

**THE NONPROFIT HEALTH CARE CORPORATION REFORM ACT (EXCERPT)**  
**Act 350 of 1980**  
Part 2

**550.1201 Health care corporation; incorporation; number of persons; payment of cash or other material benefit to subscriber; applicable laws; charitable and benevolent institution; exemption from taxation; certificate of authority; health care benefits and certificates.**

Sec. 201.

(1) A health care corporation shall not be incorporated in this state except under this act.

(2) Not less than 7 persons, all of whom shall be residents of this state, may form a health care corporation under this act for the purpose of providing 1 or more health care benefits at the expense of the corporation to persons or groups of persons who become subscribers to the plan, under certificates which will entitle each subscriber to certain health care services by providers with which the corporation has contracted for that purpose.

(3) A certificate shall not provide for the payment of cash or any other material benefit to a subscriber or the estate of a subscriber on account of death, illness, or injury except where payment is made to a subscriber for health care services by a provider who has not entered into a participating contract with the corporation or to reimburse a subscriber who has made, or is obligated to make, payment directly to a provider.

(4) A health care corporation shall not be subject to the laws of this state with respect to insurance corporations, except as provided in this act. A health care corporation shall not be subject to the laws of this state with respect to corporations generally.

(5) A health care corporation subject to this act is declared to be a charitable and benevolent institution, and its funds and property shall be exempt from taxation by this state or any political subdivision of this state.

(6) A person shall not act as a health care corporation or issue a certificate except as authorized by and pursuant to a certificate of authority granted to the person by the commissioner pursuant to this act.

(7) A health care corporation shall provide only the kinds of health care benefits and certificates authorized by this act. A health care corporation shall not make or issue a certificate relative to health care benefits except as approved or otherwise authorized under this act.

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

**550.1201a Formation of health care corporation after January 1, 2014; prohibition.**

Sec. 201a.

Notwithstanding section 201, a health care corporation shall not be formed in this state on or after January 1, 2014.

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

**550.1202 Articles of incorporation; contents; number; forms; examination and certification by attorney general; fees.**

Sec. 202.

(1) Persons associating to form a health care corporation under this act shall subscribe to articles of incorporation that shall contain all of the following:

- (a) The names and addresses of the incorporators.
- (b) The location of the principal office of the corporation for the transaction of business in this state.
- (c) The name by which the corporation shall be known and all assumed names under which the corporation does business. The corporate name shall not include the words insurance, casualty, surety, health and accident, mutual, or other words descriptive of the insurance or surety business, and shall not be so similar to the name of an insurance or surety company doing business in this or other states at the time of incorporation so as to tend, in the judgment of the commissioner, to create confusion in identity with that insurance or surety company.
- (d) The purposes of the corporation, which shall be:
  - (i) To provide health care benefits.
  - (ii) To secure for all of the people of this state who apply for a certificate the opportunity for access to coverage for health care services at a fair and reasonable price.
  - (iii) To assure for nongroup and group subscribers reasonable access to, and reasonable cost and quality of, health care services.
  - (iv) To achieve the goals of the corporation relative to access, quality, and cost of health care services, as prescribed in section 504.
  - (v) To offer supplemental coverage to all medicare enrollees as provided in part 4A.
  - (vi) If under contract to serve as fiscal intermediary for the federal medicare program, to do all of the following:
    - (A) Carry out its contractual responsibilities efficiently, including the timely processing and payment of claims.
    - (B) Actively represent, in negotiations with the federal government and with providers of medical, hospital, and other health services for which benefits are provided under the federal medicare program, the interests of senior citizens as they relate to cost and quality of, and access to, health care services and administration of the program.
  - (vii) To engage in activity otherwise authorized by this act, within the purposes for which corporations may be organized under this act.
- (e) The term of existence of the corporation, which may be in perpetuity.
- (f) The time for the holding of the annual meeting of the corporation.
- (g) Other terms and conditions not inconsistent with this act, necessary for the conduct of the affairs of the corporation.
- (2) The articles shall be in triplicate and upon proper forms as prescribed by the commissioner.
- (3) Before the articles or amendments to the articles are effective for any purpose, they shall be submitted to the attorney general for examination. If the attorney general finds the articles or amendments to the articles to be in compliance with this act, the attorney general shall certify this finding to the commissioner. The articles or amendments shall be effective at the time certified by the attorney general.
- (4) Each health care corporation shall pay a fee of \$250.00 to the attorney general for the examination of its articles of incorporation, or \$100.00 for the examination of amendments to the articles of incorporation. Each health care corporation shall pay a filing fee of \$100.00 to the commissioner for filing its articles of incorporation or \$50.00 for the filing of amendments to the articles of incorporation. The fees prescribed in this subsection shall be deposited in the state treasury and credited to the general fund of the state.

**History:** 1980, Act 350, Eff. Apr. 3, 1981 ;-- Am. 1988, Act 102, Imd. Eff. Apr. 11, 1988 ;-- Am. 1994, Act 40, Imd. Eff. Mar. 14, 1994  
**Popular Name:** Blue Cross-Blue Shield  
**Popular Name:** Act 350

### **550.1203 Amendment or restatement of articles; review; approval.**

Sec. 203.

By action of its board of directors, a health care corporation may integrate into a single instrument the provisions of its articles of incorporation which are then in effect and operative, as theretofore amended. If the restated articles restate and integrate and also further amend the articles, they shall also be adopted by the board of directors. Any amendment or restatement of the articles shall be subject to review, approval, or both, as provided in section 202(3) or 701, as applicable.

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

**550.1204 Filing of statements and documents; examination; investigation; additional information; conditions; duties of commissioner.**

Sec. 204.

(1) Before entering into contracts or securing applications of subscribers, the persons incorporating a health care corporation shall file all of the following in the office of the commissioner:

(a) Three copies of the articles of incorporation, with the certificate of the attorney general required under section 202(3) attached.

(b) A statement showing in full detail the plan upon which the corporation proposes to transact business.

(c) A copy of all certificates to be issued to subscribers.

(d) A copy of the financial statements of the corporation.

(e) Proposed advertising to be used in the solicitation of certificates for subscribers.

(f) A copy of the bylaws.

(g) A copy of all proposed contracts and reimbursement methods.

