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## THE NONPROFIT HEALTH CARE CORPORATION REFORM ACT OF 1980\*

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David L. Hollister\*\*

Patience A. Drake\*\*\*

Blue Cross/Blue Shield (the "Blues") was created as a tax-exempt, "charitable and benevolent" organization<sup>1</sup> by specific enabling legislation, Michigan Public Acts 108 and 109 of 1939. It was designed to assure that poor folks received health care and, more importantly at that time, that physicians and hospitals got paid. The Blues, with its unique tax-free and semi-public status, quietly became the predominant third party payor health insurer in Michigan. In 1980, they represented a \$2.35 billion dollar business and, in addition, processed \$1.45 billion dollars for the Federal Medicare program. They insured 5.3 million Michigan residents (over sixty percent of the market) and, because of their size and control of the market, dictated health policy in this state.

In recent years, Blue Cross/Blue Shield has been the subject of considerable controversy. Its critics charge the non-profit, tax-exempt corporation with being unduly secretive, arrogantly unresponsive to consumer interest and not vigorous in its cost containment efforts. These criticisms, along with a variety of other factors, led to the legislative reform I am here to talk to you about this evening.

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\* This is a revised version of a speech delivered at the *Journal of Law Reform Alumni Banquet*, February 21, 1981, Ann Arbor, Michigan.

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<sup>1</sup> 1939 Mich. Pub. Acts No. 108 (repealed 1980). MICH. COMP. LAWS § 550.315 (1970) (repealed 1980) defines the Blues as a "charitable and benevolent institution" and grants it tax-exempt status.

## I. THE LEGISLATIVE HISTORY

### A. Background

Health care costs have increased from 6.2 percent of the Gross National Product in 1965 to 9.1 percent in 1978. The rate of growth of health care expenditures is twice the Consumer Price Index, and Michigan's costs are among the highest in the nation. These cost spirals are a function of the premise that the health care industry does not respond to traditional market incentives. Health care is removed from the market because the providers control the demand and utilization of facilities, drugs, and other services. Generally, consumers are ignorant of the range of health services, have no comparative price information, and usually seek out services when they are ill or in crisis and unable to evaluate and judge the services rendered by health care professionals. Health care providers, having escaped the competitive marketplace, have been reimbursed on a cost-plus basis. There are, therefore, no incentives to contain costs. With over ninety percent of all Michigan health care expenses covered by third party payors,<sup>2</sup> neither the physician nor the consumer have any out-of-pocket economic incentive to economize. As costs escalate at faster and faster rates, those without insurance are forced out of the health care market.

It was with this in mind that Representative Perry Bullard and I first introduced legislation in 1977. Representative Bullard's bill was a major restructuring of Blue Cross/Blue Shield, while my bills<sup>3</sup> would have required that the Blues Board conform to the Open Meetings Act.<sup>4</sup> While none of these bills moved in that session of the Legislature, significant public interest was stimulated. A consensus was developing that the 1939 statutes needed major revision.

In an October 1978 ruling, the Michigan Supreme Court in *Blue Cross/Blue Shield of Michigan v. Demlow*<sup>5</sup> ruled that the

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<sup>2</sup> Hospital, surgical, regular medical, and major medical insurance covered 93.9%, 94.5%, 96.5%, and 68.6% of the Michigan population, respectively. Nationally, the respective percentages were 82.5%, 79.8%, and 77.5% with major medical data unavailable. These estimates are based on 1974 data of persons under 65 covered by private insurance. MICHIGAN STATE HEALTH PLANNING ADVISORY COUNCIL & OFFICE OF HEALTH AND MEDICAL AFFAIRS, NATIONAL HEALTH INSURANCE 59 (1977).

<sup>3</sup> H.R. 5450, 79th Sess. (Mich. 1977) (Bullard); H.R. 5295, 79th Sess. (Mich. 1977); H.R. 5296, 79th Sess. (Mich. 1977) (Hollister).

<sup>4</sup> MICH. COMP. LAWS ANN. §§ 15.261-.275 (Supp. 1980).

<sup>5</sup> 403 Mich. 399, 270 N.W.2d 845 (1978).

Insurance Commissioner had differing degrees of control over Blue Cross and Blue Shield even though the two distinct programs had been organizationally consolidated through legislation in 1974. The Blues management was not opposed to legislation. In the spring of 1979, the Blues management came to Representative William Ryan and me requesting us to introduce their version of a rewrite of P.A. 108 & 109.<sup>6</sup> Representative Ryan sponsored and I co-sponsored a bill<sup>7</sup> which, upon introduction, was referred to the House Insurance Committee for consideration. During the first hearing, the committee room was packed with groups insisting that the legislature reject the incremental, patchwork approach contained in the Blues draft and work instead to reform and reorganize fundamentally the Blues. It became apparent that the restructuring of the Blues and the initiation of cost containment were to become the major consumer issues to face the 79th Session of the Michigan Legislature.

