THE INSURANCE CODE OF 1956 (EXCERPT)
Act 218 of 1956

500.3472 Open enrollment period; prohibitions; establishment of reasonable periods for health insurance policies; minimum standards for frequency and duration of open enrollment periods; denial of coverage.

Sec. 3472.

(1) During an applicable open enrollment period, an insurer that offers, delivers, issues for delivery, or renews in this state a health insurance policy shall not deny or condition the issuance or effectiveness of the policy and shall not discriminate in the pricing of the policy on the basis of health status, claims experience, receipt of health care, or medical condition.

(2) Subject to prior approval of the director, an insurer shall establish reasonable open enrollment periods for all health insurance policies offered, delivered, issued for delivery, or renewed in this state.

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

(4) Subject to approval by the director, an insurer may deny health insurance coverage in the group or individual market if the insurer does not have the network capacity or financial reserves necessary to offer additional coverage. An insurer described in this subsection shall act uniformly with regard to all employers or individuals in the group or individual market. An insurer described in this subsection shall act without regard to the claims experience of an individual or employer and its employees and the employee's dependents and without regard to any health-status-related factor relating to the individual or employer and its employees and the employee's dependents.

(5) Subject to approval by the director, an insurer that denies health insurance coverage to an employer or individual under subsection (4) shall not offer coverage in the group or individual market, as applicable, before the later of the one hundred eighty-first day after the date the insurer denies the coverage or the date the insurer demonstrates to the director that the insurer has sufficient network capacity or financial reserves, as applicable, to underwrite additional coverage.

(6) Subject to approval by the director, subsection (4) does not limit the insurer's ability to renew coverage already in force or relieve the insurer of the responsibility to renew the coverage.

(7) The director may provide for the application of subsection (4) on a service-area-specific basis for health maintenance organizations.

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