to continue any incentive associated with a
10 health behavior wellness, maintenance, or improvement program.

11 **SEC. 3428. BEGINNING JANUARY 1, 2014, AN INSURER SHALL**
12 **ESTABLISH AND MAINTAIN A PROVIDER NETWORK THAT, AT A MINIMUM,**
13 **SATISFIES ANY NETWORK ADEQUACY REQUIREMENTS IMPOSED BY THE**
14 **COMMISSIONER PURSUANT TO FEDERAL LAW.**

15 **SEC. 3472. (1) BEGINNING JANUARY 1, 2014, DURING AN APPLICABLE**
16 **OPEN ENROLLMENT PERIOD, AN INSURER SHALL NOT DENY OR CONDITION THE**
17 **ISSUANCE OR EFFECTIVENESS OF A POLICY AND SHALL NOT DISCRIMINATE IN**
18 **THE PRICING OF A POLICY ON THE BASIS OF HEALTH STATUS, CLAIMS**
19 **EXPERIENCE, RECEIPT OF HEALTH CARE, OR MEDICAL CONDITION.**

20 (2) SUBJECT TO PRIOR APPROVAL OF THE COMMISSIONER, AN INSURER
21 SHALL ESTABLISH REASONABLE OPEN ENROLLMENT PERIODS FOR ALL
22 DISABILITY POLICIES OFFERED, DELIVERED, ISSUED FOR DELIVERY, OR
23 RENEWED IN THIS STATE ON OR AFTER JANUARY 1, 2014.

24 (3) THE COMMISSIONER SHALL ESTABLISH MINIMUM STANDARDS FOR THE
25 FREQUENCY AND DURATION OF OPEN ENROLLMENT PERIODS ESTABLISHED UNDER
26 SUBSECTION (2). THE COMMISSIONER SHALL UNIFORMLY APPLY THE MINIMUM
27 STANDARDS FOR THE FREQUENCY AND DURATION OF OPEN ENROLLMENT PERIODS

1 ESTABLISHED UNDER THIS SUBSECTION TO ALL INSURERS.

2 SEC. 3474A. THE PREMIUM RATE CHARGED BY AN INSURER, HEALTH
3 MAINTENANCE ORGANIZATION, OR NONPROFIT HEALTH CARE CORPORATION FOR
4 HEALTH INSURANCE COVERAGE OFFERED THROUGH A POLICY OR CERTIFICATE
5 DELIVERED, ISSUED FOR DELIVERY, OR RENEWED IN THIS STATE ON OR
6 AFTER JANUARY 1, 2014 IN THE INDIVIDUAL OR SMALL GROUP MARKET SHALL
7 VARY BASED ON THE FOLLOWING FACTORS ONLY:

8 (A) WHETHER THE POLICY OR CERTIFICATE COVERS AN INDIVIDUAL OR
9 FAMILY.

10 (B) THE RATING AREA.

11 (C) AGE, EXCEPT THAT THE PREMIUM RATE SHALL NOT VARY BY MORE
12 THAN 3 TO 1 FOR ADULTS FOR ALL PLANS OTHER THAN CHILD-ONLY PLANS.

13 (D) TOBACCO USE, EXCEPT THAT THE PREMIUM RATE SHALL NOT VARY
14 BY MORE THAN 1.5 TO 1.

15 SEC. 3612A. NOTWITHSTANDING SECTION 3612(8), FOR A POLICY
16 DELIVERED, ISSUED FOR DELIVERY, OR RENEWED IN THIS STATE ON OR
17 AFTER JANUARY 1, 2014, THE PREMIUM FOR AN INDIVIDUAL CONVERSION
18 POLICY UNDER SECTION 3612 SHALL BE DETERMINED ONLY BY USING THE
19 RATING FACTORS SET FORTH IN SECTION 3474A.

20 Sec. 3705. (1) For adjusting premiums for health benefit plans
21 subject to this chapter, a carrier may establish up to 10
22 geographic areas in this state. A nonprofit health care corporation
23 shall establish geographic areas that cover all counties in this
24 state.

