THE NONPROFIT HEALTH CARE CORPORATION REFORM ACT (EXCERPT)
Act 350 of 1980
Part 6

550.1601 Regulation and supervision of health care corporation; delegation of authority.

Sec. 601.

(1) A health care corporation shall be subject to regulation and supervision by the commissioner as provided in this act.

(2) A designee of the commissioner shall not be authorized to act on behalf of the commissioner under this act unless prior written notice of the delegation of authority has been given to a health care corporation subject to that delegated authority.

History: 1980, Act 350, Eff. Apr. 3, 1981
Popular Name: Blue Cross-Blue Shield
Popular Name: Act 350

550.1602 Statement of condition; statistical, financial, and other reports.

Sec. 602.

(1) Not later than March 1 each year, subject to a 30-day extension that may be granted by the commissioner, a health care corporation shall file in the office of the commissioner a sworn statement verified by at least 2 of the principal officers of the corporation showing its condition as of the preceding December 31. The statement shall be in a form and contain those matters that the commissioner prescribes for a health care corporation, including those matters contained in section 204a. The statement shall include the number of members and the number of subscribers' certificates issued by the corporation and outstanding.

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

History: 1980, Act 350, Eff. Apr. 3, 1981 ;-- Am. 2003, Act 59, Eff. July 23, 2003
Popular Name: Blue Cross-Blue Shield
Popular Name: Act 350

550.1603 Visitation and examination; access to books, papers, and documents; witnesses; expenses; disclosure of information; reporting violation; action by attorney general; ex parte order directing compliance.

Sec. 603.

(1) The commissioner may visit and examine the affairs of a health care corporation. The corporation shall in every way facilitate an examination or visitation.

(2) The power of examination shall include free access to all of the books, papers, and documents that relate to the business of the corporation, except as provided in section 304(2)(d). Free access shall include the right to copy and reproduce at the place of business of the health care corporation and to require delivery of any materials to the office of the commissioner in Lansing within 5 working days after the request is made. If the corporation is unable to respond to the request within 5 working days, the corporation shall specify a date certain by which the corporation will respond. However, the date certain shall not be later than 15 working days after the request is made unless the commissioner agrees to a longer period of time. Witnesses may be summoned and qualified under oath, and examination may be made of the corporation's officers, agents, or employees or of other persons having knowledge of the affairs, transactions, and conditions of the corporation. Except as provided in section 603a, the per diem, traveling, reproduction, and other necessary expenses in connection with visitation and examination shall

be paid by the corporation and shall be credited to the general fund of the state.

(3) Information provided to the commissioner that is disclosable only to the commissioner under section 304(2) shall not be disclosed by the commissioner to other persons until such time as the minutes pertaining to that information may be disclosed under section 304(3).

(4) If it appears from any examination or report that this act or any other law of this state has been violated, the commissioner immediately shall report the violation to the attorney general in writing. The attorney general shall then take action on the alleged violation, as the facts warrant. Unless the public health, safety, or welfare otherwise clearly requires, before commencement of a proceeding against a health care corporation resulting from a report, the corporation shall be furnished a copy of the examination report and shall be given an informal opportunity to show compliance with the law.

(5) Upon the request of the commissioner, the attorney general may petition for, and the circuit court may issue, an ex parte order from the circuit court directing a corporation to comply with this section. The corporation shall be entitled to an expedited hearing to challenge the ex parte order.

History: 1980, Act 350, Eff. Apr. 3, 1981 ;-- Am. 1994, Act 169, Imd. Eff. June 17, 1994
Popular Name: Blue Cross-Blue Shield
Popular Name: Act 350

550.1603a Health care corporation subject to MCL 500.224 and 500.225; costs and expenses.

Sec. 603a.

A health care corporation is subject to sections 224(4) through (13) and 225 of the insurance code of 1956, Act No. 218 of the Public Acts of 1956, being sections 500.224 and 500.225 of the Michigan Compiled Laws, instead of the costs and expenses that may be imposed by the commissioner pursuant to section 603.

History: Add. 1994, Act 169, Imd. Eff. June 17, 1994
Popular Name: Blue Cross-Blue Shield
Popular Name: Act 350

550.1604 Confidentiality; violation as misdemeanor; penalty.

Sec. 604.

