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

PART 1

550.1101 Short title.

Sec. 101. This act shall be known and may be cited as "the nonprofit health care corporation reform act".

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

Constitutionality: Procedural fairness is required by the due process clause before governmental action drastically alters essential terms of the contract between nonprofit group health care plans and hospitals and nursing homes providing health care services; however, the guarantee of procedural due process does not necessarily require an adversary proceeding. Convalescent Center v Blue Cross, 414 Mich 247; 324 NW2d 851 (1982).

Administrative hearings under the Administrative Procedures Act, however informal, comport with the procedural fairness required by due process in the absence of an explicit statutory requirement that a contested evidentiary hearing be held. Convalescent Center v Blue Cross, 414 Mich 247; 324 NW2d 851 (1982).

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).

Compiler's note: For transfer of the Department of Insurance and Office of the Commissioner on Insurance from the Department of Licensing and Regulation to the Department of Commerce, see E.R.O. No. 1991-9, compiled at MCL 338.3501 of the Michigan Compiled Laws.

For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1102 Legislative intent and policy.

Sec. 102. (1) It is the purpose of and intent of this act, and the policy of the legislature, to promote an appropriate distribution of health care services for all residents of this state, to promote the progress of the science and art of health care in this state, and to assure for nongroup and group subscribers, reasonable access to, and reasonable cost and quality of, health care services, in recognition that the health care financing system is an essential part of the general health, safety, and welfare of the people of this state. Each 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.

(2) It is the intention of the legislature that this act shall be construed to provide for the regulation and supervision of nonprofit health care corporations by the commissioner of insurance so as to secure for all of the people of this state who apply for a certificate, the opportunity for access to health care services at a fair and reasonable price.

(3) It is the public policy of this state that, in the interest of facilitating access to health care services at a fair and reasonable price, an alternate, expeditious, and effective procedure for the resolution of issues and the maintenance of administrative appeals relative to provider class plans be established and utilized, and to that end, the provisions of this act regarding administrative review of those provider class plans shall be construed so as to minimize uncertainty and delays.

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

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1103 Meanings of words and phrases.

Sec. 103. For the purposes of this act, the words and phrases defined in sections 104 to 108 shall have the meanings ascribed to them in those sections.

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

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1104 Definitions; A to C.

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 24.328 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 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. 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 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.

History: 1980, Act 350, Eff. Apr. 3, 1981;—Am. 1993, Act 127, Imd. Eff. July 21, 1993.

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

550.1105 Definitions; H.

Sec. 105. (1) "Health care benefit" means the right under a certificate to have payment made by a health care corporation for a specified health care service, regardless of whether or not the payment is made pursuant to an administrative services only or cost-plus arrangement.

(2) "Health care corporation" means a nonprofit hospital service corporation, medical care corporation, or a consolidated hospital service and medical care corporation incorporated or reincorporated under this act, or incorporated or consolidated under former Act No. 108 or 109 of the Public Acts of 1939.

(3) "Health care facility" means a facility or agency as defined in section 22104 of Act No. 368 of the Public Acts of 1978, being section 333.22104 of the Michigan Compiled Laws, and includes a home health agency, or other facility with the approval of the commissioner.

(4) "Health care provider" or "provider", except as provided in section 301(8)(a), means a health care facility; a person licensed, 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; any other person or facility, with the approval of the commissioner, who or which meets the standards set by the health care corporation for all contracting providers; and, for purposes of section 414a, any person or facility who or which provides intermediate or outpatient care for substance abuse, as defined in section 414a.

(5) "Health care services" means services provided, ordered, or prescribed by a health care provider, including health and rehabilitative services and medical supplies, medical and rehabilitative services and medical supplies, medical prosthetics and devices, and medical services ancillary or incidental to the provision of those services.

History: 1980, Act 350, Eff. Apr. 3, 1981;—Am. 1980, Act 430, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1106 Definitions; L to O.

Sec. 106. (1) "Large subscriber group" means a group of 10,000 or more subscribers.

(2) "Medium subscriber group" means a group of 150 or more subscribers, but less than 10,000 subscribers.

(3) "Member", except as used in parts 2 and 3, means a subscriber, a dependent of a subscriber, or any other individual entitled to receive health care benefits under a nongroup or group certificate.

(4) "Nongroup subscriber" means an individual subscriber who is not enrolled as a subscriber through any subscriber group.

(5) "Objectives" means an expected achievement level by a health care corporation of the goals provided in section 504, for a provider class. Insofar as is reasonably practicable, objectives shall be capable of quantitative measurement.

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

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1107 Definitions; P.

Sec. 107. (1) "Participating provider" means a provider that has entered into a participating contract with a health care corporation and that meets the standards set by the corporation for that class of providers.

(2) "Participating contract" means an agreement, contract, or other arrangement under which a provider agrees to accept the payment of the health care corporation as payment in full for health care services or parts of health care services covered under a certificate, as provided for in section 502(1).

(3) "Person" means an individual, corporation, partnership, organization, or association.

(4) "Personal data" means a document incorporating medical or surgical history, care, treatment, or service; or any similar record, including an automated or computer accessible record, relative to a member, which is maintained or stored by a health care corporation.

(5) "Proposed rate" means any of the following:

(a) A proposed increase or decrease in the rates to be charged to nongroup subscribers.

(b) For group subscribers, any proposed changes in the methodology or definitions of any rating system, formula, component, or factor subject to prior approval by the commissioner.

(c) A proposed increase or decrease in deductible amounts or coinsurance percentages.

(d) A proposed extension of benefits, additional benefits, or a reduction or limitation in benefits.

(e) A review pursuant to section 608(2).

(6) "Provider class" means classes of providers, as defined in section 105(4), that have a provider contract or a reimbursement arrangement with a health care corporation to render health care services to subscribers, as those classes are established by the corporation.

(7) "Provider class plan" or "plan" means a document containing a reimbursement arrangement and objectives for a provider class, and, in the case of those providers with which a health care corporation contracts, provisions that are included in that contract.

(8) "Provider contract" or "contract" means an agreement between a provider and a health care corporation that contains provisions to implement the provider class plan.

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

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1108 Definitions; R, S.

Sec. 108. (1) "Reimbursement arrangement" means policies, practices, and methods by which a health care corporation makes payments to a provider to implement the provider class plan.

(2) "Small subscriber group" means a group of less than 150 subscribers.

(3) "Subscriber" means an individual who contracts for health care benefits, either individually or through a group, with a health care corporation. Subscriber includes an individual whose contract contains an administrative services only or cost-plus arrangement authorized under section 207(1)(g).

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

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