25 (2) Premiums for a health benefit plan under this chapter are
26 subject to the following:

27 (a) For a nonprofit health care corporation, only industry and

1 age may be used for determining the premiums within a geographic
2 area for a small employer or sole proprietor located in that
3 geographic area. For a health maintenance organization, only
4 industry, age, and group size may be used for determining the
5 premiums within a geographic area for a small employer or sole
6 proprietor located in that geographic area. For a commercial
7 carrier, only industry, age, group size, and health status may be
8 used for determining the premiums within a geographic area for a
9 small employer or sole proprietor located in that geographic area.

10 ~~(b) The premiums charged during a rating period by a nonprofit~~
11 ~~health care corporation or a health maintenance organization for a~~
12 ~~health benefit plan in a geographic area to small employers or sole~~
13 ~~proprietors located in that geographic area shall not vary from the~~
14 ~~index rate for that health benefit plan by more than 35% of the~~
15 ~~index rate. However, for a health benefit plan issued before the~~
16 ~~effective date of this chapter by a nonprofit health care~~
17 ~~corporation or health maintenance organization, the premiums for~~
18 ~~the plan are subject to the following:~~

19 ~~—— (i) For a renewal occurring on or after the effective date of~~
20 ~~this chapter and through December 31, 2004, the premiums charged~~
21 ~~for a health benefit plan in a geographic area to small employers~~
22 ~~or sole proprietors located in that geographic area shall not be~~
23 ~~higher than 15% above the index rate or lower than 35% below the~~
24 ~~index rate.~~

25 ~~—— (ii) For a renewal occurring on or after January 1, 2005, the~~
26 ~~premiums charged for a health benefit plan in a geographic area to~~
27 ~~small employers or sole proprietors located in that geographic area~~

1 ~~shall not vary from the index rate for that health benefit plan by~~
2 ~~more than 35% of the index rate.~~ **FOR A HEALTH BENEFIT PLAN**
3 **DELIVERED, ISSUED FOR DELIVERY, OR RENEWED IN THIS STATE ON OR**
4 **AFTER JANUARY 1, 2014, THE PREMIUMS CHARGED DURING A RATING PERIOD**
5 **TO SMALL EMPLOYERS SHALL BE DETERMINED ONLY BY USING THE RATING**
6 **FACTORS SET FORTH IN SECTION 3474A.**

7 (c) The premiums charged during a rating period by a **NONPROFIT**
8 **HEALTH CARE CORPORATION, HEALTH MAINTENANCE ORGANIZATION, OR**
9 commercial carrier for a health benefit plan in a geographic area
10 to small employers or sole proprietors located in that geographic
11 area shall not vary from the index rate for that health benefit
12 plan by more than 45% of the index rate. ~~However, for a health~~
13 ~~benefit plan issued before the effective date of this chapter by a~~
14 ~~commercial carrier, the premiums for the plan are subject to the~~
15 ~~following:~~

16 ~~—— (i) For a renewal occurring on or after the effective date of~~
17 ~~this chapter and through December 31, 2004, the premiums charged~~
18 ~~for a health benefit plan in a geographic area to small employers~~
19 ~~or sole proprietors located in that geographic area shall not vary~~
20 ~~from the index rate for that health benefit plan by more than 70%~~
21 ~~of the index rate.~~

22 ~~—— (ii) For a renewal occurring on or after January 1, 2005 and~~
23 ~~through December 31, 2005, the premiums charged for a health~~
24 ~~benefit plan in a geographic area to small employers or sole~~
25 ~~proprietors located in that geographic area shall not vary from the~~
26 ~~index rate for that health benefit plan by more than 55% of the~~
27 ~~index rate.~~

1 ~~—— (iii) For a renewal occurring on or after January 1, 2006, the~~
2 ~~premiums charged for a health benefit plan in a geographic area to~~
3 ~~small employers or sole proprietors located in that geographic area~~
4 ~~shall not vary from the index rate for that health benefit plan by~~
5 ~~more than 45% of the index rate.~~