(1) The commissioner shall ensure that confidentiality of records containing personal data which may be associated with identifiable individuals. Except as is necessary to comply with a court order, or for the purposes of claim adjudication or when required by law, the commissioner shall not disclose records containing personal data which may be associated with an identifiable individual without the prior informed consent of the individual to whom the data pertain. The individual's consent shall be in writing. If an individual has authorized the release of personal data to a specific person, that person shall not release the data to a third person unless the individual executes in writing another informed consent authorizing that additional release.

(2) The commissioner shall ensure the confidentiality of data which discloses reimbursement levels for specific procedures or services of specific providers and data which, if disclosed, can be used to calculate those reimbursement levels. This subsection shall apply only if the data are not already generally known to providers and if the disclosure of the data would be harmful to the achievement of the goals set forth in section 504. Only that portion of a record dealing with data described in this subsection shall be exempt from disclosure. A person, whose request for a hearing has been granted by the commissioner, may examine the data and shall be subject to the same confidentiality requirements as the commissioner under this subsection.

(3) The commissioner shall ensure the confidentiality of any trade secrets of the corporation, except for information required to be disclosed under Act No. 442 of the Public Acts of 1976, as amended, being sections 15.231 to 15.246 of the Michigan Compiled Laws.

(4) Subject to the provisions of subsections (1) to (3), information which a health care corporation provides to or files with the commissioner shall be governed by Act No. 442 of the Public Acts of 1976, as amended, being sections 15.231 to 15.246 of the Michigan Compiled Laws.

(5) A person who violates the confidentiality provisions of this section is guilty of a misdemeanor, punishable by a fine of not more than $1,000.00 for each violation.

History: 1980, Act 350, Eff. Apr. 3, 1981
Popular Name: Blue Cross-Blue Shield
Popular Name: Act 350

550.1605 Certificate of authority; suspension or limitation; circumstances; order; hearing; notice.

Sec. 605.

(1) Upon due notice and an opportunity for an evidentiary hearing pursuant to the administrative procedures act, the commissioner may suspend or limit the certificate of authority of a health care corporation if the commissioner determines that any of the following circumstances exist:

(a) The health care corporation does not meet the requirements of this act respecting the adequacy of its reserves.

(b) The health care corporation is using methods or practices in the conduct of its business which render further transactions hazardous or injurious to subscribers of the corporation or the public.

(c) The health care corporation refuses or fails to comply with this act or with a lawful order of the commissioner.

(2) If the commissioner finds that the public health, safety, or welfare requires emergency action and incorporates this finding into an order, a summary suspension or limitation of a certificate of authority may be ordered. The suspension or limitation shall be effective on the date specified in the order or upon service of a certified copy of the order on the health care corporation, whichever is later, and shall be effective during the proceedings. The corporation shall have the right to an administrative hearing within 5 days to show why the summary suspension or limitation should be terminated.

(3) An order of limitation may restrict the solicitation of certificates, the renewal of business in force, and the solicitation, offer, or acceptance of contracts, and may impose other conditions to continued authorization as are reasonably necessary to protect the subscribers of the corporation or the public. The commissioner shall terminate an order of limitation when the circumstance giving rise to the order ceases to exist.

(4) Upon suspension or limitation of a corporation's certificate of authority, if the commissioner considers it necessary or desirable for the protection of the subscribers of the corporation or the public, the commissioner may publish notice of the suspension or limitation in 1 or more newspapers of general circulation in the state.

(5) An emergency order by the commissioner which suspends or limits a corporation's certificate of authority shall be for a period not to exceed 1 year and, after opportunity of hearing, the commissioner for good cause may extend the period of suspension or limitation for additional periods not to exceed 1 year.

History: 1980, Act 350, Eff. Apr. 3, 1981
Popular Name: Blue Cross-Blue Shield
Popular Name: Act 350

550.1606 Authority of commissioner regarding officers and directors; authority as to dissolution, taking over, or liquidation of corporations; insolvency defined.

Sec. 606.

(1) The commissioner shall have the same authority regarding the officers and directors of a health care corporation as the commissioner has with respect to the officers and directors of insurers under sections 249 and 250 of the insurance code of 1956, 1956 PA 218, MCL 500.249 and 500.250.

