HOUSE BILL No. 4752

June 14, 2011, Introduced by Rep. Shaughnessy and referred to the Committee on Education.

A bill to amend 2007 PA 106, entitled

"Public employees health benefit act,"

by amending sections 5 and 15 (MCL 124.75 and 124.85).

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Sec. 5. (1) Subject to collective bargaining requirements, a public employer may provide medical, optical, or dental benefits to public employees and their dependents by any of the following methods:

(a) By establishing and maintaining a plan on a self-insured basis. A plan under this subdivision does not constitute doing the business of insurance in this state and is not subject to the insurance laws of this state.

HOUSE BILL No. 4752

(b) By joining with other public employers and establishing and maintaining a public employer pooled plan to provide medical, optical, or dental benefits to not fewer than 250 public employees on a self-insured basis as provided in this act. A pooled plan shall accept any public employer that applies to become a member of the pooled plan, agrees to make the required payments, agrees to remain in the pool for a 3-year period, and satisfies the other reasonable provisions of the pooled plan. A public employer that leaves a pooled plan may not rejoin the pooled plan for 2 years after leaving the plan. A pooled plan under this subdivision does not constitute doing the business of insurance in this state and, except as provided in this act, is not subject to the insurance laws of this state. A pooled plan under this subdivision may enter into contracts and sue or be sued in its own name.

(c) By procuring coverage or benefits from 1 or more carriers, either on an individual basis or with 1 or more other public employers.

(2) A public employer or pooled plan procuring coverage or benefits from 1 or more carriers shall solicit **FROM INDEPENDENT ENTITIES** 4 or more bids when establishing a medical benefit plan, including at least 1 bid from a voluntary employees' beneficiary association described in section 501(c)(9) of the internal revenue code, 26 USC 501(c)(9). A public employer or pooled plan procuring coverage or benefits from 1 or more carriers shall solicit **FROM INDEPENDENT ENTITIES** 4 or more bids every 3 years when renewing or continuing a medical benefit plan, including at least 1 bid from a voluntary employees' beneficiary association described in section

501(c)(9) of the internal revenue code, 26 USC 501(c)(9). A public employer or pooled plan that provides for administration of a medical benefit plan using an authorized third party administrator, an insurer, a nonprofit health care corporation, or other entity authorized to provide services in connection with a noninsured medical benefit plan shall solicit **FROM INDEPENDENT ENTITIES** 4 or more bids for those administrative services when establishing a medical benefit plan. A public employer or pooled plan that provides for administration of a medical benefit plan using an authorized third party administrator, an insurer, a nonprofit health care corporation, or other entity authorized to provide services in connection with a noninsured medical benefit plan shall solicit **FROM INDEPENDENT ENTITIES** 4 or more bids for those administrative services every 3 years when renewing or continuing a medical benefit plan.

(3) This act does not prohibit a public employer from participating, for the payment of medical benefits and claims, in a purchasing pool or coalition to procure insurance, benefits, or coverage, or health care plan services or administrative services.

(4) A public university may establish a medical benefit plan to provide medical, dental, or optical benefits to its employees and their dependents by any of the methods set forth in this section.

(5) A medical benefit plan that provides medical benefits shall provide to covered individuals case management services that meet the case management accreditation standards established by the national committee on quality assurance, the joint commission on

health care organizations, or the utilization review accreditation commission.

Sec. 15. (1) Notwithstanding subsection (2), a public employer that has 100 or more employees in a medical benefit plan shall be provided with claims utilization and cost information as provided in subsection (3).

(2) A public employer ~~who~~ **THAT** is in an arrangement with 1 or more other public employers, and together have 100 or more employees in a medical benefit plan or have signed a letter of intent to enter together 100 or more public employees into a medical benefit plan, shall be provided with claims utilization and cost information as provided in subsection (3) that is aggregated for all the public employees together of those public employers, and, except as otherwise permitted under subsection (1), shall not be separated out for any of those public employers.