6 (d) For a sole proprietor, a small employer carrier may charge
7 an additional premium of up to 25% above the premiums in
8 subdivision (b). ~~or (c).~~

9 (e) Except as otherwise provided in this section, the
10 percentage increase in the premiums charged to a small employer or
11 sole proprietor in a geographic area for a new rating period shall
12 not exceed the sum of the annual percentage adjustment in the
13 geographic area's index rate for the health benefit plan and an
14 adjustment pursuant to subdivision (a). The adjustment pursuant to
15 subdivision (a) shall not exceed 15% annually and shall be adjusted
16 pro rata for rating periods of less than 1 year. This subdivision
17 does not prohibit an adjustment due to change in coverage.

18 (3) ~~Beginning 1 year after the effective date of this chapter~~
19 **JANUARY 23, 2005**, if a small employer had been covered by a self-
20 insured health benefit plan immediately preceding application for a
21 health benefit plan subject to this chapter, a carrier may charge
22 an additional premium of up to 33% above the premium in subsection
23 (2) (b) ~~or (c)~~ for no more than 2 years.

24 (4) Health benefit plan options, number of family members
25 covered, and medicare eligibility may be used in establishing a
26 small employer's or sole proprietor's premium.

27 (5) A small employer carrier shall apply all rating factors

1 consistently with respect to all small employers and sole
2 proprietors in a geographic area. Except as **OTHERWISE** provided in
3 subsection (4), a small employer carrier shall bill a small
4 employer group only with a composite rate and shall not bill so
5 that 1 or more employees in a small employer group are charged a
6 higher premium than another employee in that small employer group.

7 Sec. 3712. (1) If a small employer carrier decides to
8 discontinue offering all small employer health benefit plans in a
9 geographic area, all of the following apply:

10 (a) The small employer carrier shall provide notice to the
11 commissioner and to each small employer covered by the small
12 employer carrier in the geographic area of the discontinuation at
13 least 180 days prior to the date of the discontinuation of the
14 coverage.

15 (b) All small employer health benefit plans issued or
16 delivered for issuance in the geographic area are discontinued and
17 all current health benefit plans in the geographic area are not
18 renewed.

19 (c) The small employer carrier shall not issue or deliver for
20 issuance any small employer health benefit plans in the geographic
21 area for 5 years beginning on the date the last small employer
22 health benefit plan in the geographic area is not renewed under
23 subdivision (b).

24 (d) The small employer carrier shall not issue or deliver for
25 issuance for 5 years any small employer health benefit plans in an
26 area that was not a geographic area where the small employer
27 carrier was issuing or delivering for issuance small employer

1 health benefit plans on the date notice was given under subdivision
2 (a). The 5-year period under this subdivision begins on the date
3 notice was given under subdivision (a).

4 (2) ~~A nonprofit health care corporation shall not cease to~~
5 ~~renew all health benefit plans in a geographic area.~~ **A SMALL**
6 **EMPLOYER CARRIER SHALL NOT DISCONTINUE OFFERING A PARTICULAR PLAN**
7 **OR PRODUCT IN THE SMALL EMPLOYER GROUP MARKET UNLESS THE SMALL**
8 **EMPLOYER CARRIER DOES ALL OF THE FOLLOWING:**

9 (A) PROVIDES NOTICE TO THE COMMISSIONER AND TO EACH SMALL
10 EMPLOYER PROVIDED COVERAGE UNDER THE PLAN OR PRODUCT OF THE
11 DISCONTINUATION AT LEAST 90 DAYS BEFORE THE DATE OF THE
12 DISCONTINUATION.

13 (B) OFFERS TO EACH SMALL EMPLOYER PROVIDED COVERAGE UNDER THE
14 PLAN OR PRODUCT THE OPTION TO PURCHASE ANY OTHER PLAN OR PRODUCT
15 CURRENTLY BEING OFFERED IN THE SMALL EMPLOYER GROUP MARKET BY THAT
16 SMALL EMPLOYER CARRIER WITHOUT EXCLUDING OR LIMITING COVERAGE FOR A
17 PREEXISTING CONDITION OR PROVIDING A WAITING PERIOD.

