HOUSE BILL No. 4534

March 23, 1993, Introduced by Reps. Brown and Martin and referred to the Committee on Insurance.

A bill to amend sections 104, 205, 207, 211, and 502 of Act No. 350 of the Public Acts of 1980, entitled as amended "The nonprofit health care corporation reform act," section 205 as amended by Act No. 74 of the Public Acts of 1991, section 207 as amended by Act No. 260 of the Public Acts of 1989, section 211 as amended by Act No. 181 of the Public Acts of 1984, and section 502 as amended by Act No. 38 of the Public Acts of 1988, being sections 550.1104, 550.1205, 550.1207, 550.1211, and 550.1502 of the Michigan Compiled Laws; and to add section 211a.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Section 1. Sections 104, 205, 207, 211, and 502 of Act No. 350 of the Public Acts of 1980, section 205 as amended by Act No. 74 of the Public Acts of 1991, section 207 as amended by Act No. 260 of the Public Acts of 1989, section 211 as amended by Act No. 181 of the Public Acts of 1984, and section 502 as amended by

Act No. 38 of the Public Acts of 1988, being sections 550.1104, 550.1205, 550.1207, 550.1211, and 550.1502 of the Michigan Compiled Laws, are amended and section 211a is added to read as follows:

Sec. 104. (1) "Administrative procedures act" means THE ADMINISTRATIVE PROCEDURES ACT OF 1969, Act No. 306 of the Public Acts of 1969, as amended, being sections 24.201 to ~~24.315~~ 24.328 of the Michigan Compiled Laws, or a successor act.

(2) "Bargaining representative" means a representative designated or selected by a majority of employees for the purposes of collective bargaining in respect to rates of pay, wages, hours of employment, or other conditions of employment relative to the employees ~~so~~ represented.

(3) "Certificate" means a contract between a health care corporation and a subscriber or a group of subscribers under which health care benefits are provided to members. ~~, including a contract containing an administrative services only or cost plus arrangement.~~ A certificate includes any approved riders amending the contract.

(4) "Collective bargaining agreement" means an agreement entered into between the employer and the bargaining representative of its employees, and includes those agreements entered into on behalf of groups of employers with the bargaining representative of their employees pursuant to the national labor relations act, CHAPTER 372, 49 STAT. 449, 29 U.S.C. 151 to ~~169~~ 158 AND 159 TO 169, under Act No. 176 of the Public Acts of 1939, as amended, being sections 423.1 to 423.30 of the Michigan Compiled

Laws, or under Act No. 336 of the Public Acts of 1947, as amended, being sections 423.201 to 423.216 of the Michigan Compiled Laws.

(5) "Commissioner" means the commissioner of insurance. Commissioner includes an authorized designee of the commissioner, if written notice of the delegation of authority has been given as provided in section 601.

(6) "Contingency reserve" means the sum of all assets minus the sum of all liabilities of a health care corporation, as shown in the annual financial statement filed under section 602.

Sec. 205. (1) A health care corporation shall record or estimate liabilities at reasonable values, neither excessive nor inadequate, and in accordance with sound actuarial practices and generally accepted accounting principles, to provide for the payment of all debts of the corporation. The assets of the corporation shall be valued in accordance with sound actuarial practices and generally accepted accounting principles. The commissioner shall disapprove the amount of any assets or liabilities that violate this subsection. The commissioner shall have the authority to disapprove the creation of any new liability that is properly includable in the contingency reserves. A liability shall be considered to be a new liability if the liability was not in existence on or before December 31, 1978.

(2) At all times while engaged in business, a health care corporation shall maintain a contingency reserve that, on a projected basis, progresses toward the target contingency reserve level established pursuant to this section. Until a target

contingency reserve level is established pursuant to this section, the corporation shall maintain a contingency reserve in the form and amount determined by the commissioner, or 11.5% of the previous year's total incurred claims and incurred expenses, whichever is greater.

(3) Within 30 days after the filing of a health care corporation's annual financial statement under section 602, the commissioner shall determine the target contingency reserve level for the corporation, expressed as a percentage of the total incurred claims and incurred expenses of the corporation for the previous calendar year. The target shall be equal to the adjustment factor established in subsection (7) multiplied by the sum of the risk factors weighted by the distribution of business of the corporation as of the previous December 31. The commissioner shall transmit a copy of the target to the corporation, rounded up to the nearest 1/10 of a percent.