It was clear that the Blues proposal to address minimal, incremental reform was dead. Within days after the first Insurance Committee hearing, the Insurance Commissioner, the Attorney General and the Citizens Lobby came forward with different versions of legislation fundamentally reorganizing Blue Cross/Blue Shield. Representative Ryan and I co-sponsored all of the proposals, and began the process of building the public support necessary to enact the legislation. We agreed to use the Attorney General's draft as the vehicle bill<sup>8</sup> to address the issues raised in the committee meeting and at hearings with various interest groups.

### *B. The Major Goals of the Legislation*

As we began to refine the legislation, it was important to articulate the basic goals of any reform legislation. Based on my knowledge of the Blues and the testimony from the first hearing, it was apparent that legislation would have to achieve at least the following goals. First, the legislation would have to restructure the Board of Directors in order to make the Board more representative of and accountable to the various constituencies. One way to do this, it seemed, would be to reduce the control of

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<sup>6</sup> 1939 Mich. Pub. Acts Nos. 108-09 (repealed 1980). Public Act 109 provides the framework for supervision and regulation of nonprofit hospital service corporations in Michigan.

<sup>7</sup> H.R. 4340, 79th Sess. (Mich. 1979).

<sup>8</sup> H.R. 4555, 79th Sess. (Mich. 1979).

the providers and give operational control to subscribers, making a representative selection of the Board more open. Another step would be to reduce the size of the Board and provide minimum safeguards for conduct of Board operations. Second, the legislation would have to make cost containment a central theme. Third, the internal operations of the Blues would have to be streamlined. The 1939 statute needed to be updated to reflect the realities of 1980, and to remedy the administrative problems raised by *Demlow*.<sup>9</sup> Overall, the internal operations of the Blues would have to be more responsive and sensitive to subscribers. As a final goal of the legislation, the power of the Insurance Commissioner would have to be clarified.

### C. *The Politics of Reform*

Most bills of the complexity involved here take five to seven years to shepard through the legislative process. To do this in one session — two years — was a major challenge. It required establishing a broad-based coalition of interest groups, consumers and agencies of state government. To organize and undertake the task, Insurance Committee Chair Matthew McNeely established a three-member subcommittee in the spring of 1978, of which I was an ad-hoc member. At approximately the same time, two different coalitions coalesced as work began on the bill. The first was known as the "Reform Coalition." The Reform Coalition was composed of consumer groups (Michigan Legal Services, Citizens for Better Care, the UAW, AFL-CIO, Michigan Citizens Lobby, Michigan Catholic Conference, and the Area Agencies on Aging Association) and state departments (Attorney General, Insurance Commissioner, Office of Health and Medical Affairs).

The Reform Coalition, at the direction of the subcommittee, worked during the summer to synthesize the four consumer-oriented bills into one and to resolve and minimize differences with representatives from the Blues. In August, the Reform Coalition presented their rough draft, House Bill 4555, to the subcommittee.

The subcommittee began intensive deliberations on the bill. The Reform coalition sent representatives to all subcommittee meetings in the House where the bill was laboriously reworked one line and one page at a time. Together, with input from sev-

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<sup>9</sup> 403 Mich. 399, 270 N.W.2d 845 (1978).

eral Blues management representatives, the Coalition worked to develop a comprehensive reform bill that was fair to Blue Cross/Blue Shield. As the Coalition members participated in the drafting, they also developed "ownership" of the bill by becoming actively involved in the legislative process to pass the bill.

The second group was known as the "Shelton Coalition." While the Reform Coalition was spending months working to clarify language and refine policy, the Speaker asked Jack Shelton of Ford Motor Company to reconvene the Cost Containment Coalition and tackle the linchpin of language and policy, the method and level of reimbursement to providers by the Blues. This Coalition was made up of the Big Three Auto Companies (General Motors, Ford, Chrysler), the UAW and AFL-CIO, and members of Blue Cross/Blue Shield of Michigan (BCBSM). Contributing as technical advisors, but not voting participants, were members of the Medical Society and Hospital Association. Jack Shelton worked diligently to separate his task — a cost containment scheme — from the rest of the bill. The final product, Section V, stood independently from the rest of the bill and consequently avoided the controversy involved in the Board restructuring and corporate powers sections. Shelton formulated a unique compromise designed to allow the free market place to work while allowing governmental intervention if the Blues and the providers failed to achieve their goals regarding access to reasonably priced, quality care.