18 (C) ACTS UNIFORMLY WITHOUT REGARD TO ANY HEALTH STATUS FACTOR
19 OF ENROLLED INDIVIDUALS OR INDIVIDUALS WHO MAY BECOME ELIGIBLE FOR
20 COVERAGE IN MAKING THE DETERMINATION TO DISCONTINUE COVERAGE AND IN
21 OFFERING OTHER PLANS OR PRODUCTS.

22 Sec. 5008. (1) The commissioner shall prepare and keep on hand
23 blank forms of articles of incorporation for insurers desiring to
24 incorporate under this act, which forms may be had on application.

25 (2) The incorporators shall subscribe articles of
26 incorporation in duplicate, which articles shall contain all of the
27 following:

1 (a) The names of the incorporators and their places of
2 residence respectively.

3 (b) The location of the principal office for the transaction
4 of business in this state.

5 (c) The name by which the incorporation shall be known, which
6 if it be upon the mutual plan shall contain the word "mutual".

7 **HOWEVER, A NONPROFIT MUTUAL DISABILITY INSURER INTO WHICH A**
8 **NONPROFIT HEALTH CARE CORPORATION THAT IS ORGANIZED UNDER THE**
9 **NONPROFIT HEALTH CARE CORPORATION REFORM ACT, 1980 PA 350, MCL**
10 **550.1101 TO 550.1704, IS MERGED OR CONSOLIDATED MAY RETAIN AND USE**
11 **TRADE NAMES IN USE BY THE NONPROFIT HEALTH CARE CORPORATION BEFORE**
12 **THE MERGER OR CONSOLIDATION.**

13 (d) The purposes of the incorporation and the reference to the
14 chapter of this act under which the purposes are enumerated and
15 under which the company intends to operate.

16 (e) The manner in which the corporate powers are to be
17 exercised; the number of directors and other officers; the manner
18 of electing the directors and other officers, and how many of the
19 directors ~~shall~~ constitute a quorum, and the manner of filling all
20 vacancies; and, in the case of mutual life or life and disability
21 insurers, the names and mailing addresses of the directors who
22 shall serve until the first annual meeting of the corporation.

23 (f) The amount of capital stock, if any, what proportion is to
24 be paid in before the corporation commences business, and the value
25 of the stock, as provided in section 5014.

26 (g) The term of existence of the corporation, subject to
27 section 5010.

1 (h) The time for the holding of the annual meetings of the
2 corporation.

3 (i) Any terms and conditions of membership that the
4 incorporators have agreed upon and which they consider important to
5 have set forth in the articles.

6 (j) Any other terms and conditions prescribed by law for that
7 class of insurer.

8 (k) If a mutual company operating on the assessment plan, the
9 number of classes or divisions of members and the object or purpose
10 of the classification or division, all of which shall be definitely
11 and correctly stated; and in what manner assessments, premiums, or
12 payments are to be required from the members, the purpose and
13 objects for which the money so realized are to be appropriated, and
14 the names and objects of each fund into which any the money shall
15 be paid.

16 (3) The articles of any stock insurer formed or existing under
17 this act may contain, or may be amended to contain, a provision
18 that the shareholders shall have no preemptive rights to subscribe
19 for any additional shares of capital stock and authorizing the
20 board of directors to prescribe the terms and conditions upon which
21 additional shares of capital stock shall be offered for
22 subscription including the price of the stock, which shall not be
23 less than the par value of the stock; and to offer shares that have
24 not been subscribed by stockholders within the time duly fixed by
25 the board of directors for subscription to any other person or
26 persons at a price and upon terms not less favorable than those
27 offered to the stockholders.

1 (4) The articles of incorporation may contain a provision
2 providing that a director is not personally liable to the
3 corporation or its shareholders or policyholders for monetary
4 damages for a breach of the director's fiduciary duty. However, the
5 provision does not eliminate or limit the liability of a director
6 for any of the following:

7 (a) A breach of the director's duty of loyalty to the
8 corporation or its shareholders or policyholders.