(2) The commissioner shall examine the statements and documents filed under subsection (1), may conduct any investigation that he or she considers necessary, may request additional oral and written information from the incorporators, and may examine under oath any persons interested in or connected with the proposed health care corporation. The commissioner shall ascertain whether all of the following conditions are met:

(a) The solicitation of certificates will not work a fraud upon the persons solicited by the corporation.

(b) The rates to be charged and the benefits to be provided are adequate, equitable, and not excessive, as defined in section 609.

(c) The amount of money actually available for working capital is sufficient to carry all acquisition costs and operating expenses for a reasonable period of time from the date of issuance of the certificate of authority, and is not less than \$500,000.00 or a greater amount, if the commissioner considers it necessary.

(d) The amounts contributed as the working capital of the corporation are payable only out of amounts in excess of minimum required reserves of the corporation.

(e) Adequate and unimpaired surplus is provided, as determined under section 204a.

(3) If the commissioner finds that the conditions prescribed in subsection (2) are met, the commissioner shall do all of the following:

(a) Return to the incorporators 1 copy of the articles of incorporation, certified for filing with the director of the department of consumer and industry services or of any other agency or department authorized by law to administer the business corporation act, 1972 PA 284, MCL 450.1101 to 450.2098, or his or her designated representative, and 1 copy of the articles of incorporation certified for the records of the corporation itself.

(b) Retain 1 copy of the articles of incorporation for the commissioner's office files.

(c) Deliver to the corporation a certificate of authority to commence business and to issue certificates that have been approved by the commissioner, or that are exempted from prior approval pursuant to section 607(2) or (8), entitling subscribers to certain health care benefits.

**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

**550.1204a Unimpaired surplus.**

Sec. 204a.

(1) A health care corporation shall possess and maintain unimpaired surplus in an amount determined adequate by the commissioner to comply with section 403 of the insurance code of 1956, 1956 PA 218, MCL 500.403. The commissioner shall follow the risk-based capital requirements as developed by the national association of insurance commissioners in order to determine whether a health care corporation is in adequate compliance with section 403 of the insurance code of 1956, 1956 PA 218, MCL 500.403.

(2) If a health care corporation files a risk-based capital report that indicates that its surplus is less than the amount determined adequate by the commissioner under subsection (1), the health care corporation shall prepare and submit a plan for remedying the deficiency in accordance with risk-based capital requirements adopted by the commissioner. Among the remedies that a health care corporation may employ are planwide viability contributions

to surplus by subscribers.

(3) If contributions for planwide viability under subsection (2) are employed, those contributions shall be made in accordance with the following:

(a) If the health care corporation's surplus is less than 200% but more than 150% of the authorized control level under risk-based capital requirements, the maximum contribution rate shall be 0.5% of the rate charged to subscribers for the benefits provided.

(b) If the health care corporation's surplus is 150% or less than the authorized control level under risk-based capital requirements, the maximum contribution rate shall be 1% of the rate charged to subscribers for the benefits provided.

(c) The actual contribution rate charged is subject to the commissioner's approval.

(4) As used in subsection (3), "authorized control level" means the number determined under the risk-based capital formula in accordance with the instructions developed by the national association of insurance commissioners and adopted by the commissioner.

(5) Subject to this subsection, a health care corporation shall not maintain surplus in an amount that equals or is greater than 200% of the authorized control level under risk-based capital requirements multiplied by 5. If a health care corporation files a risk-based capital report that indicates that its surplus is more than the allowable maximum surplus permitted under this subsection for 2 successive calendar years, the health care corporation shall file a plan for approval by the commissioner to adjust its surplus to a level below the allowable maximum surplus. If the commissioner disapproves the health care corporation's plan, the commissioner shall formulate an alternate plan and forward the alternate plan to the health care corporation. The health care corporation shall begin implementation of the plan immediately upon receipt of approval of its plan by the commissioner or upon receipt of the commissioner's alternate plan.

**History:** Add. 2003, Act 59, Eff. July 23, 2003

**Popular Name:** Blue Cross-Blue Shield

**Popular Name:** Act 350

#### **550.1205 Repealed. 2003, Act 59, Eff. July 23, 2003.**

**Compiler's Notes:** The repealed section pertained to accounting and filing practices of health care corporation.

**Popular Name:** Blue Cross-Blue Shield

**Popular Name:** Act 350

#### **550.1205a Actuarial practices and accounting principles; financial report.**

Sec. 205a.

A health care corporation shall report financial information in conformity with sound actuarial practices and statutory accounting principles in the same manner as designated by the commissioner for other carriers pursuant to section 438(2) of the insurance code of 1956, 1956 PA 218, MCL 500.438. Approved permitted practices for the sole purpose of effectuating the transfer to statutory accounting principles under this section may be used by a health care corporation until January 1, 2007.

**History:** Add. 2003, Act 59, Eff. July 23, 2003

**Popular Name:** Blue Cross-Blue Shield

**Popular Name:** Act 350

#### **550.1206 Funds, property, and business of health care corporation; investments; insurance; prepaid health care benefits.**

Sec. 206.

(1) The funds and property of a health care corporation shall be acquired, held, and disposed of only for the lawful purposes of the corporation and for the benefit of the subscribers of the corporation as a whole. A health care corporation shall only transact business, receive, collect, and disburse money, and acquire, hold, protect, and convey property, that is properly within the scope of the purposes of the corporation as specifically set forth in section 202(1)(d), for the benefit of the subscribers of the corporation as a whole, and consistent with this act.

(2) The funds of a health care corporation shall be invested only in securities permitted by the laws of this state for the investments of assets of life insurance companies, as described in chapter 9 of the insurance code of 1956, 1956 PA 218, MCL 500.901 to 500.947.

(3) Without regard to the limitation in subsection (2), up to 2% of the assets of the health care corporation may be invested in venture-type investments. For purposes of calculating adequate and unimpaired surplus under section 204a, a venture-type investment shall be carried on the books of a health care corporation at the original acquisition cost, and losses may only be realized as an offset against gains from venture-type investments. All venture-type investments under this subsection shall provide employment or capital investment primarily within this state. Each investment under this subsection is subject to prior approval by the board of directors. As used in this subsection, "venture-type investments" include:

(a) Common stock, preferred stock, limited partnerships, or similar equity interests acquired from the issuer subject to a provision barring resale without consent of the issuer for 5 years from the date of acquisition by the corporation.