When Shelton completed his work, he elicited and obtained the support of the Medical Society, the Hospital Association, and the Nurses Association for Section V — the only section that they were really interested in. They became advocates for the reform, a very important accomplishment. With all the providers supporting Section V and staying neutral on the rest of the bill, the Blues had no major interest group to turn to as they tried to stop passage of the legislation.

Slowly and deliberately, we went through the drafting of the bill. An early summer deadline faded to early fall. Finally, the bill began to take shape. Section by section of the bill fell into place as the coalition labored to negotiate a final and equitable version. The Blues tried to delay. They continuously raised issues and questions, never attending a meeting without eight to fourteen experts and staff.

When the House Insurance Committee received the subcommittee's work and prepared to report the bill to the full House, the Blues asked that over eighty amendments be considered. All of the amendments failed. The bill had been thoughtfully devel-

oped and the various coalition members were informed and actively supporting the negotiated version. To have adopted the amendments would have been a betrayal of the process and the coalition's efforts to construct the bill. The bill quickly moved from the Insurance Committee to the full House where it passed by a vote of ninety-five to seven. It then moved to the Senate for deliberation.

In the Senate, the Blues focused their opposition to the Board restructuring issues, and worked to break the coalition that had supported the bill in the House. Quietly and secretly, they went to every member of the Reform Coalition and the special interests (Medical Society, Hospital Association), talking with them about the issues they lost in the year-long negotiations. Having identified those losses, the Blues drafted a version of the bill that would more accurately reflect their interest and that was designed to "buy" the support of others. The Blues had three objectives: (1) to make the bill more palatable; (2) to break the powerful coalition which had drafted and lobbied for the House version of the bill; and (3) to dilute the reform contained in the bill to make it the least progressive possible.

Unfortunately, they were successful. In a move which astounded most observers, they were able to garner the votes in the Commerce Committee to have their own draft replace the House draft on which the Commerce Committee had deliberated for several months. The sixty-plus-page Blues-drafted version was adopted at one meeting despite the fact that several committee members had not even been given the opportunity to read the Blues' draft before voting. Thus, the Senate began consideration on the Blues' draft. It appeared that all the work in the House was lost. The coalition was broken; the Blues were in the driver's seat. Attempts to modify incrementally the bill in Committee and on the Senate floor were moderately successful, but the bill remained a far different version than the consumer-oriented bill that passed the House. After several days of floor debate, during which over forty amendments were vociferously disputed, the Senate passed the bill on July 3, 1980, with a vote of twenty-six to nine.

When the bill returned to the House, we rejected it immediately by a vote of seventy-seven to five and sent it to a Conference Committee. Before the Conference were two distinct versions of reform — one written by a consumer coalition in an open, deliberate process, and another written by the entity to be regulated, the Blues, after secretive meetings with various elements of the coalition. The Conference lasted four months and

the final draft was somewhere between the House and Senate version. Surprisingly, however, the Blues were still not supporting the bill because they had not been able to win the Board restructuring issues. The absolute bottom line always was management control of the Board; we continuously won that battle.

Slowly we rebuilt the coalition, and slowly the bill came back together. The Conference Committee completed its reconciliation of the disparate bills and reported it to the House for consideration, where it was adopted on December 4, 1980. The next day the bill passed the Senate and was sent to the Governor for his signature. On December 29, 1980, the Governor signed the bill, making it Public Act No. 350.<sup>10</sup>

## II. P.A. 350 — ESSENTIALS OF REFORM

### A. Board Structure

First, P.A. 350, the "Nonprofit Health Care Corporation Reform Act" (the "Act") reorganizes the Board of Directors to no more than thirty-five voting members,<sup>11</sup> a reduction from forty-seven members. Four of the directors would be public members, two of whom would be retirees.<sup>12</sup> Of the remainder, at least seventy-five percent must be subscribers and no more than twenty-five percent could be providers.<sup>13</sup> (The Blues Board at present has forty-seven members: twenty-five subscriber representatives, nineteen provider members, two public members appointed by the Insurance Commissioner, and the President of the Corporation. However, because some of the twenty-five subscribers also have health care provider ties, such as a trustee of a hospital, many groups have argued that Board members with provider allegiance currently hold majority control.)