9 (b) Acts or omissions not in good faith or that involve
10 intentional misconduct or knowing violation of law.

11 (c) A violation of section 5036, 5276, or 5280.

12 (d) A transaction from which the director derived an improper
13 personal benefit.

14 (e) An act or omission occurring before January 1, 1989.

15 (5) The articles shall be acknowledged by the person signing
16 the articles before some officer of this state authorized to take
17 acknowledgments of deeds, who shall attach his or her certificate
18 of acknowledgment.

19 Sec. 5104. (1) Subject to the requirements of this act
20 applicable to domestic stock insurers, domestic mutual insurers,
21 reciprocals, or inter-insurance exchanges, and the further
22 requirements of this chapter, 13 or more persons may organize a
23 stock insurer or 20 or more persons may organize a mutual insurer
24 for the purpose of transacting any or all of the following kinds of
25 insurance: property, marine, inland navigation and transportation,
26 casualty, or fidelity and surety, all as defined in chapter 6. Once
27 organized and authorized, the acquiring insurer is subject to all

1 applicable provisions of this act.

2 (2) ~~If~~ **DURING THE PERIOD THAT** the acquiring insurer is a
3 domestic stock insurer owned by a nonprofit health care corporation
4 formed pursuant to the nonprofit health care corporation reform
5 act, 1980 PA 350, MCL 550.1101 to 550.1704, then for insurance
6 products and services the acquiring insurer under this chapter
7 whether directly or indirectly shall only transact worker's
8 compensation insurance and employer's liability insurance, transact
9 disability insurance limited to replacement of loss of earnings,
10 and act as an administrative services organization for an approved
11 self-insured worker's compensation plan or a disability insurance
12 plan limited to replacement of loss of earnings. This subsection
13 does not preclude the acquiring insurer from providing either
14 directly or indirectly noninsurance products and services as
15 otherwise provided by law.

16 Sec. 5209. ~~An~~ **EXCEPT AS OTHERWISE PROVIDED IN THIS SECTION, AN**
17 insurer shall transact its business under its own name ~~and~~ shall
18 not adopt any assumed name. ~~and~~ ~~excepting that an~~ **AN** insurer, by
19 amending its articles of incorporation, may change its name or take
20 a new name. **A NONPROFIT MUTUAL DISABILITY INSURER INTO WHICH A**
21 **NONPROFIT HEALTH CARE CORPORATION THAT IS ORGANIZED UNDER THE**
22 **NONPROFIT HEALTH CARE CORPORATION REFORM ACT, 1980 PA 350, MCL**
23 **550.1101 TO 550.1704, IS MERGED OR CONSOLIDATED MAY RETAIN AND USE**
24 **TRADE NAMES IN USE BY THE NONPROFIT HEALTH CARE CORPORATION BEFORE**
25 **THE MERGER OR CONSOLIDATION.**

26 Sec. 5800. (1) This chapter applies only to domestic mutual
27 insurers transacting property, casualty, disability, and other

1 insurances, ~~and~~ to mutual holding companies resulting from the
2 reorganization of those mutual insurers, **AND TO NONPROFIT MUTUAL**
3 **DISABILITY INSURERS.**

4 (2) This chapter does not apply to any domestic insurer doing
5 business on August 10, 1917, unless the insurer fully complies with
6 this chapter and by resolution of its board of directors duly
7 certified to by the president and secretary and filed with and
8 approved by the commissioner elects to adopt the provisions of this
9 chapter, in which case the insurer may thereafter effect such kind
10 or kinds of insurance as specified in its articles of incorporation
11 as then or thereafter amended or as may be specified in the
12 resolution.

13 (3) A person incorporating under this chapter after January 1,
14 1984, is subject to the minimum financial requirements of sections
15 408 and 410. Any corporation incorporated under this chapter on or
16 before January 1, 1984, ~~shall continue~~ **CONTINUES** to be subject to
17 the provisions of section 5810(3).

