Legislative Analysis

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MEDICAL BENEFIT PLAN CLAIMS DATA PROVIDED TO PUBLIC EMPLOYERS

House Bill 4752
Sponsor: Rep. Deb Shaughnessy
Committee: Education

Complete to 6-14-11

A SUMMARY OF HOUSE BILL 4752 AS INTRODUCED 6-14-11

The bill would amend the Public Employees Health Benefit Act (MCL 124.75 and 124.85) to revise the kinds of claims data that must be provided by medical benefit plans to public employers (including school districts).

The act requires, generally speaking, that a public employer with 100 or more employees in a medical benefit plan must be provided with certain claims utilization and cost information. House Bill 4752 would revise the list of information that must be provided. The bill would require that the following information be provided to the policyholders.

- A census of all covered employees, including all of the following: year of birth, gender, zip code, the contract coverage type (single, dependent, or family, and number of covered individuals) and employee job classification.

- Claims data for the employee group covered by the medical benefit plan, including all of the following:

    - For a *plan that provided health benefits*, information about hospital and medical claims presented in a manner that clearly shows all of the following for each of the three most recent experience years: number and total expenditures for hospital and medical claims, as well as the number of those claims exceeding $50,000, the total expenditures for claims exceeding $50,000, provider discounts received versus charged amount, and network access fee.

    - For a *plan that provided prescription drug benefits*, information concerning prescription drug claims under the plan, presented in a manner that clearly shows all of the following: the amount charged and the amount paid for prescription drugs claims, brand prescription drugs, and generic prescription drugs for each of the three most recent experience years; the top 50 brand and generic prescriptions for which claims were made for the most recent experience period; and rebates received by the carrier or pharmacy benefits manager for each of the three most recent experience years.

- For a *plan that provided dental benefits and for a plan that provided optical benefits*, information concerning claims and total expenditures for these claims, presented in a manner that clearly showed at least all of the following for each of the three most recent experience years: number of claims submitted and total charge; the number of and total expenditures for claims paid; total expenditures for claims submitted to network providers; total savings realized by network providers; and network access fee.

- Fees and administrative expenses for the most recent experience year, reported separately for health, dental, and optical plans, and presented in a manner that clearly shows at least all of the following: (1) the total dollar amount of fees and administrative expenses for the current rating year; (2) commissions or fees paid to agents, brokers, or consultants (including an stop loss insurance commission); (3) administration fees charged by an insurance carrier or third party administrator, including claim administration, risk, non-group conversion subsidy, and taxes; (4) specific stop loss insurance charges and attachment point; (5) aggregate stop loss insurance charges and attachment point; (6) additional fees for case management, precertification, or other claim services; and (7) other fees.

- For health, dental, and optical plans, a summary plan description or certificate for the current year's plan and, if benefits have changed during any of the three most recent experience years, a brief benefit summary for each of those experience years for which the benefits were different.

Finally, throughout the Public Employees Health Benefit Act, public employers are required to solicit bids from more than one carrier of health insurance, and to solicit at least four bids every three years. House Bill 4752 would retain these requirements, but clarify that public employers solicit *"from independent entities"* four or more bids when establishing their medical benefit plans.

CURRENT LAW:

Under current law, the following information must be provided to public employers:

- For persons covered under the medical benefit plan, census information, including date of birth, gender, zip code, and medical tier, such as single, dependent, or family.
- Monthly claims by provider type and service category reported by the total number and dollar amounts of claims paid and reported separately for in-network and out-of-network providers.
- The number of claims paid over $50,000 and the total dollar amount of those claims.
- The dollar amounts paid for specific and aggregate stop-loss insurance.
- The dollar amount of administrative expenses incurred or paid, reported separately for medical, pharmacy, dental, and vision.

- The total dollar amount for all service fees paid.
- The dollar amount of any fees or commissions paid to agents, consultants, or brokers by the plan or by any public employer or carrier participating in or providing services to the plan, reported separately for medical, pharmacy, stop-loss, dental, and vision.

These provisions would all be deleted from the act and replaced with those described earlier.

FISCAL IMPACT:

The bill would have an indeterminate fiscal impact on public employers.

To the extent that the bill would allow public employers more complete access to health care claims and experience data, the bill could create potential savings for public employers with low health care cost histories to more competitively bid out their health insurance.

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