Under the Act, the Board is reorganized to represent more fairly various constituencies — providers and subscribers; group and individual subscribers; large, medium, and small groups; and employers and employees. The actual selection process is not dictated by the Act, but is left to the Blue Cross bylaws<sup>14</sup>

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<sup>10</sup> 1980 Mich. Pub. Acts No. 350 (codified at MICH. COMP. LAWS ANN. §§ 550.1101-1704 (Mich. Legis. Serv. 1980)).

<sup>11</sup> *Id.* § 301(1) (MICH. COMP. LAWS ANN. § 550.1301(1)).

<sup>12</sup> *Id.* § 301(2) (MICH. COMP. LAWS ANN. § 550.1301(2)).

<sup>13</sup> *Id.* § 301(3) (MICH. COMP. LAWS ANN. § 550.1301(3)).

<sup>14</sup> *Id.* § 301(6) (MICH. COMP. LAWS ANN. § 550.1301(6)).

which are to be written by the current Board of Directors.<sup>15</sup> Open meetings are not required, and certain sensitive material need not be included in the minutes of the Board meetings.

The Act required that Board action have the support of the majority of members serving (sixteen affirmative votes) on key issues such as rate revisions and provider contracts.<sup>16</sup> The purposes of this provision are: (1) assure subscriber control; (2) require board action to have the genuine support of the Board; (3) prevent a small minority from taking action opposed by the vast majority; and (4) to protect against conflicts of interest when providers must vote on their own methods and rates of reimbursement.

The basic philosophy behind this section is that the Board ought to be broadly representative and responsive to various constituencies. Thus, subscribers ought to have a role in determining the actions and policies of Blue Cross. It is important to note that, unlike private insurance companies which are accountable to their shareholders, Blue Cross is a non-profit corporation and does not have shareholders. Its accountability ought to be predominately to its subscribers and, secondarily, to the public.

The Act provides for this accountability. In addition to the restructuring of the Board, it provides for Board action to be open to subscriber scrutiny. It is proper and reasonable that subscribers have the ability to know how their representatives on the Board are voting on important items, and what decisions the Board is making.

The Act does not, however, require open meetings. Unfortunately the Blues argued successfully that too much openness would put them at a competitive disadvantage and be harmful in recruiting potential Board members. Instead of open meetings, the Board is required to keep minutes of its meetings.<sup>17</sup> Record roll call votes are required upon the request of any five Board members.<sup>18</sup> Any subscriber can request minutes through a Board member.<sup>19</sup>

The Blues found this section of the Reform Act to be the most dangerous and threatening. They agree with a smaller, subscriber-controlled Board but they violently oppose roll call votes, recorded minutes, accountability to subscriber constituencies,

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<sup>15</sup> *Id.* § 302(1) (MICH. COMP. LAWS ANN. § 550.1302(1)).

<sup>16</sup> *Id.* § 303(4)(c) (MICH. COMP. LAWS ANN. § 550.1303(4)(c)).

<sup>17</sup> *Id.* § 304(1) (MICH. COMP. LAWS ANN. § 550.1304(1)).

<sup>18</sup> *Id.* § 303(5) (MICH. COMP. LAWS ANN. § 550.1303(5)).

<sup>19</sup> *Id.* § 304(1) (MICH. COMP. LAWS ANN. § 550.1304(1)).

public members, and the absolute majority voting provisions. Taken together, they allege that the provisions hamper their operations and cripple the Board's ability to function.

To the Reform Coalition, this section was essential to any reform. Without some degree of openness and accountability, it is business as usual. Any public body can decry openness, but it is a fundamental component of accountability as are record roll call votes. Even though complete openness and complete roll call votes on all issues were lost in the negotiations on the bill, the legislation maintains a major policy commitment to openness and accountability.

### *B. Regulation and Cost Containment*

When it came to cost containment, there were two diametrically opposing views which came into play. On one end of the spectrum were those arguing for a state-controlled rate-setting mechanism which simply dictated costs and initiated controls. On the other end of the spectrum were those who advocated the free marketplace, eliminating all governmental regulation and letting the Blues and the providers figure ways to limit growth.

Months went by as the debate raged. Finally, Speaker Bobby Crim asked Jack Shelton of the Cost Containment Coalition to develop a strategy on cost containment. He had been successful earlier in developing Michigan's Bed Reduction Legislation. The final strategy developed by the Shelton Coalition was a creative compromise encompassing both aspects of the diverse opinions.

First, the Act establishes three goals for health care: (1) reasonable access; (2) reasonable cost; and (3) quality health care services. The cost goal is designed to assure a rate of growth that does not exceed the compound rate of inflation and real economic growth.