(b) Unsecured debt instruments that are either convertible into equity or have equity acquisition rights. These debt instruments shall be subordinated by their terms to all borrowings of the issuer from other institutional lenders and shall have no part amortized during the first 5 years.

(4) A health care corporation shall not market or transact, as defined in sections 402a and 402b of the insurance code of 1956, 1956 PA 218, MCL 500.402a and 500.402b, any type of insurance described in chapter 6 of the insurance code of 1956, 1956 PA 218, MCL 500.600 to 500.644. This subsection shall not be construed to prohibit the provision of prepaid health care benefits.

**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

**550.1207 Powers of health care corporation; interests of senior citizens; validity of corporate acts.**

Sec. 207.

(1) A health care corporation, subject to any limitation provided in this act, in any other statute of this state, or in its articles of incorporation, may do any or all of the following:

(a) Contract to provide computer services and other administrative consulting services to 1 or more providers or groups of providers, if the services are primarily designed to result in cost savings to subscribers.

(b) Engage in experimental health care projects to explore more efficient and economical means of implementing the corporation's programs, or the corporation's goals as prescribed in section 504 and the purposes of this act, to develop incentives to promote alternative methods and alternative providers, including nurse midwives, nurse anesthetists, and nurse practitioners, for delivering health care, including preventive care and home health care.

(c) For the purpose of providing health care services to employees of this state, the United States, or an agency, instrumentality, or political subdivision of this state or the United States, or for the purpose of providing all or part of the costs of health care services to disabled, aged, or needy persons, contract with this state, the United States, or an agency, instrumentality, or political subdivision of this state or the United States.

(d) For the purpose of administering any publicly supported health benefit plan, accept and administer funds, directly or indirectly, made available by a contract authorized under subdivision (c), or made available by or received from any private entity.

(e) For the purpose of administering any publicly supported health benefit plan, subcontract with any organization that has contracted with this state, the United States, or an agency, instrumentality, or political subdivision of this state or the United States, for the administration or furnishing of health services or any publicly supported health benefit plan.

(f) Provide administrative services only and cost-plus arrangements for the federal medicare program established by parts A and B of title XVIII of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1395c to 1395i, 1395i-2 to 1395i-5, 1395j to 1395t, 1395u to 1395w, and 1395w-2 to 1395w-4; for the federal medicaid program

established under title XIX of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1396 to 1396r-6, and 1396r-8 to 1396v; for title V of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 701 to 704 and 705 to 710; for the program of medical and dental care established by the military medical benefits amendments of 1966, Public Law 85-861, 80 Stat. 862; for the Detroit maternity and infant care--preschool, school, and adolescent project; and for any other health benefit program established under state or federal law.

(g) Provide administrative services only and cost-plus arrangements for any noninsured health benefit plan, subject to the requirements of sections 211 and 211a.

(h) Establish, own, and operate a health maintenance organization, subject to the requirements of the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302.

(i) Guarantee loans for the education of persons who are planning to enter or have entered a profession that is licensed, certified, or registered under parts 161 to 182 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18237, and has been identified by the commissioner, with the consultation of the office of health and medical affairs in the department of management and budget, as a profession whose practitioners are in insufficient supply in this state or specified areas of this state and who agree, as a condition of receiving a guarantee of a loan, to work in this state, or an area of this state specified in a listing of shortage areas for the profession issued by the commissioner, for a period of time determined by the commissioner.

(j) Receive donations to assist or enable the corporation to carry out its purposes, as provided in this act.

(k) Bring an action against an officer or director of the corporation.

(l) Designate and maintain a registered office and a resident agent in that office upon whom service of process may be made.

(m) Sue and be sued in all courts and participate in actions and proceedings, judicial, administrative, arbitral, or otherwise, in the same cases as natural persons.

(n) Have a corporate seal, alter the seal, and use it by causing the seal or a facsimile to be affixed, impressed, or reproduced in any other manner.

(o) Subject to chapter 9 of the insurance code of 1956, 1956 PA 218, MCL 500.901 to 500.947, invest and reinvest its funds and, for investment purposes only, purchase, take, receive, subscribe for, or otherwise acquire, own, hold, vote, employ, sell, lend, lease, exchange, transfer, or otherwise dispose of, mortgage, pledge, use, and otherwise deal in and with, bonds and other obligations, shares, or other securities or interests issued by entities other than domestic, foreign, or alien insurers, as defined in sections 106 and 110 of the insurance code of 1956, 1956 PA 218, MCL 500.106 and 500.110, whether engaged in a similar or different business, or governmental or other activity, including banking corporations or trust companies. However, a health care corporation may purchase, take, receive, subscribe for, or otherwise acquire, own, hold, vote, employ, sell, lend, lease, exchange, transfer, or otherwise dispose of bonds or other obligations, shares, or other securities or interests issued by a domestic, foreign, or alien insurer, so long as the activity meets all of the following:

(i) Is determined by the attorney general to be lawful under section 202.

(ii) Is approved in writing by the commissioner as being in the best interests of the health care corporation and its subscribers.

(iii) For an activity that occurred before the effective date of the amendatory act that added subparagraph (iv), will not result in the health care corporation owning or controlling 10% or more of the voting securities of the insurer or will not otherwise result in the health care corporation having control of the insurer, either before or after the effective date of the amendatory act that added subparagraph (iv). As used in this subparagraph and subparagraph (iv), "control" means that term as defined in section 115 of the insurance code of 1956, 1956 PA 218, MCL 500.115.

(iv) Subject to section 218 and beginning on the effective date of the amendatory act that added this subparagraph, will not result in the health care corporation owning or controlling part or all of the insurer unless the transaction satisfies chapter 13 of the insurance code of 1956, 1956 PA 218, MCL 500.1301 to 500.1379, and the insurer being acquired is only authorized to sell disability insurance as defined under section 606 of the insurance code of 1956, 1956 PA 218, MCL 500.606, or under a statute or regulation in the insurer's domiciliary jurisdiction that is substantially similar to section 606 of the insurance code of 1956, 1956 PA 218, MCL 500.606.

(p) Purchase, receive, take by grant, gift, devise, bequest or otherwise, lease, or otherwise acquire, own, hold, improve, employ, use and otherwise deal in and with, real or personal property, or an interest therein, wherever situated.

(q) Sell, convey, lease, exchange, transfer or otherwise dispose of, or mortgage or pledge, or create a security interest in, any of its property, or an interest therein, wherever situated.