(2) The commissioner shall have the same authority with respect to the dissolution, taking over, or liquidation of corporations formed or doing business under this act as is provided in chapter 81 of the insurance code of 1956, 1956 PA 218, MCL 500.8101 to 500.8159. For purposes of this subsection, a health care corporation shall be considered to be insolvent if its liabilities exceed its assets, unless otherwise defined in chapter 81 of the insurance code of 1956, 1956 PA 218, MCL 500.8101 to 500.8159.

History: 1980, Act 350, Eff. Apr. 3, 1981 ;-- Am. 2003, Act 59, Eff. July 23, 2003
Popular Name: Blue Cross-Blue Shield
Popular Name: Act 350

550.1607 Submission of new or revised certificate and applicable proposed rates; approval or disapproval; exemption; circumstances and conditions; notice; implementation of certificates and rates.

Sec. 607.

(1) A health care corporation shall submit a copy of any new or revised certificate to the commissioner along with applicable proposed rates and rate rationale. The certificates, and applicable proposed rates, shall be deemed approved and effective 30 days after filing with the commissioner, except as otherwise provided in this section. The commissioner may subsequently disapprove any certificate deemed approved.

(2) The commissioner shall exempt from prior approval certificates resulting from a collective bargaining agreement.

(3) The commissioner may disapprove, or approve with modifications, a certificate and applicable rates under 1 or more of the following circumstances:

(a) If the rate charged for the benefits provided is not equitable, not adequate, or excessive, as defined in section 609.

(b) If the certificate contains 1 or more provisions which are unjust, unfair, inequitable, misleading, deceptive, or which encourage misrepresentation of the coverage.

(c) If a certificate reduces the scope, amount, or duration of benefits so as to have the effect of reducing the comprehensiveness of existing health care benefits available to groups or to individuals. The commissioner may approve a certificate which reduces the scope, amount, or duration of health care benefits if the commissioner determines that the certificate will be offered as an alternative in addition to an existing certificate which provides comprehensive health care benefits and if the commissioner determines that approval of the alternative certificate will not adversely affect the opportunity for groups or individuals to obtain comprehensive health care benefits.

(4) The commissioner shall approve a certificate and applicable proposed rates if all of the following conditions are met:

(a) If the rate charged for the benefits provided is equitable, adequate, and not excessive, as defined in section 609.

(b) If the certificate does not contain any provision which is unjust, unfair, inequitable, misleading, deceptive, or which encourages misrepresentation of the coverage.

(5) If the commissioner disapproves a certificate and any applicable proposed rates under this section, he or she shall issue a notice of disapproval which specifies in what respects a filing fails to meet the requirements of this act. The notice shall state that the filing shall not become effective.

(6) If the commissioner approves, or approves with modifications, a certificate and any applicable proposed rates under this section, he or she shall issue a notice of approval or approval with modifications. If the notice is of approval with modifications, the notice shall specify what modifications in the filing are required for approval under this act, and the reasons for the modifications. The notice shall also state that the filing shall become effective after the modifications are made and approved by the commissioner.

(7) Upon request by a health care corporation, the commissioner may allow certificates and rates to be implemented prior to filing to allow implementation of a new certificate on the date requested.

History: 1980, Act 350, Eff. Apr. 3, 1981
Constitutionality: This act is unconstitutional in the following three particulars:(1) The act's provision for an actuary panel to resolve risk factor disputes is an unconstitutional delegation of legislative authority in that it lacks adequate standards (MCL 550.1205(6)).(2) The statutory restrictions on administrative services only (ASO) contracts violate equal protection of the laws insofar as they result in arbitrary and discriminatory treatment of health care corporations vis-a-vis commercial insurers (MCL 550.1104(3), 550.1211, 550.1414a, 550.1415, and 550.1607(1)).(3) The commissioner's authority to issue a cease and desist order based on probable cause against a health care corporation for noncompliance with the act establishes an improper burden of proof (MCL 550.1402(7)).The Supreme Court ruling on these three areas of this act does not affect the constitutionality of the remainder of the act. Where, as here, the unconstitutional provisions are easily severable, the remainder of the act need not be affected. Blue Cross and Blue Shield of Michigan v Governor, 422 Mich 1; 367 NW2d 1 (1985).
Popular Name: Blue Cross-Blue Shield
Popular Name: Act 350

550.1608 Rates charged to nongroup subscribers for certificate; methodology and definitions of rating system, formula, component, and factor used to calculate rates for group subscribers for certificate; filing; approval, disapproval, or modification; standard; burden of proof; effective date of proposed rate; rate adjustments; implementation prior to approval; examination of financial arrangement; formulae, and factors.