To achieve these three goals, the Blues negotiate a Provider Class Plan with each of the provider groups (as defined by Blue Cross/Blue Shield)—physicians, hospitals, pharmacies, *et cetera*. The Plan must address access, quality, and cost containment. The Plan is operable for two years, without governmental involvement or interference. If after two years the goals are met, the government continues to have a passive monitoring role and the Blues negotiate a further plan or continue the existing plan. The scheme here is simple. If the Blues can successfully work with the providers to meet their goals and limit the growth of costs, the free market will go forward without governmental in-

terference. If, on the other hand, the goals are not met, and one of the goals is violated, the Insurance Commissioner triggers a mechanism of review and rewriting of the Plan. Essentially, the Plan calls for governmental intervention if the free market fails. In the event the Plan fails, and for certain decisions which the Commissioner may exercise, an elaborate appeal mechanism is established to hear appeals.

It is true that Blue Cross has begun to progress towards containing costs, especially in the case of the prospective reimbursement system with hospitals. The Act gives Blue Cross additional cost restraint powers. If they are able to achieve cost containment there will be no governmental involvement; this section will result in less regulation than has historically been the case for Blue Cross.

The Act substantially adopts the provisions of the Shelton Coalition. Every major provider group and consumer group has supported this section. It was estimated that over \$137 million would have been saved if these provisions had been in effect the past four years.

One legitimate criticism is that there will be cost containment goals for Blue Cross, but not for private insurance companies. In part, this is because Blue Cross has such a substantial share of the market (over sixty-five percent) that it only makes sense first to establish goals for Blue Cross. Furthermore, Blue Cross/Blue Shield of Michigan is the only corporation to which the Legislature has granted the privilege and authority to contract directly with providers of health care. But in addition, this will aid Blue Cross' competitive position — lower payments to providers means lower rates to subscribers; this could greatly benefit Blue Cross.

### *C. Improving Internal Operations*

Especially in the last ten to twelve years, significant questions over the powers of Blue Cross/Blue Shield of Michigan have arisen. Many of these questions have ended up in court resulting in great expenditures of time, money, and energy. The Legislature felt it was important to define, as much as possible, exactly what Blue Cross can and cannot do.<sup>30</sup> As a result, many provisions of corporate law are inserted directly in P.A. 350, and with these provisions carry any case law developed over the years.

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<sup>30</sup> See *id.* § 207 (MICH. COMP. LAWS ANN. § 550.1207).

Other sections of corporate law had no applicability to Blue Cross and were not included in the Act. But in virtually every case where Blue Cross asked for and offered a rationale for including a section of corporate law in P.A. 350, it was included. Rather than place a burden on Blue Cross, this should aid them by reducing the number of court cases they are needlessly involved in.

The Act significantly increases the ability of Blue Cross/Blue Shield of Michigan to offer their customers and subscribers services which they desire. Blue Cross is now given explicit power in the areas of cost saving services, experimental health care projects, governmental services, Health Maintenance Organizations (HMO), *et cetera*. In other areas, governmental regulation is reduced or eliminated (*e.g.*, some areas of provider contracts, rate regulation, and reserves). This should add to Blue Cross' flexibility and ability to respond to the market.

1. *Rates*— The Act revises the rate approval process for Blue Cross. In some areas, the authority of the Insurance Commissioner is reduced from that of current law, in other areas current law is clarified, and in a few areas, the authority of the Commissioner is increased. We believe that this area of P.A. 350 will result in a better rate procedure—one resulting in more timely rate approval. (One could hardly imagine a less timely process than current law, which has allowed a 1978 filing to drag on without an end in sight).

*a. Intervention*— The Act provides that upon receipt of a rate filing, the Insurance Commissioner must notify "interested persons" of the filing.<sup>21</sup> If "the interested person or any other person on whose behalf the interested person is acting is aggrieved by the proposed rate change," and if the Commissioner agrees that the person is, in fact, aggrieved (or reasonably might be), that person is entitled to a hearing.<sup>22</sup> The hearing procedure parallels the Administrative Procedures Act.<sup>23</sup> The Legislature received testimony that aggrieved persons have a constitutional right to this kind of a procedure and that failure to provide this kind of process in P.A. 350 would result in almost certain (and undoubtedly, successful) legal challenge. There are standards for intervention, and the procedure specified in the Act is orderly, timely, and fair to both the aggrieved persons and Blue Cross. It should also be noted that many areas are exempted from prior

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<sup>21</sup> *Id.* § 612 (MICH. COMP. LAWS ANN. § 550.1612).

<sup>22</sup> *Id.* § 613 (MICH. COMP. LAWS ANN. § 550.1613).