(3) All medical benefit plans in this state shall compile, and shall make available electronically as provided in subsections (1) and (2), complete and accurate claims utilization and cost information for the medical benefit plan in the aggregate and for each public employer as follows:

~~(a) 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.~~

~~(b) 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.~~

~~(c) The number of claims paid over $50,000.00 and the total~~

~~dollar amount of those claims.~~

~~(d) The dollar amounts paid for specific and aggregate stop-loss insurance.~~

~~(e) The dollar amount of administrative expenses incurred or paid, reported separately for medical, pharmacy, dental, and vision.~~

~~(f) The total dollar amount of retentions and other expenses.~~

~~(g) The dollar amount for all service fees paid.~~

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

~~(i) Other information as may be required by the commissioner.~~

(A) A CENSUS OF ALL COVERED EMPLOYEES, INCLUDING ALL OF THE FOLLOWING:

(*i*) YEAR OF BIRTH.

(*ii*) GENDER.

(*iii*) ZIP CODE.

(*iv*) THE CONTRACT COVERAGE TYPE FOR THE EMPLOYEE, SUCH AS SINGLE, DEPENDENT, OR FAMILY, AND NUMBER OF INDIVIDUALS COVERED BY CONTRACT.

(*iv*) EMPLOYEE JOB CLASSIFICATION.

(B) CLAIMS DATA FOR THE EMPLOYEE GROUP COVERED BY THE MEDICAL BENEFIT PLAN, INCLUDING AT LEAST ALL OF THE FOLLOWING:

(*i*) FOR A PLAN THAT PROVIDES HEALTH BENEFITS, INFORMATION CONCERNING HOSPITAL AND MEDICAL CLAIMS UNDER THE PLAN, PRESENTED IN

A MANNER THAT CLEARLY SHOWS ALL OF THE FOLLOWING FOR EACH OF THE 3 MOST RECENT EXPERIENCE YEARS:

(A) NUMBER AND TOTAL EXPENDITURES FOR HOSPITAL CLAIMS.

(B) NUMBER AND TOTAL EXPENDITURES FOR MEDICAL CLAIMS.

(C) NUMBER OF HOSPITAL CLAIMS EXCEEDING $50,000.00.

(D) NUMBER OF MEDICAL CLAIMS EXCEEDING $50,000.00.

(E) TOTAL EXPENDITURES FOR CLAIMS EXCEEDING $50,000.00.

(F) PROVIDER DISCOUNTS RECEIVED VERSUS CHARGED AMOUNT.

(G) NETWORK ACCESS FEE.

(*ii*) FOR A PLAN THAT PROVIDES PRESCRIPTION DRUG BENEFITS, INFORMATION CONCERNING PRESCRIPTION DRUGS CLAIMS UNDER THE PLAN, PRESENTED IN A MANNER THAT CLEARLY SHOWS ALL OF THE FOLLOWING:

(A) AMOUNT CHARGED AND AMOUNT PAID FOR PRESCRIPTION DRUGS CLAIMS FOR EACH OF THE 3 MOST RECENT EXPERIENCE YEARS.

(B) TOTAL AMOUNT CHARGED AND AMOUNT PAID FOR BRAND PRESCRIPTION DRUGS CLAIMS FOR EACH OF THE 3 MOST RECENT EXPERIENCE YEARS.

(C) TOTAL AMOUNT CHARGED AND AMOUNT PAID FOR GENERIC PRESCRIPTION DRUGS CLAIMS FOR EACH OF THE 3 MOST RECENT EXPERIENCE YEARS.

(D) TOP 50 BRAND PRESCRIPTIONS FOR WHICH CLAIMS WERE MADE FOR THE MOST RECENT EXPERIENCE PERIOD.

(E) TOP 50 GENERIC PRESCRIPTIONS FOR WHICH CLAIMS WERE MADE FOR THE MOST RECENT EXPERIENCE PERIOD.

(F) REBATES RECEIVED BY THE CARRIER OR PHARMACY BENEFITS MANAGER FOR EACH OF THE 3 MOST RECENT EXPERIENCE YEARS.

(*iii*) FOR A PLAN THAT PROVIDES DENTAL BENEFITS, INFORMATION

CONCERNING DENTAL CLAIMS AND TOTAL EXPENDITURES FOR THESE CLAIMS UNDER THE PLAN, PRESENTED IN A MANNER THAT CLEARLY SHOWS AT LEAST ALL OF THE FOLLOWING FOR EACH OF THE 3 MOST RECENT EXPERIENCE YEARS:

(A) NUMBER OF CLAIMS SUBMITTED AND TOTAL CHARGED.

