

**STATE OF MICHIGAN**

**DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES**

**Before the Director of the Department of Insurance and Financial Services**

In the matter of the Hospital Provider  
Class Plan Determination Report  
pursuant to Public Act 350 of 1980

No. 13-031-BC

Issued and entered  
this 18<sup>th</sup> day of July 2013  
by R. Kevin Clinton  
Director

**FINAL ORDER APPROVING REVISED HOSPITAL PROVIDER CLASS PLAN**

I

**BACKGROUND**

Pursuant to Public Act 350 of 1980, as amended, MCL 550.1101 *et seq.*, the Nonprofit Health Care Corporation Reform Act (the Act), Blue Cross Blue Shield of Michigan (BCBSM) must develop and maintain a provider class plan for each type of health care provider providing services to BCBSM subscribers. A provider class plan must include a description of the reimbursement arrangements made by BCBSM to pay providers; measurable objectives for meeting the access, quality of care, and cost goals specified by section 504 of the Act; and a copy of the provider contract. Each provider class plan must also show how BCBSM proposes to balance the goals set forth in section 504 of the Act.

On January 12, 2012, pursuant to section 509(2) of the Act, the Director (Director) of the Department of Insurance and Financial Services (DIFS) issued Order No. 12-001-BC, providing notice of intent to make a determination on the hospital provider class plan submitted by BCBSM. The Director issued an Order Issuing Determination Report on July 18, 2012, Order No. 12-026-BC (the Order), finding that BCBSM's hospital provider class plan did "not substantially achieve the cost goal as provided in section 504(1) of the Act" and requiring BCBSM, consistent with section 511(1) of the Act, to submit a revised hospital provider class plan within six months that substantially achieves the statutory goals and "overcomes the deficiencies" detailed in the Order. Pursuant to section 512 of the Act, the Director extended the section 511(1) six-month deadline for an additional 90 days.

On April 18, 2013, consistent with the requirements of sections 511(1) and 512 of the Act and the Order, BCBSM submitted its revised hospital provider class plan. Pursuant to section 505(2) of the Act, the Director established a procedure to obtain input regarding the

review and development of provider class plans prepared by BCBSM. The Director specifically requested submission of public comments regarding the revised hospital provider class plan. Public comments were accepted through June 5, 2013.

II

ANALYSIS

In the Order, the Director concluded that BCBSM's hospital provider class plan, peer group 1-4 reimbursement methodology did not recognize government shortfalls related to Medicaid and Medicare programs, and that such shortfalls are necessary factors in determining whether the cost goals under section 504 of the Act have been met. Order, ¶¶ 10-11. The Director also concluded that by failing to recognize government shortfalls, the reimbursement methodology had caused or was likely to cause other health care purchasers to bear portions of BCBSM's fair share of reasonable costs to the provider and/or hospitals' reasonable financial requirements, as well as inequitable reimbursement to participating providers. *Id.*, ¶¶ 12-13. Responding to these conclusions, BCBSM's revised provider class plan included a reimbursement methodology that recognized government shortfalls.

Public comments submitted to DIFS focused on BCBSM's exclusion of non-Traditional lines of business from its peer group 1-4 reimbursement methodology in accounting for governmental Medicare and Medicaid shortfalls. In particular, commenters claimed that the Director should require BCBSM to also account for government shortfalls in the provider reimbursement agreements for its preferred provider organization (PPO), health maintenance organization (HMO), and Medicare Advantage products.

Only BCBSM's Traditional business is subject to this provider class plan review, and the Director therefore declines to expand BCBSM's obligation to account for government shortfalls beyond its Traditional business. BCBSM's PPO business is expressly excluded from provider class plan review under section 502a(10) of the Act. In addition, the Director has no express authority to review BCBSM's contracts entered into under the Prudent Purchaser Act (PPA), including its PPO arrangements. The PPA discusses only the receipt of such arrangements, not a review by the Director.<sup>1</sup> Further, the Act does not govern the provider arrangements of BCBSM's HMO, Blue Care Network, which is regulated under Chapter 35 of the Insurance Code. Finally, Medicare Advantage products are regulated under the Social Security Act and are not included in the provider class plan review set forth in the Act. Accordingly, the Director cannot subject BCBSM's PPO, HMO, or Medicare Advantage lines of business to the hospital provider class plan review standards of section 504 of the Act. Therefore, the Director can only require that the reimbursement methodology applicable to BCBSM's Traditional line of business must

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<sup>1</sup> See MCL 550.53(3), which requires only that prudent purchaser agreements be "filed by the organization with the [Director] on a form and in a manner that is uniformly developed and applied by the [Director] before the initial provider panel is formed."

account for government shortfalls.<sup>2</sup>

Commenters also noted that BCBSM's various lines of business are linked to some degree by their incorporation of a single Participating Hospital Agreement. While this may be true, it does not alter the fact that the Director cannot require the provider reimbursement agreements for BCBSM's non-Traditional lines of business to achieve the 504 goals set forth under the Act. Again, only BCBSM's Traditional business is subject to this provider class plan review; thus, the Director can only require that the reimbursement methodology applicable to BCBSM's Traditional line of business must account for government shortfalls. In addition, commenters noted that the revised Participating Hospital Agreement contains an exhibit that limits the remedies available to any hospital that is dissatisfied with the outcome of an internal appeals process to either litigation or contract termination. The commenters asserted that this provision contravenes the Act's goals of lowered costs and avoidance of market disruption, and urged the Director to require BCBSM to substitute a provision requiring binding arbitration in the event of an unresolved appeal.