(r) Borrow money and issue its promissory note or bond for the repayment of the borrowed money with interest.

(s) Make donations for the public welfare, including hospital, charitable, or educational contributions that do not significantly affect rates charged to subscribers.

(t) Participate with others in any joint venture with respect to any transaction that the health care corporation would have the power to conduct by itself.

(u) Cease its activities and dissolve, subject to the commissioner's authority under section 606(2).

(v) Make contracts, transact business, carry on its operations, have offices, and exercise the powers granted by



this act in any jurisdiction, to the extent necessary to carry out its purposes under this act.

(w) Have and exercise all powers necessary or convenient to effect any purpose for which the corporation was formed.

(x) Notwithstanding subdivision (o) or any other provision of this act, establish, own, and operate a domestic stock insurance company only for the purpose of acquiring, owning, and operating the state accident fund pursuant to chapter 51 of the insurance code of 1956, 1956 PA 218, MCL 500.5100 to 500.5114, so long as all of the following are met:

(i) For insurance products and services the insurer whether directly or indirectly only transacts worker's compensation insurance and employer's liability insurance, transacts disability insurance limited to replacement of loss of earnings, and acts as an administrative services organization for an approved self-insured worker's compensation plan or a disability insurance plan limited to replacement of loss of earnings and does not transact any other type of insurance notwithstanding the authorization in chapter 51 of the insurance code of 1956, 1956 PA 218, MCL 500.5100 to 500.5114. This subparagraph does not preclude the insurer from providing either directly or indirectly noninsurance products and services as otherwise provided by law.

(ii) The activity is determined by the attorney general to be lawful under section 202.

(iii) The health care corporation does not directly or indirectly subsidize the use of any provider or subscriber information, loss data, contract, agreement, reimbursement mechanism or arrangement, computer system, or health care provider discount to the insurer.

(iv) Members of the board of directors, employees, and officers of the health care corporation are not, directly or indirectly, employed by the insurer unless the health care corporation is fairly and reasonably compensated for the services rendered to the insurer if those services were paid for by the health care corporation.

(v) Health care corporation and subscriber funds are used only for the acquisition from the state of Michigan of the assets and liabilities of the state accident fund.

(vi) Health care corporation and subscriber funds are not used to operate or subsidize in any way the insurer including the use of such funds to subsidize contracts for goods and services. This subparagraph does not prohibit joint undertakings between the health care corporation and the insurer to take advantage of economies of scale or arm's-length loans or other financial transactions between the health care corporation and the insurer.

(2) In order to ascertain the interests of senior citizens regarding the provision of medicare supplemental coverage, as described in section 202(1)(d)(v), and to ascertain the interests of senior citizens regarding the administration of the federal medicare program when acting as fiscal intermediary in this state, as described in section 202(1)(d)(vi), a health care corporation shall consult with the office of services to the aging and with senior citizens' organizations in this state.

(3) An act of a health care corporation, otherwise lawful, is not invalid because the corporation was without capacity or power to do the act. However, the lack of capacity or power may be asserted:

(a) In an action by a director or a member of the corporate body against the corporation to enjoin the doing of an act.

(b) In an action by or in the right of the corporation to procure a judgment in its favor against an incumbent or former officer or director of the corporation for loss or damage due to an unauthorized act of that officer or director.

(c) In an action or special proceeding by the attorney general to enjoin the corporation from the transacting of unauthorized business, to set aside an unauthorized transaction, or to obtain other equitable relief.

(4) A health care corporation shall not condition the sale or vary the terms or conditions of any product sold by the corporation or by a subsidiary of the corporation by requiring the purchase of any other product from the corporation or from a subsidiary of the corporation.

**History:** 1980, Act 350, Eff. Apr. 3, 1981 ;-- Am. 1989, Act 260, Imd. Eff. Dec. 26, 1989 ;-- Am. 1993, Act 127, Imd. Eff. July 21, 1993 ;-- Am. 1993, Act 201, Imd. Eff. Oct. 19, 1993 ;-- Am. 1999, Act 210, Imd. Eff. Dec. 21, 1999 ;-- Am. 2003, Act 59, Eff. July 23, 2003

**Popular Name:** Blue Cross-Blue Shield

**Popular Name:** Act 350

## **550.1208 Action by member; complaint.**

Sec. 208.

(1) An action may be brought in the right of a health care corporation to procure a judgment in its favor, by a member of the corporate body.

(2) In such an action, the complaint shall allege:

(a) That the plaintiff is a member of the corporate body at the time of bringing the action, and that he or she was

a member of the corporate body at the time of the transaction of which he or she complains.

(b) With particularity, the effort of the plaintiff to secure the initiation of the action by the board or the reasons for not making the effort.

**History:** 1980, Act 350, Eff. Apr. 3, 1981

**Popular Name:** Blue Cross-Blue Shield

**Popular Name:** Act 350

**550.1209 Action by member; discontinuance, compromise, or settlement; notice; expense.**

Sec. 209.

An action authorized by section 208 shall not be discontinued, compromised, or settled without approval by the court having jurisdiction of the action. If the court determines that the interest of the members of the corporate body or of any component thereof will be substantially affected by the discontinuance, compromise, or settlement, the court may direct that notice, by publication or otherwise, be given to the members of the corporate body or any component thereof, whose interests it determines will be so affected. If notice is so directed to be given, the court may determine which 1 or more of the parties to the action shall bear the expense of giving the notice, in an amount which the court determines and finds reasonable under the circumstances. The amount of this expense shall be awarded as special costs of the action and shall be recoverable in the same manner as statutory taxable costs.

**History:** 1980, Act 350, Eff. Apr. 3, 1981

**Popular Name:** Blue Cross-Blue Shield

**Popular Name:** Act 350

**550.1210 Action by member; reasonable expenses; attorney's fees.**

Sec. 210.

(1) If an action brought in the right of the corporation is successful, in whole or in part, or if anything is received by the plaintiff or a claimant as a result of a judgment, compromise, or settlement of an action or claim, the court may award the plaintiff or claimant reasonable expenses, including reasonable attorney's fees, and shall direct him or her to account to the corporation for the remainder of the proceeds so received by him or her. This section does not apply to a judgment rendered for the benefit of an injured corporate body member only and limited to a recovery of the loss or damage sustained by him or her.