Sec. 608.

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

(2) The methodology and definitions of each rating system, formula, component, and factor used to calculate rates for group subscribers for each certificate, including the methodology and definitions used to calculate administrative costs for administrative services only and cost-plus arrangements, shall be filed in accordance with section 610 and shall be subject to the prior approval of the commissioner. The definition of a group, including any clustering principles applied to nongroup subscribers or small group subscribers for the purpose of group formation, shall be subject to the prior approval of the commissioner. However, if a Michigan caring program is created under section 436, that program shall be defined as a group program for the purpose of establishing rates. The commissioner shall approve, disapprove, or modify and approve the methodology and definitions of each rating system, formula, component, and factor for each certificate subject to the standard that the resulting rates for group subscribers must be determined to be equitable, adequate, and not excessive, as defined in section 609. In addition, the commissioner may from time to time review the records of the corporation to determine proper application of a rating system, formula, component, or factor with respect to any group. The corporation shall refile for approval under this subsection, every 3 years, the methodology and definitions of each rating system, formula, component, and factor used to calculate rates for group subscribers, including the methodology and definitions used to calculate administrative costs for administrative services only and cost-plus arrangements. The burden of proof that the resulting rates to be charged meet these standards shall be upon the health care corporation proposing to use the rating system, formula, component, or factor.

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

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

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

History: 1980, Act 350, Eff. Apr. 3, 1981 ;-- Am. 1991, Act 73, Imd. Eff. July 11, 1991
Popular Name: Blue Cross-Blue Shield
Popular Name: Act 350

550.1609 Excessive rate; administrative expense budget; equitable rate; adequate rate; line of business to be self-sustaining; cost transfers for benefit of senior citizens and group conversion subscribers.

Sec. 609.

(1) A rate is not excessive if the rate is not unreasonably high relative to the following elements, individually or collectively; provision for anticipated benefit costs; provision for administrative expense; provision for cost transfers, if any; provision for a contribution to or from surplus that is consistent with the attainment or

maintenance of adequate and unimpaired surplus as provided in section 204a; and provision for adjustments due to prior experience of groups, as defined in the group rating system. A determination as to whether a rate is excessive relative to these elements, individually or collectively, shall be based on the following: reasonable evaluations of recent claim experience; projected trends in claim costs; the allocation of administrative expense budgets; and the present and anticipated unimpaired surplus of the health care corporation. To the extent that any of these elements are considered excessive, the provision in the rates for these elements shall be modified accordingly.

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

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

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

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

History: 1980, Act 350, Eff. Apr. 3, 1981 ;-- Am. 1991, Act 61, Eff. July 11, 1991 ;-- Am. 2003, Act 59, Eff. July 23, 2003
Popular Name: Blue Cross-Blue Shield
Popular Name: Act 350

550.1610 Filing of information and materials relative to proposed rate; notice; approval, approval with modifications, or disapproval; additional information and materials; determination; notice; visitation and examination; expenses; order; effect of inability to approve 1 or more rating classes of business within line of business; information in support of nongroup rate filing; public inspection of information; forms and instructions for filing proposed rates.

Sec. 610.

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

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

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

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

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

other necessary expenses in connection with visitation and examination shall be paid by the corporation, and shall be credited to the general fund of the state.

(4) If a filing is approved, approved with modifications, or disapproved under subsection (2)(a), the commissioner shall issue a written order of the approval, approval with modifications, or disapproval. If the filing was approved with modifications or disapproved, the order shall state specifically in what respects the filing fails to meet the requirements of this act and, if applicable, what modifications are required for approval under this act. If the filing was approved with modifications, the order shall state that the filing shall take effect after the modifications are made and approved by the commissioner. If the filing was disapproved, the order shall state that the filing shall not take effect.

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

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

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

(b) Actual prior trend experience.

(c) Actual prior administrative expenses.

(d) Projected trend factors.

(e) Projected administrative expenses.

(f) Contributions for risk and contingency reserve factors.