(4) A health care corporation, for purposes of this section, shall define at least 5 lines of business and shall assign a risk factor to each line of business. The risk factors shall be established in accordance with sound actuarial practices, and the health care corporation shall file these risk factors with the commissioner within 6 months after the following times:

(a) ~~In the case of~~ FOR a health care corporation established under former Act No. 108 or 109 of the Public Acts of 1939, upon the effective date of this act.

(b) ~~In the case of~~ FOR a health care corporation newly incorporated under this act, upon formation of the corporation.

(c) ~~In the case of~~ FOR a health care corporation that has previously determined risk factors pursuant to this section, upon request of either the corporation or the commissioner, provided that the request is not made within 3 years after a previous determination of risk factors pursuant to this section, except as provided in subsection (8).

(5) Within 30 days after receipt of the risk factors filed pursuant to subsection (4), the commissioner shall do 1 of the following:

(a) ~~Approve~~ IF THE COMMISSIONER DETERMINES THE RISK FACTORS ARE ACTUARIALLY SOUND, THE COMMISSIONER SHALL APPROVE the factors and proceed under subsection (7).

(b) Define 1 or more additional lines of business, transmit the definitions to the health care corporation, and request that the corporation establish risk factors for those additional lines. The corporation shall then have 60 days to submit a risk factor for each line of business defined by either the commissioner or the corporation, which shall be approved or disapproved by the commissioner under this subsection. A health care corporation may revise a previously filed risk factor under this subsection.

(c) ~~Disapprove~~ IF THE COMMISSIONER DETERMINES THE RISK FACTORS ARE NOT ACTUARIALLY SOUND, THE COMMISSIONER SHALL DISAPPROVE the factors, and proceed under subsection (6).

(6) If the risk factors are disapproved by the commissioner pursuant to subsection (5)(c), the commissioner shall immediately notify the health care corporation of the disapproval. Within 6

months following notification, a panel of 3 actuaries, 1 appointed by the commissioner, 1 by the corporation, and 1 appointed by the 2 previously appointed actuaries, shall determine ~~a~~ AN ACTUARIALLY SOUND risk factor for each line of business. The agreement of any 2 actuaries on the panel shall be sufficient for the determination of the risk factors, and the panel shall transmit a copy of the risk factors to both the commissioner and the corporation.

(7) Within 15 days after the determination of the risk factors under subsection (6), or the approval of the risk factors under subsection (5)(a), the commissioner shall calculate an adjustment factor, which shall be transmitted to the health care corporation and the legislature. The adjustment factor shall equal:

(a) ~~In the case of~~ FOR a filing pursuant to subsection (4)(a), 11.5% divided by the sum of the risk factors weighted by the distribution of business of the corporation as of December 31, 1979.

(b) ~~In the case of~~ FOR a filing pursuant to subsection (4)(b), 11.5% divided by the sum of the risk factors weighted by the distribution of business of the corporation as of 6 months following the formation of the corporation.

(c) ~~In the case of~~ FOR a filing pursuant to subsection (4)(c), the current target contingency reserve level divided by the sum of the risk factors weighted by the distribution of business of the corporation as of the previous December 31.

(8) At any time the health care corporation and the commissioner, by mutual agreement, may enter into a stipulation setting forth lines of business, risk factors for each line of business, and an adjustment factor.

(9) The contingency reserve of a health care corporation shall not be less than 65%, or more than 120% of the target contingency reserve level. If the contingency reserve is above the required range at the end of a calendar year, the corporation shall implement adjustments as necessary to achieve the required range and shall file with the commissioner, for information, a description of the adjustments.

(10) The commissioner shall examine a health care corporation's annual financial statement filed in accordance with section 602 to determine, in accordance with generally accepted accounting principles, whether the contingency reserve is outside the required range described in subsection (9). If the contingency reserve is outside the required range at the end of 2 successive calendar years, the corporation shall file a plan, for approval by the commissioner, to adjust the contingency reserve to a level within the required range. If the commissioner disapproves the corporation's plan, the commissioner shall formulate a plan and shall forward the plan to the corporation. The corporation shall begin implementation of the commissioner's plan immediately upon receipt of the plan in writing.

(11) Contributions to the contingency reserve shall consist of 2 contribution components. The first is the contribution for risk which shall be actuarially determined as a normal part of

the rate-making process. The second is the contribution for plan-wide viability. Both components shall be considered contributions to the contingency reserve and shall be taken into consideration in determining compliance with this section.