(2) In an action brought in the right of the corporation by a member of the corporate body, the court having jurisdiction, upon final judgment and finding that the action was brought without reasonable cause, may require the plaintiff to pay to the parties named as defendants the reasonable expenses, including fees of attorneys, incurred by them in the defense of the action.

**History:** 1980, Act 350, Eff. Apr. 3, 1981

**Popular Name:** Blue Cross-Blue Shield

**Popular Name:** Act 350

**550.1211 Administrative services only and cost-plus arrangements; service contracts; fees; administrative costs; marketing policy; notice; coverage, rights, and obligations under collective bargaining agreement; liability of individual; report; noninsured benefit plan defined.**

Sec. 211.

(1) Pursuant to section 207(1)(g), a health care corporation may enter into service contracts containing an



administrative services only or cost-plus arrangement. Except as otherwise provided in this section, a corporation shall not enter into a service contract containing an administrative services only or cost-plus arrangement for a noninsured benefit plan covering a group of less than 500 individuals, except that a health care corporation may continue an administrative services only or cost-plus arrangement with a group of less than 500, which arrangement is in existence in September of 1980. A corporation may enter into contracts containing an administrative services only or cost-plus arrangement for a noninsured benefit plan covering a group of less than 500 individuals if either the corporation makes arrangements for excess loss coverage or the sponsor of the plan that covers the individuals is liable for the plan's liabilities and is a sponsor of 1 or more plans covering a group of 500 or more individuals in the aggregate. The commissioner, upon obtaining the advice of the corporations subject to this act, shall establish the standards for the manner and amount of the excess loss coverage required by this subsection. It is the intent of the legislature that the excess loss coverage requirements be uniform as between corporations subject to this act and other persons authorized to provide similar services. The corporation shall offer in connection with a noninsured benefit plan a program of specific or aggregate excess loss coverage.

(2) Relative to actual administrative costs, fees for administrative services only and cost-plus arrangements shall be set in a manner that precludes cost transfers between subscribers subject to either of these arrangements and other subscribers of the health care corporation. Administrative costs for these arrangements shall be determined in accordance with the administrative costs allocation methodology and definitions filed and approved under part 6, and shall be expressed clearly and accurately in the contracts establishing the arrangements, as a percentage of costs rather than charges. This subsection shall not be construed to prohibit the inclusion, in fees charged, of contributions to adequate and unimpaired surplus as provided in section 204a.

(3) Before a health care corporation may enter into contracts containing administrative services only or cost-plus arrangements pursuant to section 207(1)(g), the board of directors of the corporation shall approve a marketing policy for these arrangements that is consistent with this section. The marketing policy may contain other provisions as the board considers necessary. The marketing policy shall be carried out by the corporation consistent with this act.

(4) A corporation providing services under a contract containing an administrative services only or cost-plus arrangement in connection with a noninsured benefit plan shall provide in its service contract a provision that the person contracting for the services in connection with a noninsured benefit plan shall notify each covered individual of what services are being provided; the fact that individuals are not insured or are not covered by a certificate from the corporation, or are only partially insured or are only partially covered by a certificate from the corporation, as the case may be; which party is liable for payment of benefits; and of future changes in benefits.

(5) A service contract containing an administrative services only arrangement between a corporation and a governmental entity not subject to the employee retirement income security act of 1974, Public Law 93-406, 88 Stat. 829, whose plan provides coverage under a collective bargaining agreement utilizing a policy or certificate issued by a carrier before the signing of the service contract, is void unless the governmental entity has provided the notice described in subsection (4) to the collective bargaining agent and to the members of the collective bargaining unit not less than 30 days before signing the service contract. The voiding of a service contract under this subsection shall not relieve the governmental entity of any obligations to the corporation under the service contract.

(6) Nothing in this section shall be construed to permit an actionable interference by a corporation with the rights and obligations of the parties under a collective bargaining agreement.

(7) An individual covered under a noninsured benefit plan for which services are provided under a service contract authorized under subsection (1) is not liable for that portion of claims incurred and subject to payment under the plan if the service contract is entered into between an employer and a corporation, unless that portion of the claim has been paid directly to the covered individual.

(8) A corporation shall report with its annual statement the amount of business it has conducted as services provided under subsection (1) that are performed in connection with a noninsured benefit plan, and the commissioner shall transmit annually this information to the state treasurer. The commissioner shall submit to the legislature on April 1, 1994, a report detailing the impact of this section on employers and covered individuals, and similar activities under other provisions of law, and in consultation with the state treasurer the total financial impact on the state for the preceding legislative biennium.

(9) As used in this section, "noninsured benefit plan" or "plan" means a health benefit plan without coverage by a health care corporation, health maintenance organization, or insurer or the portion of a health benefit plan without coverage by a health care corporation, health maintenance organization, or insurer that has a specific or aggregate excess loss coverage.

**History:** 1980, Act 350, Eff. Apr. 3, 1981 ;-- Am. 1984, Act 181, Imd. Eff. July 3, 1984 ;-- Am. 1993, Act 127, Imd. Eff. July 21, 1993 ;-- Am. 2003, Act 59, Eff. July 23, 2003

**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

**550.1211a Definitions; prohibited acts by corporation; processing claims for benefits on timely basis; claim form; notice to covered individuals; notice to corporation of complaint and proceedings contemplated; hearing; findings; order; violation of order; penalty; action and award of actual monetary damages; review; stay of enforcement.**

Sec. 211a.

(1) As used in this section:

(a) "Noninsured benefit plan" means a health benefit plan without coverage by a health care corporation, health maintenance organization, or insurer or the portion of a health benefit plan without coverage by a health care corporation, health maintenance organization, or insurer that has a specific or aggregate excess loss coverage.

(b) "Process a claim" means the services performed in connection with a claim for benefits including the disbursement of benefit amounts.

(2) A health care corporation providing services under section 211 shall not do any of the following:

(a) Misrepresent pertinent facts relating to coverage.

(b) Fail to acknowledge promptly or to act reasonably and promptly upon communications with respect to a claim for benefits.

(c) Fail to adopt and implement reasonable standards for the prompt investigation of a claim for benefits.

(d) Refuse to process claims without conducting a reasonable investigation based upon the available information.

(e) Fail to communicate affirmation or denial of coverage of a claim for benefits within a reasonable time after a claim has been received.

(f) Fail to attempt in good faith to promptly, fairly, and equitably process a claim for benefits.