(g) Actual health care corporation contingency reserve position.

(h) Projected health care corporation contingency reserve position.

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

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

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

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

History: 1980, Act 350, Eff. Apr. 3, 1981
Popular Name: Blue Cross-Blue Shield
Popular Name: Act 350

550.1611 Legislative intent.

Sec. 611.

It is the intent of the legislature to promote uniformity of rates among subscribers to the greatest extent practicable.

History: 1980, Act 350, Eff. Apr. 3, 1981
Popular Name: Blue Cross-Blue Shield
Popular Name: Act 350

550.1612 Notice of rate filing; contents of request for hearing; advertisements; limitation on fee for copy of rate filing; waiver or reduction of fee; calculation of costs.

Sec. 612.

(1) Upon receipt of a rate filing under section 610, the commissioner immediately shall notify each person who

has requested in writing notice of those filings within the previous 2 years, specifying the nature and extent of the proposed rate revision and identifying the location, time, and place where the copy of the rate filing described in section 610(7) shall be open to public inspection and copying. The notice shall also state that if the person has standing, the person shall have, upon making a written request for a hearing within 60 days after receiving notice of the rate filing, an opportunity for an evidentiary hearing under section 613 to determine whether the proposed rates meet the requirements of this act. The request shall identify the issues which the requesting party asserts are involved, what portion of the rate filing is requested to be heard, and how the party has standing. The corporation shall place advertisements giving notice, containing the information specified above, in at least 1 newspaper which serves each geographic area in which significant numbers of subscribers reside.

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

History: 1980, Act 350, Eff. Apr. 3, 1981
Popular Name: Blue Cross-Blue Shield
Popular Name: Act 350

550.1613 Request for hearing; standing of person; access to filing; confidentiality; penalty; appointment and qualifications of independent hearing officer; commencement of hearing; discovery; conducting hearing; burden of proving compliance; factors in rendering proposal for decision; order rendering decision; withdrawal of order.

Sec. 613.

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

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

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

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

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

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

(4) Within 30 days after receipt of the hearing officer's proposal for decision, the commissioner shall by order

render a decision which shall include a statement of findings.

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

History: 1980, Act 350, Eff. Apr. 3, 1981
Popular Name: Blue Cross-Blue Shield
Popular Name: Act 350

550.1614 Interim rates; petition; determination; granting interim rate; final rate determination; refunds or adjustments; limitation on order establishing interim rate adjustment; rates to which section applicable.

Sec. 614.

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

(2) The commissioner shall grant an interim rate, in an amount as determined by the commissioner, if the commissioner makes a finding that the corporation has made a convincing showing that there is probable cause to believe that the failure to grant the interim rate will result in an underwriting loss for that line of business for the period for which rates are being requested. As used in this subsection, "underwriting loss" means the difference between income from current rates plus investment income, and projected claims plus projected administrative expenses.

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

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

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

History: 1980, Act 350, Eff. Apr. 3, 1981
Popular Name: Blue Cross-Blue Shield
Popular Name: Act 350

550.1615 Review of final order or decision.

Sec. 615.

Any final order or decision made, issued, or executed by the commissioner under this act after a hearing held before the commissioner or a deputy commissioner pursuant to the administrative procedures act shall be subject to review as provided in chapter 6 of the administrative procedures act without leave by the circuit court for Ingham county.

History: 1980, Act 350, Eff. Apr. 3, 1981
Popular Name: Blue Cross-Blue Shield
Popular Name: Act 350

550.1616 Endorsing, filing, and indexing documents; notice of refusal to file; judicial review; certificate of correction; persons adversely affected by correction; documents to which section inapplicable.

Sec. 616.

(1) If a document required or permitted to be filed with the commissioner under this act substantially conforms to the requirements of this act, the commissioner shall endorse upon it the word "filed" with the commissioner's official title and the dates of receipt and of filing, and shall file and index the document or a reproduction of the document pursuant to the records media act in his or her office. If so requested at the time of delivery of the document to his or her office, the commissioner shall include the hour of filing in his or her endorsement on the document.