<sup>23</sup> MICH. COMP. LAWS § 24.201 (1970).

approval by the Commissioner (e.g. collective bargaining agreements,<sup>24</sup> national accounts,<sup>25</sup> mandated benefits<sup>26</sup>) — a regulatory reduction from current law.

*b. Relationship to other private insurers*— Individual commercial health insurance policies are subject to regulatory review and approval for both the rates and the form (policy). Though hearings on such policies are held infrequently, if a company or affected party requested a hearing, it would be held. Similarly, the Act does not mandate hearings; it provides a procedure for holding hearings in the event that a hearing is requested. The purpose of a hearing is not to provide “interminable delay” in rate decisions, but to afford due process on rate decisions as outlined in the Administrative Procedures Act. When considering the frequency with which hearings are held, one must bear in mind the relationship with market share. For example, Blue Cross provides Other-than-Group Complementary and Group Complementary coverage (wrap-around Medicare benefits) to over seventy percent of Michigan’s seniors. When such a large percent of the population is affected by one corporation, it is reasonable to expect that parties will be interested in the outcome of rate decisions.

*c. Interim relief*— It is important to note that current law does not provide for interim rates — under any circumstances! The Act provides mandatory interim rate increases requested by the Corporation in the case of a delay in a rate filing approval.<sup>27</sup> This would happen when there is probable cause to believe that an underwriting loss would occur without the interim relief.<sup>28</sup> For the first time, interim rates are permitted.

*d. Senior citizens’ rates*— The Act does permit (but does not require) the Corporation to establish cost transfers to benefit senior citizen subscribers.<sup>29</sup> This is important, because at retirement seniors suffer a drastic income reduction. Seniors have paid their dues into our society and should be allowed to live the rest of their days without being in constant fear that illness could wipe them out. In any event, P.A. 350 gives Blue Cross authority in this area, without any requirements.

In summary, the Act provides for a reasonable and orderly

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<sup>24</sup> 1980 Mich. Pub. Acts No. 350, § 606(2) (codified at MICH. COMP. LAWS ANN. § 550.1607(2) (Mich. Legis. Serv. 1980)).

<sup>25</sup> *Id.* § 608(5) (MICH. COMP. LAWS ANN. § 550.1608(5)).

<sup>26</sup> *Id.* § 608(4) (MICH. COMP. LAWS ANN. § 550.1608(4)).

<sup>27</sup> *Id.* § 614(1) (MICH. COMP. LAWS ANN. § 550.1614(1)).

<sup>28</sup> *Id.* § 614(2) (MICH. COMP. LAWS ANN. § 550.1614(2)).

<sup>29</sup> *Id.* § 609(5) (MICH. COMP. LAWS ANN. § 550.1609(5)).

process for rate approval. There are provisions for intervention, which is required by due process, and necessary to allow aggrieved parties to have an opportunity to present their case. This procedure should result in fairer and more timely rates.

2. *Benefits*— The current statute provides for prior and periodic approval of benefits and rates by the Insurance Commissioner for all contracts involving both Blue Cross and any other commercial health insurer. The Act reduces the Commissioner's statutory authority in this area for the Blues, especially in the case of collectively bargained agreements;<sup>30</sup> however, historically, Commissioners have not exercised this authority over collectively bargained benefits because of the operation of the informed buyer concept in the case of collectively bargained benefits.

Benefits and rates offered by commercial insurers are subject to approval by the Commissioner. Though a 1968 order exempted group benefits from such approval, every individual health insurance policy and rate is reviewed and approved by the Commissioner.

A provision on comprehensiveness of benefits is included to provide protection for the public. Many individuals and small groups have no market power to influence the decisions of BCBSM regarding benefit levels and accessibility. A case in point is the decision by BCBSM to limit the offering of coverage to the medicare eligible; this action was set aside by court order.

BCBSM does "not think they should be forced to offer any benefits by law." The Legislature disagrees. Commercial insurers are required to offer coverage for prosthetic devices as well as for treatment for alcoholism and substance abuse.<sup>31</sup> In addition, P.A. 350 merely requires Blue Cross to offer or include, at an additional cost, prosthetic coverage so that those who wish to purchase such additional coverage may.<sup>32</sup> This section on benefits actually reduces the authority of the Insurance Commissioner!

3. *Contingency reserves*— Currently, the Insurance Commissioner has the right to regulate all reserves; reserves shall be maintained "in such form and amount as the commissioner of insurance may determine."<sup>33</sup> Although unclear, it appears that total BCBSM reserves equaled about \$800 million as of Decem-

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<sup>30</sup> *Id.* § 607(2) (MICH. COMP. LAWS ANN. § 550.1607(2)).