(g) Knowingly compel covered individuals to institute litigation to recover amounts due under a benefit plan or certificate by offering substantially less than the amounts due.

(h) For the purpose of coercing a covered individual to accept a settlement or compromise in a claim, inform the covered individual of a corporation policy of appealing administrative hearing decisions that are in favor of covered individuals.

(i) Delay the investigation or processing of a claim by requiring a covered individual, or the provider of services to the covered individual, to submit a preliminary claim and then requiring subsequent submission of a formal claim, seeking solely the duplication of a verification.

(j) Fail to promptly provide a reasonable explanation of the basis for denial or partial denial of a claim for benefits.

(k) Fail to promptly process a claim where liability has become reasonably clear under 1 portion of a benefit plan or certificate in order to influence a settlement under another portion of the benefit plan or certificate.

(l) Refuse to enter into a service contract, or refuse to provide services under a service contract because of race, color, creed, marital status, sex, national origin, residence, age, disability, or lawful occupation.

(3) A corporation providing services under section 211 in connection with a noninsured benefit plan shall not, in order to induce a person to contract or to continue to contract with the corporation for the provision of services under a service contract or certificate offered by the corporation; to induce a person to lapse, forfeit, or surrender a certificate or service contract issued by the corporation; or to induce a person to secure or terminate coverage with an insurer, health care corporation, health maintenance organization, or other person, directly or indirectly, do any of the following:

(a) Issue or deliver to the person money or any other valuable consideration.

(b) Offer to make or make an agreement relating to a service contract or certificate other than as plainly expressed in the service contract or certificate.

(c) Offer to give or pay, or give or pay, directly or indirectly, a rebate or adjustment of the rate payable on the service contract or certificate, or an advantage in the services thereunder, except as reflected in the rate and expressly provided in the service contract or certificate. Readjustment of the rate for services provided under the service contract or certificate may be made at the end of a contract or certificate year or contract or certificate period and may be made retroactive.

(d) Make, issue, or circulate, or cause to be made, issued, or circulated, an estimate, illustration, circular, or statement misrepresenting the terms of a service contract or certificate, the advantages provided thereunder, or the true nature thereof.

(e) Make a misrepresentation or incomplete comparison, whether oral or written, between service contracts or certificates of the corporation or between service contracts or certificates of the corporation and an insurer, hospital service corporation, health maintenance organization, or other person.

(4) A corporation providing services under section 211 in connection with a noninsured benefit plan shall process claims for benefits on a timely basis. If not paid on a timely basis, benefits payable to a covered individual shall bear simple interest from a date 60 days after a satisfactory claim form was received by the corporation, at a rate of 12% interest per annum. The interest shall be paid by the noninsured benefit plan in addition to, and at the time of payment of, the claim.

(5) A corporation providing services under section 211 in connection with a noninsured benefit plan shall specify in writing the materials that constitute a satisfactory claim form not later than 30 days after receipt of a claim, unless the claim is settled within 30 days. If a claim form is not supplied as to the entire claim, the amount supported by the claim form shall be considered to be paid on a timely basis if paid within 60 days after receipt of the claim form by the corporation.

(6) A corporation providing services under section 211 in connection with a noninsured benefit plan shall provide in its service contract a provision that the person contracting for the services in connection with a noninsured benefit plan shall notify each covered individual as to what services are being provided; the fact that individuals are not insured or are not covered by a certificate from the corporation, or are only partially insured or are only partially covered by a certificate from the corporation, as the case may be; which party is liable for payment of benefits; and of future changes in benefits.

(7) If the commissioner has probable cause to believe that a corporation is violating, or has violated subsection (2), indicating a persistent tendency to engage in conduct prohibited by that subsection, or has probable cause to believe that a corporation is violating, or has violated any other subsection of this section, he or she shall give written notice to the corporation, pursuant to the administrative procedures act, setting forth the general nature of the complaint against the corporation and the proceedings contemplated under this section. Before the issuance of a notice of hearing, the staff of the insurance bureau responsible for the matters that would be at issue in the hearing shall give the corporation an opportunity to confer and discuss the possible complaint and proceedings in person with the commissioner or a representative of the commissioner, and the matter may be disposed of summarily upon agreement of the parties. This subsection shall not be construed to diminish the right of a person to bring an action for damages under this section.

(8) A hearing held pursuant to subsection (7) shall be held pursuant to the administrative procedures act. If, after the hearing, the commissioner determines that the corporation is violating, or has violated subsection (2), indicating a persistent tendency to engage in conduct prohibited by that subsection, or has violated or is violating any other subsection of this section, the commissioner shall reduce his or her findings and decision to writing, and shall issue and cause to be served upon the corporation a copy of the findings and an order requiring the corporation to cease and desist from engaging in the prohibited activity. In addition to a cease and desist order, the commissioner may order any of the following:

(a) Payment of a monetary penalty of not more than \$500.00 for each violation but not to exceed an aggregate penalty of \$5,000.00, unless the corporation knew or reasonably should have known it was in violation of this section, in which case the penalty shall not be more than \$2,500.00 for each violation and shall not exceed an aggregate penalty of \$25,000.00 for all violations committed in a 6-month period.

(b) Suspension or revocation of the corporation's license or certificate of authority if the corporation knowingly and persistently violated this section.

(c) Refund of any overcharges.

(9) A corporation that violates a cease and desist order of the commissioner issued under subsection (8), after notice and an opportunity for a hearing, and upon order of the commissioner, may be subject to a civil fine of not more than \$10,000.00 for each violation.

(10) In addition to other remedies provided by law, an aggrieved covered individual may bring an action for actual monetary damages sustained as a result of a violation of this section. If successful on the merits, the covered individual shall be awarded actual monetary damages or \$200.00, whichever is greater. If the corporation shows by a preponderance of the evidence that a violation of this section resulted from a bona fide error notwithstanding the maintenance of procedures reasonably adapted to avoid the error, the amount of recovery shall be limited to actual monetary damages.

(11) The filing of a petition for review does not stay enforcement of action pursuant to this section, but the commissioner may grant, or the appropriate court may order, a stay upon appropriate terms.

(12) The commissioner may at any time, by order, after notice and opportunity for hearing, reopen and alter, modify, or set aside, in whole or in part, an order issued by him or her under this section, when in his or her opinion conditions of fact or of law have so changed as to require that action or if the public interest shall so require.