18 (4) ~~A~~ **EXCEPT AS OTHERWISE PROVIDED IN SECTION 5801(2), A**
19 domestic mutual insurer transacting property, casualty, disability,
20 and other insurances may be reorganized pursuant to chapters 59 and
21 60.

22 **SEC. 5801. (1) A DOMESTIC MUTUAL INSURER MAY BE FORMED WITH**
23 **NONPROFIT STATUS.**

24 (2) **A NONPROFIT MUTUAL DISABILITY INSURER HAS ALL POWERS OF A**
25 **MUTUAL INSURER ORGANIZED UNDER THIS CHAPTER UNLESS EXPRESSLY**
26 **RESERVED. A NONPROFIT MUTUAL DISABILITY INSURER THAT HAS MERGED**
27 **WITH A NONPROFIT HEALTH CARE CORPORATION AS PROVIDED IN SECTION**

1 5805(1) SHALL NOT CONVERT ITS STATUS TO A STOCK INSURER UNDER
2 CHAPTER 59 OR REORGANIZE UNDER CHAPTER 60.

3 SEC. 5805. (1) AS SET FORTH IN SECTION 220 OF THE NONPROFIT
4 HEALTH CARE CORPORATION REFORM ACT, 1980 PA 350, MCL 550.1220, A
5 NONPROFIT HEALTH CARE CORPORATION MAY MERGE WITH A NONPROFIT MUTUAL
6 DISABILITY INSURER WHERE THE SURVIVING ENTITY IS GOVERNED BY THIS
7 CHAPTER. A MERGER DESCRIBED IN THIS SECTION IS EXEMPT FROM THE
8 APPLICATION OF SECTIONS 1311 TO 1319. NOTWITHSTANDING ANY PROVISION
9 OF THIS ACT TO THE CONTRARY, THE RESULTING NONPROFIT MUTUAL
10 DISABILITY INSURER SHALL CONTINUE AS A NONPROFIT ENTITY AND SHALL
11 CONTINUE TO PROVIDE COVERAGE TO THE INDIVIDUAL AND SMALL GROUP
12 HEALTH MARKETS IN THIS STATE.

13 (2) A NONPROFIT MUTUAL DISABILITY INSURER THAT HAS MERGED WITH
14 A NONPROFIT HEALTH CARE CORPORATION AS DESCRIBED IN SUBSECTION (1)
15 MAY, AT ITS OPTION, CONTINUE TO OFFER ANY PRODUCT THAT WAS OFFERED
16 TO THE SUBSCRIBERS OF THE NONPROFIT HEALTH CARE CORPORATION.

17 (3) A NONPROFIT MUTUAL DISABILITY INSURER THAT HAS MERGED WITH
18 A NONPROFIT HEALTH CARE CORPORATION AS DESCRIBED IN SUBSECTION (1)
19 MAY OFFER SUPPLEMENTAL COVERAGE TO MEDICARE ENROLLEES AS PROVIDED
20 IN CHAPTER 38. NOTWITHSTANDING ANY OTHER PROVISION OF THIS ACT TO
21 THE CONTRARY AND UNTIL JULY 31, 2016, BOTH OF THE FOLLOWING APPLY
22 TO AN INSURER DESCRIBED IN THIS SUBSECTION:

23 (A) THE INSURER SHALL CONTINUE TO OFFER TO CURRENT OR NEW
24 ELIGIBLE POLICYHOLDERS WHO ARE RESIDENTS OF THIS STATE, AT THE SAME
25 RATES AS OFFERED TO SUBSCRIBERS BY THE NONPROFIT HEALTH CARE
26 CORPORATION ON THE EFFECTIVE DATE OF THIS SECTION, THE SUPPLEMENTAL
27 COVERAGE TO MEDICARE ENROLLEES.