<sup>31</sup> *Id.* § 414(1) (MICH. COMP. LAWS ANN. § 550.1414(1)).

<sup>32</sup> *Id.* § 415 (MICH. COMP. LAWS ANN. § 550.1415).

<sup>33</sup> MICH. COMP. LAWS § 550.509 (1970).

ber 31, 1978 (total premiums were \$2.13 billion). The major item of controversy is contingency reserves, which amounted to \$275 million.

The Act spells out in great detail the level of contingency reserves and how the various lines of business will contribute to them.<sup>34</sup> An initial target of 11.5 percent of income is set with a range of seven to fourteen percent.<sup>35</sup> The reserves may fluctuate within this range. However, when they exceed the fourteen percent, the Blues must make adjustments to bring them nearer the target.<sup>36</sup> The target and range are permitted to shift over time as the distribution of Blues business becomes more or less risky. In addition, the portion of rates which is to be contributed toward contingency reserves is clearly and equitably specified amongst all lines of business.

It is important to note that current Blue Cross policy is to target contingency reserves at 12.5 percent. This target was established in 1977, prior to implementation of an experience rating system which has subsequently reduced substantially the risk assumed by the corporation, by providing for retrospective premium adjustments for certain groups (over forty percent of their business)!

There is a need for prudent contingency reserves, and P.A. 350 recognizes that need. But it also recognizes that these reserves are funded by subscribers' money; thus excessive reserves are inappropriate. Reserves are funded by, and belong to, subscribers. *Higher reserves mean higher premiums, which may not be justified.* Lower reserves can result in lower premiums, which should improve the competitive posture of Blue Cross!

4. *Investments*— It is important to remember that since BCBSM has no stockholders, money available for investment by Blue Cross belongs to its subscribers. Thus, it is essential that investments be prudent and safe. The investment section parallels that of domestic commercial life insurance companies, but also allows up to two percent of assets to be invested in "venture capital" in Michigan-based operations.<sup>37</sup> With the "venture capital" section, the Committee recognized the value of some more risky investments both to the state's economy and to the corporation in the form of increased yields for the corporation.

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<sup>34</sup> 1980 Mich. Pub. Acts No. 350, § 205 (codified at MICH. COMP. LAWS ANN. § 550.1205 (Mich. Legis. Serv. 1980)).

<sup>35</sup> *Id.* § 205(9) (MICH. COMP. LAWS ANN. § 550.1205(9)).

<sup>36</sup> *Id.*

<sup>37</sup> *Id.* § 206(3) (MICH. COMP. LAWS ANN. § 550.1206(3)).

Yet it is important that these more risky investments *not* be large enough to result in a potential loss of a substantial portion of reserves.

The Act would permit investments such as Trapper's Alley and the Chrysler loan. P.A. 350's investment provisions are reasonable, workable, and flexible.

5. *Safeguarding competitive data*— Through the Freedom of Information Act,<sup>38</sup> the Legislature has determined that all governmental records should be subject to public inspection unless there is a compelling reason for their privacy. This Act contains specific exemptions for the release of certain information (e.g. trade secrets, personal information, etc., would be exempt from disclosure), and any material filed by Blue Cross with the Insurance Commissioner would be subject to these exemptions. In addition, certain provider reimbursement data would be exempted from disclosure under specific conditions.<sup>39</sup>

The question of the release of information filed by Blue Cross with the Insurance Commissioner has been the subject of protracted litigation. The Court of Appeals has ruled the BCBSM filings are subject to the Freedom of Information Act and their filings to date have not contained bona fide trade secrets.<sup>40</sup>

It is important to note that other corporations, including insurance companies, file similar kinds of information or more sensitive kinds of information, and are also subject to the Freedom of Information Act. In the case of casualty insurers, for example: "Every insurer shall file with the commissioner every manual of classification, every manual of rules and rates, every rating plan and every modification of any of the foregoing. . . ."<sup>41</sup> This information is public.

a. *Competitive position*— It has been alleged that release of this information would harm the competitive position of Blue Cross. First, it is important to look at the overall competitive position of Blue Cross under P.A. 350. It is estimated that BCBSM currently has about a fourteen percent competitive advantage over private insurance companies which results from special legislative privileges such as hospital discounts and tax exemptions. Other sections of this Act result in an *improvement* in Blue Cross's advantage.

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<sup>38</sup> MICH. COMP. LAWS ANN. §§ 15.231-.246 (Supp. 1980).