**History:** Add. 1993, Act 127, Imd. Eff. July 21, 1993 ;-- Am. 1998, Act 24, Imd. Eff. Mar. 12, 1998

**Popular Name:** Blue Cross-Blue Shield

**Popular Name:** Act 350

#### **550.1212 Action without notice or lapse of time periods; waiver; attorney-in-fact.**

Sec. 212.

When, under this act or the articles of incorporation or bylaws of a health care corporation or by the terms of an agreement or instrument, a health care corporation or the board of directors of the health care corporation or any committee of the board may take action after notice to any person or after lapse of a prescribed period of time, the action may be taken without notice and without lapse of the period of time, if at any time before or after the action is completed the person entitled to notice or to participate in the action to be taken or, in case of a subscriber, by his or her attorney-in-fact, submits a signed waiver of those requirements. The attorney-in-fact may not be employed by, or receive substantial income from, the health care corporation.

**History:** 1980, Act 350, Eff. Apr. 3, 1981

**Popular Name:** Blue Cross-Blue Shield

**Popular Name:** Act 350

#### **550.1213 Indemnification.**

Sec. 213.

(1) A health care corporation may indemnify any person who was or is a party to, or is threatened to be made a party to, any threatened, pending, or completed action, suit, or proceeding, whether civil, criminal, administrative, or investigative, other than an action by or in the right of the health care corporation, by reason of the fact that he or she is or was a director, member of the corporate body, officer, employee, or agent of the health care corporation, or is or was serving at the request of the health care corporation as a director, officer, employee, or agent of another corporation, partnership, joint venture, trust, or other enterprise. This indemnification shall be against expenses, including attorneys' fees, judgments, fines, and amounts paid in settlement, actually and reasonably incurred by him or her in connection with the action, suit, or proceeding, if he or she acted in good faith and in a manner which he or she reasonably believed to be in, or not opposed to, the best interests of the health care corporation, or its subscribers as a whole, and, with respect to any criminal action or proceeding, had no reasonable cause to believe his or her conduct was unlawful. The termination of any action, suit, or proceeding by judgment, order, settlement, conviction, or upon a plea of nolo contendere or its equivalent, shall not, of itself, create a presumption that the person did not act in good faith and in a manner which he or she reasonably believed to be in or not opposed to the best interests of the health care corporation, or its subscribers as a whole, and, with respect to any criminal action or proceeding, had reasonable cause to believe that his or her conduct was unlawful.

(2) A health care corporation may indemnify any person who was or is a party to, or is threatened to be made a party to, any threatened, pending, or completed action or suit by or in the right of the health care corporation to procure a judgment in its favor, by reason of the fact that he or she is or was a director, member of the corporate body, officer, employee, or agent of the health care corporation, or is or was serving at the request of the health care corporation as a director, officer, employee, or agent of another corporation, partnership, joint venture, trust, or other enterprise. This indemnification shall be against expenses, including attorneys' fees, actually and reasonably incurred by him or her in connection with the defense or settlement of the action or suit, if he or she acted in good faith and in a manner he or she reasonably believed to be in or not opposed to the best interests of the health care corporation, or its subscribers as a whole. However, indemnification shall not be made with respect to any claim, issue, or matter as to which the person has been adjudged to be liable for negligence or misconduct in the performance of his or her duty to the health care corporation unless, and only to the extent that, the court in which the action or suit was brought determines upon application that, despite the adjudication of liability, but in view of all circumstances of the case, the person is fairly and reasonably entitled to indemnity for those expenses which the court considers proper.

(3) To the extent that a director, member of the corporate body, officer, employee, or agent of a health care corporation has been successful on the merits or otherwise in defense of any action, suit, or proceeding referred to in subsection (1) or (2), or in defense of any claim, issue, or matter therein, he or she shall be indemnified against expenses, including attorneys' fees, actually and reasonably incurred by him or her in connection therewith.

(4) Any indemnification under subsection (1) or (2), unless ordered by a court, shall be made by the health care

corporation only as authorized in the specific case, upon a determination that indemnification of the director, member of the corporate body, officer, employee, or agent is proper in the circumstances because he or she has met the applicable standard of conduct set forth in subsections (1) and (2). The determination shall be made in any of the following ways:

(a) By the board by a majority vote of a quorum consisting of directors who were not parties to the action, suit, or proceeding.

(b) If such a quorum is not obtainable, by independent legal counsel in a written opinion.

(5) Expenses incurred in defending a civil or criminal action, suit, or proceeding described in subsection (1) or (2) may be paid by the health care corporation in advance of the final disposition of the action, suit, or proceeding, as authorized in the manner provided in subsection (4), upon receipt of an undertaking by or on behalf of the director, member of the corporate body, officer, employee, or agent to repay that amount, unless it is ultimately determined that he or she is entitled to be indemnified by the corporation.

(6) A provision made to indemnify directors, members of the corporate body, or officers in any action, suit, or proceeding referred to in subsection (1) or (2), whether contained in the articles of incorporation, the bylaws, a resolution of the directors, an agreement, or otherwise, shall be invalid only insofar as it is in conflict with subsections (1) to (5) and this subsection. Nothing contained in subsections (1) to (5) and this subsection shall affect any rights to indemnification to which persons other than directors and officers may be entitled by contract or otherwise by law. The indemnification provided in subsections (1) to (5) and this subsection continues as to a person who has ceased to be a director, member of the corporate body, officer, employee, or agent, and shall inure to the benefit of the heirs, executors, and administrators of that person.

(7) A health care corporation may purchase and maintain insurance on behalf of any person who is or was a director, officer, employee, or agent of the corporation, or is or was serving at the request of the health care corporation as a director, officer, employee, or agent of another corporation, partnership, joint venture, trust, or other enterprise against any liability asserted against him or her and incurred by him or her in that capacity, or arising out of his or her status as described in this subsection, whether or not the health care corporation would have power to indemnify him or her against this liability under subsections (1) to (6).

(8) For the purposes of subsections (1) to (7), references to a health care corporation include all constituent corporations absorbed in a consolidation or merger and the resulting or surviving corporation, so that a person who is or was a director, officer, employee, or agent of a constituent corporation or is or was serving at the request of such a constituent corporation as a director, officer, employee, or agent of another corporation, partnership, joint venture, trust, or other enterprise shall stand in the same position under the provisions of this section with respect to the resulting or surviving corporation as he or she would if he or she had served the resulting or surviving corporation in the same capacity.