(2) If the commissioner fails promptly to file a document, other than an annual report or a supplemental statement, submitted for filing under this act, the commissioner, within 10 days after receipt from the person submitting the document for filing of a written request for the filing of the document, shall give written notice of the refusal to file to that person, specifying the reasons for the failure to file the document. From the disapproval, the person may seek judicial review pursuant to sections 103, 104, and 106 of the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, being sections 24.303, 24.304, and 24.306 of the Michigan Compiled Laws.

(3) If a document relating to a health care corporation filed with the commissioner under this act is an inaccurate record of the corporation action referred to in the document or was defectively or erroneously executed, the document may be corrected by filing with the commissioner a certificate of correction on behalf of the corporation. A certificate, entitled "certificate of correction of . . . (correct title of document and name of corporation)" shall be signed as provided in this act with respect to the document being corrected and shall be filed with the commissioner. The certificate shall set forth the name of the corporation, the date the document to be corrected was filed by the commissioner, the provision in the document as corrected or eliminated, and, if the execution was defective, the proper execution. The corrected document is effective in its corrected form as of its original filing date except as to a person who relied upon the inaccurate portion of the document and was, as a result of the inaccurate portion of the document, adversely affected by the correction.

(4) This section does not apply with respect to documents filed pursuant to part 5 or this part.

History: 1980, Act 350, Eff. Apr. 3, 1981 ;-- Am. 1992, Act 197, Imd. Eff. Oct. 5, 1992
Popular Name: Blue Cross-Blue Shield
Popular Name: Act 350

550.1617 Rules.

Sec. 617.

The commissioner may promulgate rules which the commissioner considers necessary to carry out the purposes of, and to execute and enforce this act. The rules shall be promulgated pursuant to the administrative procedures act.

History: 1980, Act 350, Eff. Apr. 3, 1981
Popular Name: Blue Cross-Blue Shield
Popular Name: Act 350

550.1618 Compliance with new procedures, benefits, or contracts.

Sec. 618.

Whenever any section of this act requires a health care corporation to implement any new procedure, provide any new benefit, or enter into any new contract, the commissioner shall give the health care corporation a reasonable time to comply with the requirements.

History: 1980, Act 350, Eff. Apr. 3, 1981
Popular Name: Blue Cross-Blue Shield
Popular Name: Act 350

550.1619 Injunction; declaratory and equitable relief; enforcement of act or rules.

Sec. 619.

(1) The attorney general may bring an action, or apply to the circuit court for a court order, to enjoin a health care corporation from transacting business, receiving, collecting, or disbursing money, or acquiring, holding, protecting, or conveying property if that corporate activity is not authorized under this act.

(2) The attorney general may apply to the circuit court for a court order enjoining an alleged violation of this act or other equitable or extraordinary relief to enforce this act.

(3) A political subdivision of this state, an agency of this state, or any person may bring an action in the circuit court for Ingham county for declaratory and equitable relief against the commissioner or to compel the commissioner to enforce this act or rules promulgated under this act.

History: 1980, Act 350, Eff. Apr. 3, 1981
Popular Name: Blue Cross-Blue Shield
Popular Name: Act 350

550.1620 Certificate subject to policy and certificate issuance and rate filing requirements; establishment of reasonable open enrollment periods; frequency and duration; denial, condition, or discrimination.

Sec. 620.

(1) Notwithstanding any provision of this act to the contrary, a certificate delivered, issued for delivery, or renewed in this state on or after January 1, 2014 by a health care corporation is subject to the policy and certificate issuance and rate filing requirements of the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302, including the rating factor requirements of section 3474a of the insurance code of 1956, 1956 PA 218, MCL 500.3474a.

(2) For a certificate delivered, issued for delivery, or renewed in this state on or after January 1, 2014, subject to the prior approval of the commissioner, a health care corporation may establish reasonable open enrollment periods.

(3) The commissioner shall establish minimum standards for the frequency and duration of open enrollment periods established under subsection (2). The commissioner shall uniformly apply the minimum standards for the frequency and duration of open enrollment periods established under this subsection to all health care corporations.

(4) A health care corporation offering coverage during an open enrollment period established under subsection (2) shall not deny or condition the issuance or effectiveness of a certificate and shall not discriminate in the pricing of the certificate on the basis of health status, claims experience, receipt of health care, or medical condition.

History: Add. 2013, Act 4, Imd. Eff. Mar. 18, 2013
Popular Name: Blue Cross-Blue Shield
Popular Name: Act 350