(B) NUMBER OF AND TOTAL EXPENDITURES FOR CLAIMS PAID.

(C) TOTAL EXPENDITURES FOR CLAIMS SUBMITTED TO NETWORK PROVIDERS.

(D) TOTAL SAVINGS REALIZED BY NETWORK PROVIDERS.

(E) NETWORK ACCESS FEE.

(*iv*) FOR A PLAN THAT PROVIDES OPTICAL BENEFITS, INFORMATION CONCERNING OPTICAL CLAIMS AND TOTAL EXPENDITURES FOR THESE CLAIMS UNDER THE PLAN, PRESENTED IN A MANNER THAT CLEARLY SHOWS AT LEAST ALL OF THE FOLLOWING FOR EACH OF THE 3 MOST RECENT EXPERIENCE YEARS:

(A) NUMBER OF CLAIMS SUBMITTED AND TOTAL CHARGED.

(B) NUMBER OF AND TOTAL EXPENDITURES FOR CLAIMS PAID.

(C) TOTAL EXPENDITURES FOR CLAIMS SUBMITTED TO NETWORK PROVIDERS.

(D) TOTAL SAVINGS REALIZED BY NETWORK PROVIDERS.

(E) NETWORK ACCESS FEE.

(C) 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:

(*i*) TOTAL DOLLAR AMOUNT OF FEES AND ADMINISTRATIVE EXPENSES FOR THE CURRENT RATING YEAR.

(*ii*) COMMISSIONS OR FEES PAID TO AGENTS, BROKERS, OR CONSULTANTS. IN ADDITION TO ALL OTHER COMMISSIONS OR FEES, THIS INFORMATION SHALL INCLUDE ANY STOP LOSS INSURANCE COMMISSION.

(*iii*) ADMINISTRATION FEES CHARGED BY AN INSURANCE CARRIER OR THIRD PARTY ADMINISTRATOR, INCLUDING, BUT NOT LIMITED TO, CLAIM ADMINISTRATION, RISK, NONGROUP CONVERSION SUBSIDY, AND TAXES.

(*iv*) SPECIFIC STOP LOSS INSURANCE CHARGES AND ATTACHMENT POINT.

(*v*) AGGREGATE STOP LOSS INSURANCE CHARGES AND ATTACHMENT POINT.

(*vi*) ADDITIONAL FEES FOR CASE MANAGEMENT, PRECERTIFICATION, OR OTHER CLAIM SERVICES.

(*vii*) OTHER FEES.

(D) 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 3 MOST RECENT EXPERIENCE YEARS, A BRIEF BENEFIT SUMMARY FOR EACH OF THOSE EXPERIENCE YEARS FOR WHICH THE BENEFITS WERE DIFFERENT.

(4) ~~The~~ **EXCEPT AS OTHERWISE PROVIDED IN SUBSECTION (3),** claims utilization and cost information required to be compiled under this section shall be compiled on an annual basis and shall cover a relevant period. For purposes of this subsection, the term "relevant period" means the 36-month period ending no more than 120 days prior to the effective date or renewal date of the medical benefit plan under consideration. However, if the medical benefit plan has been in effect for a period of less than 36 months, the relevant period shall be that shorter period.

(5) A public employer or combination of public employers shall

disclose the claims utilization and cost information required to be provided under subsections (1) and (2) to any carrier or administrator it solicits to provide benefits or administrative services for its medical benefit plan, and to the employee representative of employees covered under the medical benefit plan, and upon request to any carrier or administrator who requests the opportunity to submit a proposal to provide benefits or administrative services for the medical benefit plan at the time of the request for bids. The public employer shall make the claims utilization and cost information required under this section available at cost and within a reasonable period of time.

(6) The claims utilization and cost information required under this section shall include only de-identified health information as permitted under the health insurance portability and accountability act of 1996, Public Law 104-191, or regulations promulgated under that act, 45 CFR parts 160 and 164, and shall not include any protected health information as defined in the health insurance portability and accountability act of 1996, Public Law 104-191, or regulations promulgated under that act, 45 CFR parts 160 and 164.

(7) All claims utilization and cost information described in this section is required to be compiled beginning 60 days after the effective date of this act. However, claims utilization and cost information already being compiled on the effective date of this act is subject to this section on the effective date of this act.