**History:** 1980, Act 350, Eff. Apr. 3, 1981

**Popular Name:** Blue Cross-Blue Shield

**Popular Name:** Act 350

#### **550.1214 Rate of interest.**

Sec. 214.

A health care corporation may by agreement in writing, and not otherwise, agree to pay a rate of interest in excess of the legal rate, and in that case, the defense of usury is prohibited.

**History:** 1980, Act 350, Eff. Apr. 3, 1981

**Popular Name:** Blue Cross-Blue Shield

**Popular Name:** Act 350

#### **550.1215 Health care corporation as shareholder in other nonprofit corporation; rights, powers, privileges, and liabilities.**

Sec. 215.

When a health care corporation, consistent with the purposes of the corporation prescribed in this act, is a shareholder in any other nonprofit corporation, its president and other officers or any of its directors may hold the office of director of the other nonprofit corporation the same as if they were individual shareholders in the other nonprofit corporation. The health care corporation, being a shareholder in the other nonprofit corporation, shall possess and exercise all the rights, powers, privileges, and liabilities of individual shareholders.

**History:** 1980, Act 350, Eff. Apr. 3, 1981

**Popular Name:** Blue Cross-Blue Shield

**Popular Name:** Act 350

#### **550.1216, 550.1217 Repealed. 2002, Act 559, Imd. Eff. Sept. 27, 2002.**

**Compiler's Notes:** The repealed sections pertained to merger, consolidation, or dissolution of corporation.

**Popular Name:** Blue Cross-Blue Shield

**Popular Name:** Act 350

#### **550.1218 Health care corporation; prohibited actions.**

Sec. 218.

A health care corporation shall not do any of the following:

(a) Take any action to change its nonprofit status.

(b) Except as otherwise provided in section 220, dissolve, merge, consolidate, mutualize, or take any other action that results in a change in direct or indirect control of the health care corporation or sell, transfer, lease, exchange, option, or convey assets that results in a change in direct or indirect control of the health care corporation.

**History:** Add. 2002, Act 559, Imd. Eff. Sept. 27, 2002 ;-- Am. 2013, Act 4, Imd. Eff. Mar. 18, 2013

**Popular Name:** Blue Cross-Blue Shield

**Popular Name:** Act 350

#### **550.1219 Provisions superseded.**

Sec. 219.

A nonprofit health care corporation is subject to chapter 37 of the insurance code of 1956, 1956 PA 218, MCL 500.3701 to 500.3723. To the extent that a provision of this act concerning health coverage, including, but not limited to, premiums, rates, filings, and coverages, conflicts with chapter 37 of the insurance code of 1956, 1956 PA 218, MCL 500.3701 to 500.3723, chapter 37 of the insurance code of 1956, 1956 PA 218, MCL 500.3701 to 500.3723, supersedes this act.

**History:** Add. 2003, Act 59, Eff. July 23, 2003

**Popular Name:** Blue Cross-Blue Shield

**Popular Name:** Act 350

#### **550.1220 Merger of health care corporation with nonprofit mutual disability insurer.**



Sec. 220.

(1) Notwithstanding any provision of this act to the contrary, a health care corporation may establish, own, operate, and merge with a nonprofit mutual disability insurer formed under chapter 58 of the insurance code of 1956, 1956 PA 218, MCL 500.5800 to 500.5840. The surviving entity of a merger described in this subsection is the nonprofit mutual disability insurer. A merger described in this subsection is exempt from the application of sections 1311 to 1319 of the insurance code of 1956, 1956 PA 218, MCL 500.1311 to 500.1319.

(2) The merger of a health care corporation with a nonprofit mutual disability insurer is effective upon completion of both of the following:

(a) The adoption of a plan of merger by the majority of the boards of directors of both the health care corporation and the nonprofit mutual disability insurer. The health care corporation shall include in the plan of merger that beginning in April of the first full calendar year after the adoption of the plan of merger the surviving entity of a merger described in subsection (1) shall use its best efforts to make annual social mission contributions in an aggregate amount of up to \$1,560,000,000.00 over a period of up to 18 years beginning in April of the first full calendar year after the adoption of the plan of merger to a nonprofit corporation created under part 6A. If adopted, the boards of directors shall submit the plan of merger to the commissioner for his or her consideration as provided in subdivision (b). A nonprofit mutual disability insurer is considered to be making its best effort under this subdivision if it makes the annual social mission contribution to a nonprofit corporation created in part 6A when the nonprofit mutual disability insurer's surplus is at least 375% of the authorized control level under risk-based capital requirements.

(b) The approval of the plan of merger by the commissioner. The commissioner shall make a determination to approve or disapprove a plan of merger within 90 days of receipt of the plan, and the commissioner shall not unreasonably withhold approval of a plan of merger submitted under subdivision (a).

(3) Notwithstanding any other provision of this act to the contrary, the directors of a health care corporation may serve as incorporators of the corporate body of, directors of, or officers of the nonprofit mutual disability insurer formed through a merger described in subsection (1).

(4) A merger described in subsection (1) is the dissolution of the health care corporation, and the surviving nonprofit mutual disability insurer assumes the performance of all contracts and policies of the merged health care corporation that exist on the date of the merger, including the participating hospital agreement, and its definition of certificate which excludes as covered services benefits provided pursuant to automobile no-fault or worker's compensation coverage, and all related contract obligations that result from orders relating to hospital provider class plans that are issued by the commissioner after July 1, 2012. However, the officers of a health care corporation may perform any act or acts necessary to close the affairs of the merged health care corporation after the date of the merger.

(5) Notwithstanding anything in this act to the contrary, if the merger of a health care corporation and a nonprofit mutual disability insurer becomes effective as described in subsection (2), the property of the health care corporation is subject to the collection of general ad valorem taxes and applicable specific taxes under the general property tax act, 1893 PA 206, MCL 211.1 to 211.155, beginning December 31, 2013. As provided in section 201, the property of a health care corporation is exempt from taxation before December 31, 2013. This act does not confer an exemption from taxation on a nonprofit mutual disability insurer that merges with a health care corporation.

**History:** Add. 2013, Act 4, Imd. Eff. Mar. 18, 2013

**Popular Name:** Blue Cross-Blue Shield

**Popular Name:** Act 350