(12) With respect to contributions for plan-wide viability, those contributions shall be made in accordance with the following:

(a) For contributions by small group and nongroup subscribers, if the contingency reserve is below 65% of the target, the contribution rate shall be 1% of the rate established pursuant to part 6; if the contingency reserve is between 65% and 95% of the target, the contribution rate shall be 0.5% of the rate established pursuant to part 6; if the contingency reserve is greater than 95% of the target, the contribution rate shall be 0%.

(b) For contributions by medium group and large group subscribers, if the contingency reserve is below 65% of the target, the contribution rate shall be 1% of the rate established pursuant to part 6; if the contingency reserve is between 65% and 105% of the target, the contribution shall be 0.5% of the rate established pursuant to part 6; if the contingency reserve is greater than 105% of the target, the contribution rate shall be 0%.

(c) At any time the corporation and the commissioner, by mutual agreement, may enter into a stipulation setting forth uniform adjustments to the contributions established in subdivisions (a) and (b).

(13) As used in this section:

(a) "Actuary" means a person who has the professional designation of a fellow of the society of actuaries, or a fellow of the society of casualty actuaries.

(b) "Distribution of business" means the percentage of a health care corporation's total business attributable to a given line of business, based on dollar amount of incurred claims and incurred expenses.

(c) "Risk factor" means the relative probability of loss associated with a given line of business, expressed as a percentage of incurred claims and incurred expenses for a calendar year.

(14) Arrangements for health benefit programs authorized under section 207(1)(f) shall not be included under this section unless, as part of the arrangement, contributions are made to the contingency reserve.

(15) The costs of a panel established under subsection (6) shall be split equally between a health care corporation and the commissioner, except that both the corporation and the commissioner shall pay the full costs associated with their appointed actuary.

(16) Provisions in this section concerning contributions to the contingency reserve do not apply to the Michigan Caring Program created in section 436.

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 ~~which~~

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 ~~1395w~~ 1395i, 1395i-2 TO 1395i-4, 1395j TO 1395t, 1395u TO 1395w-2, AND 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 ~~1396k~~ 1396f AND 1396i TO 1396u; for ~~the child health act of 1967, 42 U.S.C. 701 to 716~~ TITLE V OF THE SOCIAL SECURITY ACT, CHAPTER 531, 49 STAT. 620, 42 U.S.C. 701 TO 704 AND 705 TO 709; 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, ~~established by a subscriber group,~~ subject to the requirements of ~~section~~ SECTIONS 211 AND 211A.

(h) Establish, own, and operate a health maintenance organization, subject to the requirements of the public health code,

Act No. 368 of the Public Acts of 1978, as amended, being sections 333.1101 to 333.25211 of the Michigan Compiled Laws.

(i) Guarantee loans for the education of persons who are planning to enter or have entered a profession that is licensed, ~~or~~ certified, or registered under parts 161 to 182 of Act No. 368 of the Public Acts of 1978, as amended, being sections 333.16101 to 333.18237 of the Michigan Compiled Laws, 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, arbitrative, 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) 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, Act No. 218 of the Public Acts of 1956, being sections 500.106 and 500.110 of the Michigan Compiled Laws, 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*) Will not result in the health care corporation owning or controlling 10% or more of the voting securities of the insurer. Nothing in this subdivision shall be interpreted as expanding the lawful purposes of a health care corporation under this act. Except where expressly authorized by statute, a health care corporation shall not indirectly engage in any investment activity ~~which~~ THAT it may not engage in directly. A health care corporation shall not guarantee or become surety upon a bond or other undertaking securing the deposit of public money.

(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 ~~which~~ THAT do not significantly affect rates charged to subscribers.

(t) Participate with others in any joint venture with respect to any transaction ~~which~~ 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.

(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.

