House
Legislative
Analysis
Section

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BCBSM: NO ASOs, ETC.

House Bill 5027
Sponsor: Rep. Nelson W. Saunders
Committee: Insurance

Complete to 9-9-91

A SUMMARY OF HOUSE BILL 5027 AS INTRODUCED 6-27-91

The bill would amend the Nonprofit Health Care Corporation Reform Act, which regulates Blue Cross and Blue Shield of Michigan, to do the following:

-- Prohibit the corporation from entering into administrative services only contracts or cost-plus arrangements. (This means Blue Cross and Blue Shield could not provide administrative services, such as claims processing, for a self-insured health benefit plan.) Any such arrangements would have to be terminated no later than one year after the bill's effective date or on the contract's next renewal date, whichever was sooner. The section of law that currently permits the corporation to enter into such contracts would be repealed effective one year after the bill's effective date.

-- Require the corporation to provide to subscribers under ASO or cost-plus contracts with a new identification card within 60 days after the bill takes effect clearly designating that coverage is pursuant to an ASO or cost-plus arrangement.

-- Require the corporation to notify all participating providers and providers who participate on an individual case or service basis and who receive reimbursement under an ASO or cost-plus arrangement that the coverage is pursuant to such arrangements and the date the coverage will be terminated or not renewed.

-- Prohibit the corporation from directly or indirectly operating, controlling, or using the influence of an "independent committee" or a "political committee" as those entities are defined in the state's campaign finance act. The corporation could be subject to a civil fine of not more than $10,000 for each violation.

-- Require Blue Cross and Blue Shield to pay benefits to "a nonparticipating provider at a member's direction." Currently, the act requires BCBSM to pay benefits only to a member or a participating provider.

-- Require that the corporation reimburse for health care benefits received at a reasonable rate based on the average reimbursement rate for the same health care service by the same class of providers in Illinois, Indiana, Ohio, Pennsylvania, and Wisconsin.

-- Prohibit the corporation from levying a premium increase to make up for any loss that has arisen from any illegal activity or act of noncompliance with the regulatory act.

-- Require that rates charged to nongroup subscribers be "community rated." This means rates would be based on the average costs of all subscribers in a particular area and is usually contrasted with "experience rating", which bases costs on the experience of consumer subgroups.

The bill contains a statement of intent that reads as follows:

"It is the purpose and intent of the amendatory act that added this subsection to preserve the state's interest in the health and welfare of its citizens by preventing a single health care corporation from monopolizing the health care market, to eliminate the resulting negative effects of a monopoly on the state's health care market, to restore reasonable access to high quality health care at reasonable costs, to return health care corporations to compliance with this section which provides that health care corporations shall be regulated and supervised by the commissioner of insurance, and to return existing health care corporations to compliance with the original legislative intent which provided for charitable, benevolent, tax-exempt institutions, established to promote an appropriate distribution of health care services for the benefit of all residents of the state."

MCL 550.1102 et al.