House
Legislative
Analysis
Section

Olds Plaza Building, 10th Floor
Lansing, Michigan 48909
Phone: 517/373-6466

BCBSM: NO ASO'S/MEDICARE, ETC.

House Bill 4854
Sponsor: Rep. Nelson W. Saunders
Committee: Insurance

Complete to 9-22-93

A SUMMARY OF HOUSE BILL 4854 AS INTRODUCED 6-15-93

The bill would amend the Nonprofit Health Care Corporation Reform Act (MCL 550.1102 et al.), 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.

-- Require the corporation to provide 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 serving as a fiscal intermediary for the federal Medicare program once any existing contract expires.

-- Require the prior approval of the insurance commissioner and the attorney general, subsequent to a public hearing, before the corporation could own or operate a subsidiary. The corporation could only own or operate a subsidiary that enhanced its ability to provide the greatest possible access to quality health care to the greatest number of Michigan citizens.

-- Prohibit the corporation from owning or operating any off-shore captive insurers or casualty insurers including professional liability insurers.

-- 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.

-- Prohibit the corporation from refusing to pay or reimburse for covered services performed by a health care provider operating within the scope of his or her licensure and from refusing participation to a licensed health care provider because the provider was not affiliated with another health care provider. Further, if a group or nongroup certificate required the prior approval or authorization of benefits for a health care service and the approval or authorization was given, then the benefits or reimbursement could not be denied because the service was rendered by a licensed health care provider so long as the provider was operating within the scope of practice of his or her licensure.

-- Require the corporation to furnish to the insurance commissioner by December 31 of each year the names and, where applicable, the specialties of all participating providers and name the participating providers who were residents. The corporation would be prohibited from disparaging in any manner any physician who refused to participate with the corporation. The corporation would be subject to a civil action for damages for a violation of this provision.

-- Specify that the determination of the medical necessity of any medical treatment or order of goods or services from any ancillary or outside supplier or provider would be the responsibility of the treating physician and would be presumed reimbursable. The corporation would have to assert its right to refuse reimbursement based on lack of medical necessity within the same time periods fixed for submission of claims or would lose the right to refuse reimbursement.

-- 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.

-- Allow the insurance commissioner to review the corporation's continued compliance with sections of the act establishing goals for reimbursement arrangements and standards for provider class plans. If it was determined a violation had occurred, the commissioner would order a $10,000 civil fine per violation for an initial violation; a $20,000 civil fine per violation for a repeat violation; a $50,000 civil fine for an initial willful or gross violation; or a $100,000 civil fine for such a repeat violation. The commissioner could also issue a cease and desist order; put a provider contract under supervision; or order the corporation to cease doing business.

-- Require approval of the insurance commissioner for the corporation's contracts with health care facilities. The commissioner would have 90 days to approve or reject a submitted contract, and would have to explain a rejection in writing. The corporation could ask for a review of the rejection after cited problems had been corrected, and the commissioner would have 30 days to review the proposed contract. If the contract was again rejected, the corporation could again correct and request a review or could appeal the decision under the Administrative Procedures Act.

-- Require, if the corporation's contingency reserve was outside the required range at the end of two successive calendar years, that the commissioner order the corporation placed under independent supervision; order the corporation be placed under outside management for claims payment activities; or dissolve and liquidate the corporation.

-- Specify that the corporation would be subject to private causes of action by aggrieved persons, including providers and subscribers, for violations of the act and that attorney fees and costs could be awarded to a prevailing plaintiff. Causes for action would include bad faith conduct or retaliatory conduct and withholding payments to providers or subscribers.

-- Prohibit the corporation from levying a premium increase to make up for any loss that had 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 loss experience of consumer subgroups.)

-- Require among the information to be submitted in support of a nongroup rate filing all amounts paid for advertising and sponsorship of nonhealth-related activities and all grants awarded by the corporation.

-- Require the corporation to publish annually a list of all contracts entered into with a value of $1,000 or more. The list would have to include the amount and purpose of the contract and the parties subject to the contract. The list would be provided to the governor, the legislative committees on insurance and health issues, and the insurance commissioner, as well as to participating providers and subscribers, on request. The corporation would be prohibited from entering into any contracts not directly related to health care or health research.

-- Specify that the primary purpose and intent of the act was "to provide the opportunity for access to high quality health care services at a fair and reasonable cost." The current stated aims of the act would be described as "secondary."

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."