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 ~~subscribers~~ INDIVIDUALS, except that a health care corporation may continue an administrative services only or cost-plus arrangement with a ~~subscriber~~ 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 ~~subscribers~~ INDIVIDUALS if either the corporation makes arrangements for excess loss ~~insurance~~ COVERAGE or the sponsor of the plan ~~which~~ 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 ~~insurance~~ COVERAGE required by this subsection. It is the intent of the legislature that the excess loss ~~insurance~~ COVERAGE requirements be uniform as between corporations subject to this act and other persons authorized to provide similar services. ~~An administrative services only or~~

~~cost plus arrangement for a group containing less than 2,000 subscribers shall include provisions which provide that if the group's claims for a given month exceed 150% of the projected average monthly claims for the group, the group shall have at least 3 months to pay the excess over 150% prior to termination of the arrangement. Arrangements subject to this section shall include provisions which establish the liability of the health care corporation for all claims incurred up to the date of termination of the arrangement. For purposes of this subsection, the number of subscribers in a group shall be computed without regard to the residence of the subscriber.~~ 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 ~~which~~ 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 the contingency reserve of the corporation, consistent with section 205.

(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 with respect to such arrangements ~~which~~ THAT is consistent with the provisions of 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 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 ~~ERISA~~ 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) SHALL NOT BE 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 COMMISSIONER OF REVENUE. 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 REVENUE COMMISSIONER 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.

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, HANDICAP, 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.

Sec. 502. (1) A health care corporation may enter into participating contracts for reimbursement with professional health care providers practicing legally in this state for health care services ~~which~~ THAT the professional health care providers may legally perform. A participating contract may cover all members or may be a separate and individual contract on a per claim basis, as set forth in the provider class plan, if, in entering into a separate and individual contract on a per claim basis, the participating provider certifies to the health care corporation:

(a) That the provider will accept payment from the corporation as payment in full for services rendered for the specified claim for the member indicated.

(b) That the provider will accept payment from the corporation as payment in full for all cases involving the procedure specified, for the duration of the calendar year. Until January 1, ~~1993~~ 1995, as used in this subdivision, provider does not include a person licensed as a dentist under part 166 of the public health code, Act No. 368 of the Public Acts of 1978, being sections 333.16601 to 333.16648 of the Michigan Compiled Laws.

(c) That the provider will not determine whether to participate on a claim on the basis of the race, color, creed, marital status, sex, national origin, residence, age, handicap, or lawful occupation of the member entitled to health care benefits.

(2) A contract entered into pursuant to subsection (1) shall provide that the private provider-patient relationship shall be maintained to the extent provided for by law. A health care corporation shall continue to offer a reimbursement arrangement to any class of providers with which it has contracted prior to August 27, 1985 and ~~which~~ THAT continues to meet the standards set by the corporation for that class of providers.

(3) A health care corporation shall not restrict the methods of diagnosis or treatment of professional health care providers who treat members. Except as otherwise provided in section 502a, each member of the health care corporation shall at all times have a choice of professional health care providers. This subsection shall not apply to limitations in benefits contained

in certificates, to the reimbursement provisions of a provider contract or reimbursement arrangement, ~~nor~~ OR to standards set by the corporation for all contracting providers. A health care corporation may refuse to reimburse a health care provider for health care services ~~which~~ THAT are overutilized, including those services rendered, ordered, or prescribed to an extent ~~which~~ THAT is greater than reasonably necessary.

(4) A health care corporation may provide to a member, upon request, a list of providers with whom the corporation contracts, for the purpose of assisting a member in obtaining a type of health care service. However, except as otherwise provided in section 502a, an employee, agent, or officer of the corporation, or an individual on the board of directors of the corporation, shall not make recommendations on behalf of the corporation with respect to the choice of a specific health care provider. Except as otherwise provided in section 502a, an employee, agent, or officer of the corporation, or a person on the board of directors of the corporation who influences or attempts to influence a person in the choice or selection of a specific professional health care provider on behalf of the corporation, is guilty of a misdemeanor.

(5) A health care corporation shall provide a symbol of participation, which can be publicly displayed, to providers who participate on all claims for covered health care services rendered to subscribers.

(6) This section shall not be construed to impede the lawful operation of, or lawful promotion of, a health maintenance organization owned by a health care corporation.

(7) Contracts entered into under this section shall be subject to the provisions of sections 504 to 518.

(8) A health care corporation shall not deny participation to a freestanding medical or surgical outpatient facility on the basis of ownership if the facility meets the reasonable standards set by the health care corporation for similar facilities, is licensed under part 208 of the public health code, Act No. 368 of the Public Acts of 1978, being sections 333.20801 to 333.20821 of the Michigan Compiled Laws, and complies with part ~~221~~ 222 of the public health code, Act No. 368 of the Public Acts of 1978, as amended, being sections ~~333.22101 to 333.22181~~ 333.22201 TO 333.22260 of the Michigan Compiled Laws.