1 (B) THE INSURER OFFERING SUPPLEMENTAL COVERAGE UNDER
2 SUBDIVISION (A) SHALL CONTINUE ALL COST TRANSFERS AS AUTHORIZED
3 UNDER SECTION 609(5) OF THE NONPROFIT HEALTH CARE CORPORATION
4 REFORM ACT, 1980 PA 350, MCL 550.1609, ON THE EFFECTIVE DATE OF
5 THIS SECTION.

6 (4) BENEFITS PAID BY A NONPROFIT MUTUAL DISABILITY INSURER
7 THAT HAS MERGED WITH A NONPROFIT HEALTH CARE CORPORATION AS
8 DESCRIBED IN SUBSECTION (1) TO AN INSURED OR PROVIDER BY WAY OF A
9 CHECK OR OTHER SIMILAR WRITTEN INSTRUMENT FOR THE TRANSMISSION OR
10 PAYMENT OF MONEY, THAT IS NOT CASHED WITHIN THE PERIOD PRESCRIBED
11 IN THE UNIFORM UNCLAIMED PROPERTY ACT, 1995 PA 29, MCL 567.221 TO
12 567.265, SHALL ESCHEAT TO THIS STATE PURSUANT TO THE UNIFORM
13 UNCLAIMED PROPERTY ACT, 1995 PA 29, MCL 567.221 TO 567.265.

14 Sec. 5824. Every member of the company ~~shall be~~ IS entitled to
15 1 vote, or to a number of votes based upon the insurance in force,
16 the number of policies held, or the amount of premiums paid, as may
17 be provided in the bylaws. A NONPROFIT MUTUAL DISABILITY INSURER
18 MAY PERMIT ENTITIES HOLDING ADMINISTRATIVE SERVICES AGREEMENTS WITH
19 IT TO BE MEMBERS AND MAY PROVIDE IN ITS BYLAWS THE BASIS FOR THE
20 NUMBER OF VOTES THE ENTITIES WILL HAVE AS MEMBERS.

21 SEC. 5825. (1) A MEMBER OF A NONPROFIT MUTUAL DISABILITY
22 INSURER THAT HAS MERGED WITH A NONPROFIT HEALTH CARE CORPORATION AS
23 PROVIDED IN SECTION 5805(1) SHALL HAVE NO INTEREST IN, OR RESIDUAL
24 RIGHTS TO, THE ASSETS OF THE NONPROFIT MUTUAL DISABILITY INSURER;
25 SHALL NOT RECEIVE POLICY OR SURPLUS DIVIDENDS; AND SHALL NOT BE
26 REQUIRED TO PAY CAPITAL ASSESSMENTS BY THE NONPROFIT MUTUAL
27 DISABILITY INSURER.

1 (2) IN THE EVENT OF THE DISSOLUTION OR WINDING UP OF A
2 NONPROFIT MUTUAL DISABILITY INSURER DESCRIBED IN SUBSECTION (1),
3 ANY RESIDUAL VALUE REMAINING AFTER SATISFACTION OF CLAIMS FILED
4 UNDER SECTION 8142(1) (A) TO (H), SHALL BE DISTRIBUTED FOR THE
5 BENEFIT OF THE PEOPLE OF THIS STATE TO THE MICHIGAN HEALTH
6 ENDOWMENT FUND CREATED UNDER PART 6A OF THE NONPROFIT HEALTH CARE
7 CORPORATION REFORM ACT, 1980 PA 350, MCL 550.1651 TO 550.1655, AND
8 SHALL BE ADMINISTERED IN A MANNER CONSISTENT WITH THE SUPERVISION
9 OF TRUSTEES FOR CHARITABLE PURPOSES ACT, 1961 PA 101, MCL 14.251 TO
10 14.266.