The Act is silent on particular provisions that may or may not be included in BCBSM's provider agreements. Absent statutory guidance under the Act (as well as under the PPA and Chapter 35 of the Insurance Code), the Director cannot dictate the exact type of post-appeal remedy that BCBSM must include in its agreements. This is a matter for negotiation between BCBSM and its providers.

### III

#### FINDINGS OF FACT AND CONCLUSIONS OF LAW

Based upon the foregoing considerations it is FOUND and CONCLUDED that:

1. Jurisdiction and authority over this matter are vested in the Director pursuant to the Act.
2. All procedural requirements of the Act have been met.
3. DIFS staff reviewed relevant data pertaining to the revised hospital provider class plan, including written comments received during the input period on the revised provider class plan.
4. Section 509(1) of the Act provides that, in performing BCBSM provider class plan review and determination:

The [Director] may determine if the health care corporation has substantially achieved the goals of a corporation as provided in section 504 and achieved the objectives contained in the provider class plan . . .

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<sup>2</sup> To the extent that Order No. 12-026-BC deviates from this analysis, this Final Order is controlling.

5. Section 504(1) of the Act requires that:

A health care corporation shall, with respect to providers, contract with or enter into a reimbursement arrangement to assure subscribers reasonable access to, and reasonable cost and quality of, health care services, in accordance with the following goals:

(a) There will be an appropriate number of providers throughout this state to assure the availability of certificate-covered health care services to each subscriber.

(b) Providers will meet and abide by reasonable standards of health care quality.

(c) Providers will be subject to reimbursement arrangements that will assure a rate of change in the total corporation payment per member to each provider class that is not higher than the compound rate of inflation and real economic growth.

6. In addition, section 509(4) provides that:

The [Director] shall consider all of the following in making a determination pursuant to subsection [509](1):

(a) Annual reports transmitted pursuant to section 517.

(b) The overall balance of the goals provided in section 504, achieved by the health care corporation under the plan. **The [Director] shall give weight to each of the goals provided in section 504, shall not focus on 1 goal independently of the other goals of the corporation, and shall assure that no portion of the corporation's fair share of reasonable costs to the provider are borne by other health care purchasers.**

(c) Information submitted or obtained for the record concerning: demographic trends; epidemiological trends; and long-term economic trends, including changes in prices of goods and services purchased by a provider class not already reflected in the calculation in section 504(2)(d); sudden changes in circumstances; administrative agency or judicial actions; changes in health care practices and technology; and changes in benefits that affect the ability of the health care corporation to reasonably achieve the goals provided in section 504.

(d) Health care legislation of this state or of the federal government. As used in this subdivision, "health care legislation" does not include Act No. 218 of the Public Acts of 1956, as amended, being sections 500.100 to 500.8302 of the Michigan Compiled Laws.

(e) Comments received from an individual provider of the appropriate provider group, or from an organization or association that represents the appropriate provider class, and comments received pursuant to section 505(2).  
(Emphasis added).

7. Finally, with respect to hospital provider class plans, section 516(2) requires that:

(a) To the extent practicable, reimbursement control shall be expressed in the aggregate to individual hospitals.

**(b) No portion of the health care corporation's fair share of hospitals' reasonable financial requirements shall be borne by other health care purchasers.** However, this subdivision shall not preclude reimbursement arrangements which include financial incentives and disincentives.

(c) The health care corporation's programs and policies shall not unreasonably interfere with the hospital's ability and responsibility to manage its operations.  
(Emphasis added.)

8. Pursuant to Order No. 12-026-BC, BCBSM's hospital provider class plan meets the section 504 goals of quality of, and reasonable access to, health care services.

9. BCBSM's PPO, HMO, and Medicare Advantage lines of business are not subject to provider class plan review and the section 504 goals under the Act.

10. Only BCBSM's Traditional business is subject to provider class plan review and the section 504 goals under the Act.

11. The revised hospital provider class plan submitted by BCBSM fulfills the cost goals set forth in section 504 because the revised reimbursement methodology applicable to peer group 1-4 hospitals recognizes government shortfalls in accordance with the Act.

IV

ORDER

Therefore, it is ORDERED that:

1. As previously determined pursuant to Order No. 12-026-BC, BCBSM's hospital provider class plan meets the section 504 goals related to quality of, and reasonable access to, health care services.
2. BCBSM's revised hospital provider class plan, peer group 1-4 reimbursement methodology appropriately recognizes government shortfalls related to Medicaid and Medicare programs.
3. BCBSM's revised hospital provider class plan substantially achieves the cost goal in section 504(1) of the Act, and achieves its stated Cost Goal Objective.
4. BCBSM's revised hospital provider class plan substantially achieves all of the goals provided in section 504 of the Act, the objectives contained in the provider class plan, and overcomes the deficiencies enumerated in the findings made by the Director in Order No. 12-026-BC.
5. This Order is Final and shall supersede all prior Orders of the Director.

The Director retains jurisdiction of the matters contained herein and the authority to enter such further order or orders as he shall deem just, necessary, and appropriate.



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R. Kevin Clinton  
Director