<sup>39</sup> 1980 Mich. Pub. Acts No. 350, § 604 (codified at MICH. COMP. LAWS ANN. § 550.1604 (Mich. Legis. Serv. 1980)).

<sup>40</sup> *Blue Cross and Blue Shield of Michigan v. Insurance Bureau Hearing Officer*, Nos. 46857, 52454, 52714, 52485, slip op. at 10-13 (Mich. Ct. App. Mar. 3, 1981).

<sup>41</sup> MICH. COMP. LAWS § 500.2406(1) (1970).

Second, in other cases where detailed information has been filed by a company, other companies have not, as a rule, requested access to it. This may be because much of this information is already generally available to the Blues' competitors through other sources, *e.g.*, other subscribers, professional societies, other governmental bodies, other companies with which Blue Cross contracts, *et cetera*. This disclosure will not substantially affect Blue Cross' competitive position. In fact, the third party reimbursor that has used the Freedom of Information Act the most to gain information is BCBSM via requests to the Insurance Bureau on commercial health insurance policies and rates. Court decisions have ruled the BCBS has failed to demonstrate that this information may be classified as trade secrets.<sup>42</sup>

*b. Need for information*— The Act establishes explicit, objective, and detailed standards for rate approval. For the Insurance Commissioner to make a judgment regarding the legality of the proposed rates, or for an interested person to determine if he or she would like to challenge the proposed rates, this information is essential.

In summary, information established as "trade secrets" would be exempt from disclosure, as would personal information, certain provider reimbursement data, and any other information exempted by the Freedom of Information Act.<sup>43</sup> It has not been demonstrated that disclosure of any additional information will have a detrimental effect on either the Blues' competitive position or cost containment goals. It is an important legislative principle, however, that records filed with the government be available to the public, unless there is a compelling reason which overrides the principle of public access to information.

#### *D. The Blues Pulled Out All the Stops — And Continue the Fight*

Throughout the legislative history of this bill, the Blues have spared no expense to slow, stop or modify this legislation. In the early stages of the session, the Blues made a \$50 million loan to Chrysler. Even though it has proven to be a questionable business loan, it did have the effect of taking some of the vigor out of organized labor's aggressive pro-consumer advocacy. Later in

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<sup>42</sup> *Blue Cross and Blue Shield of Michigan v. Insurance Bureau Hearing Officer*, Nos. 46857, 52454, 52714, 52485, slip op. at 10-13 (Mich. Ct. App. Mar. 3, 1981).

<sup>43</sup> 1980 Mich. Pub. Acts No. 350, § 604 (codified at MICH. COMP. LAWS ANN. § 550.1604 (Mich. Legis. Serv. 1980)).

the session, when the Lansing HMO was in danger of going bankrupt, the Blues stepped in and bought it out for \$5 million. Also, the Blues sent a letter to every Michigan bank offering deposits of Blues funds in exchange for their subscriber business, a rebating practice which is explicitly outlawed for commercial insurers under chapter 20 of the Insurance Code. During Senate consideration, the Blues guaranteed a \$3.5 million loan which allowed the new Detroit Receiving Hospital to open. Though these decisions often benefited the public, they also served the Blues well.

The Blues bought radio time and advertised extensively. They bought billboards, radio and television ads, and full page newspaper ads. The newspaper advertisements directly attacked the pending legislation. The full page advertisements were reproduced and mailed to Blues subscribers. At one point the Blues even purchased a full page advertisement in a national weekly news magazine. Besides these expenses, the Blues hired experts from all over the country to testify against the pending legislation. The Blues had three people representing them at every meeting, plus eight to fourteen support people who were present to speak on any specific aspect of the legislation. No one has yet volunteered information on the cost of the opposition, which ultimately must be funded by subscribers through premium dollars.

Against this barrage of wealth and expertise, I would bring a group of senior citizen activists who inevitably would neutralize the presence and testimony of the Blues' hired guns. Overall, the seniors were more effective and believable than the hired experts the Blues brought forward.

After three years, hundreds of hours and mountains of paper work and amendments, H.R. 4555 became P.A. 350 of 1980. As a token for my efforts, the bill was to take effect on April 3, 1981, my birthday. On April 2, however, the Ingham County Circuit Court, responding to a petition by Blue Cross to enjoin the Act, placed a temporary restraining order against the law preventing its enforcement until a number of questions of law and constitutionality can be answered.<sup>44</sup>

So now the arena has shifted from the Legislature to the courts. I only hope that the courts can withstand the enormous power and wealth which the Blues will bring to bear, and allow this important consumer legislation to stand.

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<sup>44</sup> Detroit News, Apr. 3, 1981, at 3A, col. 1.