11 (3) IN THE EVENT OF A TRANSACTION OR SERIES OF TRANSACTIONS
12 PURSUANT TO WHICH THE NONPROFIT MUTUAL DISABILITY INSURER
13 DEMUTUALIZES UNDER CHAPTER 59; CONVERTS TO A MUTUAL HOLDING COMPANY
14 UNDER CHAPTER 60; SELLS, TRANSFERS, OR OTHERWISE DISPOSES OF ALL OR
15 SUBSTANTIALLY ALL OF ITS ASSETS; MERGES INTO AN ENTITY AND THE
16 NONPROFIT MUTUAL DISABILITY INSURER IS NOT THE SURVIVING ENTITY;
17 MOVES ITS PRINCIPAL EXECUTIVE OFFICE OUT OF THIS STATE;
18 REDOMESTICATES TO ANOTHER STATE; OR ALLOWS OR PERMITS A PERSON OR A
19 GROUP OF PERSONS ACTING IN CONCERT TO BENEFICIALLY OWN GREATER THAN
20 50% OF THE VOTING POWER ASSOCIATED WITH OWNERSHIP INTERESTS IN THE
21 NONPROFIT MUTUAL DISABILITY INSURER, WHETHER BY MERGER, DIVIDEND,
22 OR ANY OTHER MEANS, THEN THE NONPROFIT MUTUAL DISABILITY INSURER OR
23 THE ACQUIRING PERSON OR ENTITY SHALL MAKE PAYMENT FOR THE BENEFIT
24 OF THE PEOPLE OF THIS STATE TO THE MICHIGAN HEALTH ENDOWMENT FUND
25 CREATED UNDER PART 6A OF THE NONPROFIT HEALTH CARE CORPORATION
26 REFORM ACT, 1980 PA 350, MCL 550.1651 TO 550.1655, IN AN AMOUNT
27 EQUAL TO THE GREATER OF THE ACQUISITION PRICE OR THE FAIR MARKET

1 VALUE OF THE NONPROFIT MUTUAL DISABILITY INSURER AND ITS
2 SUBSIDIARIES, CONSIDERED ON A CONSOLIDATED HOLDING COMPANY BASIS AS
3 OF THE TIME OF THE CLOSING OF THE TRANSACTION OR SERIES OF
4 TRANSACTIONS, AS DETERMINED BY AN INDEPENDENT VALUATION BY A PERSON
5 OR ENTITY MUTUALLY AGREED UPON BY THE ATTORNEY GENERAL, THE
6 COMMISSIONER, AND THE NONPROFIT MUTUAL DISABILITY INSURER. THE COST
7 OF THE INDEPENDENT VALUATION SHALL BE PAID BY THE NONPROFIT MUTUAL
8 DISABILITY INSURER OR THE ACQUIRING PERSON OR ENTITY. THE PAYMENT
9 FOR THE BENEFIT OF THE PEOPLE OF THIS STATE SHALL BE ADMINISTERED
10 IN A MANNER CONSISTENT WITH THE SUPERVISION OF TRUSTEES FOR
11 CHARITABLE PURPOSES ACT, 1961 PA 101, MCL 14.251 TO 14.266, AND
12 SHALL BE IN SATISFACTION OF ANY CLAIM OR ASSERTION THAT
13 CONSIDERATION IS DUE WITH RESPECT TO THE CHARITABLE ASSETS OF THE
14 NONPROFIT MUTUAL DISABILITY INSURER.

15 (4) AS USED IN THIS SECTION, "BENEFICIALLY OWN" MEANS ACTUAL
16 OWNERSHIP OR THE RIGHT, DIRECTLY OR INDIRECTLY, TO CONTROL VOTING
17 POWER ASSOCIATED WITH OWNERSHIP INTERESTS IN THE NONPROFIT MUTUAL
18 DISABILITY INSURER.

19 SEC. 5826. UNTIL JANUARY 1, 2014, A NONPROFIT MUTUAL
20 DISABILITY INSURER THAT HAS MERGED WITH A NONPROFIT HEALTH CARE
21 CORPORATION AS DESCRIBED IN SECTION 5805(1) SHALL OFFER HEALTH CARE
22 BENEFITS TO ALL RESIDENTS OF THIS STATE REGARDLESS OF HEALTH
23 STATUS.

24 Enacting section 1. This amendatory act does not take effect
25 unless Senate Bill No. 1294 of the 96th Legislature is enacted into
26 law.