SB-1205, As Passed House, December 21, 2018
SB-1205, As Passed Senate, December 6, 2018

SENATE BILL No. 1205

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November 27, 2018, Introduced by Senator PAVLOV and referred to the Committee on Michigan Competitiveness.

A bill to amend 2007 PA 106, entitled

"Public employees health benefit act,"

by amending sections 3 and 15 (MCL 124.73 and 124.85), section 15 as amended by 2011 PA 93.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Sec. 3. As used in this act:

(a) "Carrier" means a health, dental, or vision insurance company authorized to do business in this state under, and a health maintenance organization or multiple employer welfare arrangement operating under, the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302; a system of health care delivery and financing operating under section 3573 of the insurance code of 1956, 1956 PA 218, MCL 500.3573; a nonprofit dental care corporation operating

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under 1963 PA 125, MCL 550.351 to 550.373; a nonprofit health care corporation operating under the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1101 to 550.1704; a voluntary employees' beneficiary association described in section 501(c)(9) of the internal revenue code, 26 USC 501(c)(9); a pharmacy benefits manager; and any other person providing a plan of health benefits, coverage, or insurance in this state.

(b) "Commissioner" means the ~~commissioner~~ **DIRECTOR** of the ~~office~~ **DEPARTMENT** of ~~financial and~~ insurance **AND FINANCIAL** services.

(C) "COVERED INDIVIDUAL" MEANS AN INDIVIDUAL COVERED BY A CONTRACT UNDER SECTION 15(3)(A)(*iv*).

(D) ~~(c)~~ "Medical benefit plan" means a plan, established and maintained by a carrier or 1 or more public employers, that provides for the payment of medical, optical, or dental benefits, including, but not limited to, hospital and physician services, prescription drugs, and related benefits, to public employees.

(E) ~~(d)~~ "Public employee" means an employee of a public employer.

(F) ~~(e)~~ "Public employer" means a city, village, township, county, or other political subdivision of this state; any intergovernmental, metropolitan, or local department, agency, or authority, or other local political subdivision; a school district, a public school academy, or an intermediate school district, as those terms are defined in the revised school code, 1976 PA 451, MCL 380.1 to 380.1852; or a community college or junior college described in section 7 of article VIII of the state constitution of

1963. Public employer includes a public university that elects to come under the provisions of this act.

(G) ~~(f)~~ "Public employer pooled plan" or "pooled plan" means a public employer pooled plan established pursuant to section 5(1)(b).

(H) ~~(g)~~ "Public university" means a public university described in section 4, 5, or 6 of article VIII of the state constitution of 1963.

(I) "SPECIALTY PRESCRIPTION DRUG" MEANS A PRESCRIPTION DRUG USED TO TREAT A RARE, COMPLEX, OR CHRONIC MEDICAL CONDITION THAT MEETS ANY OF THE FOLLOWING REQUIREMENTS:

(*i*) REQUIRES SPECIAL ADMINISTRATION INCLUDING, BUT NOT LIMITED TO, INHALATION OR INFUSION.

(*ii*) REQUIRES SPECIAL DELIVERY OR SPECIAL STORAGE.

(*iii*) REQUIRES SPECIAL OVERSIGHT, INTENSIVE MONITORING, OR CARE COORDINATION WITH A PERSON LICENSED UNDER ARTICLE 15 OF THE PUBLIC HEALTH CODE, 1978 PA 368, MCL 333.16101 TO 333.18838.

Sec. 15. (1) Notwithstanding subsection (2), a public employer that has ~~100~~ **50** or more employees in ~~a~~ medical benefit ~~plan~~ **PLANS** shall be provided with claims utilization and cost information as provided in subsection (3).

(2) ~~A public employer that is~~ **TWO OR MORE PUBLIC EMPLOYERS THAT ARE** in an arrangement ~~with 1 or more other public employers,~~ and together have ~~100~~ **50** or more employees in ~~a~~ medical benefit ~~plan~~ **PLANS** or have signed a letter of intent to enter together ~~100~~ **50** or more public employees into ~~a~~ medical benefit ~~plan,~~ **PLANS,** shall **EACH** 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),~~ **IN AN ELECTRONIC, SPREADSHEET-COMPATIBLE FORMAT** complete and accurate claims utilization and cost information for the medical benefit plan in the aggregate and for each public employer **ENTITLED TO THAT INFORMATION UNDER SUBSECTION (1) OR (2) AND EACH SUBGROUP OF PUBLIC EMPLOYEES OF SUCH A PUBLIC EMPLOYER IF THE SUBGROUP HAS 50 OR MORE PUBLIC EMPLOYEES COVERED BY THE MEDICAL BENEFIT PLAN,** as follows:

(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,~~ **2-PERSON,** or family, and number of individuals covered by contract.

(b) ~~Claims~~ **INCURRED AND PAID 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~~ **MEDICAL** benefits, information concerning **ENROLLMENT AND** 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) FOR EACH MONTH, THE TOTAL NUMBER OF COVERED EMPLOYEES AND THE NUMBER OF COVERED EMPLOYEES IN EACH CONTRACT COVERAGE TYPE INCLUDED IN THE CENSUS UNDER SUBDIVISION (A)(*iv*).

(B) FOR EACH MONTH, THE TOTAL NUMBER OF COVERED INDIVIDUALS AND THE NUMBER OF COVERED INDIVIDUALS IN EACH CONTRACT COVERAGE TYPE INCLUDED IN THE CENSUS UNDER SUBDIVISION (A)(*iv*).

(C) ~~(A)~~ Number and total expenditures for ~~hospital~~ **INPATIENT** claims **FOR EACH MONTH.**

(D) ~~(B)~~ Number and total expenditures for ~~medical~~ **OUTPATIENT** claims **FOR EACH MONTH.**

~~(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.~~

(E) NUMBER AND TOTAL EXPENDITURES FOR ALL OTHER MEDICAL CLAIMS FOR EQUIPMENT, DEVICES, AND SERVICES, INCLUDING SERVICES RENDERED IN THE PRIVATE OFFICE OF A PHYSICIAN OR OTHER HEALTH PROFESSIONAL, FOR EACH MONTH.

(*ii*) For a plan that provides prescription drug benefits, information concerning **ENROLLMENT AND** prescription drugs claims under the plan, presented in a manner that clearly shows all of the following:

(A) FOR EACH MONTH, THE TOTAL NUMBER OF COVERED EMPLOYEES AND THE NUMBER OF COVERED EMPLOYEES IN EACH CONTRACT COVERAGE TYPE INCLUDED IN THE CENSUS UNDER SUBDIVISION (A)(*iv*).

(B) FOR EACH MONTH, THE TOTAL NUMBER OF COVERED INDIVIDUALS AND THE NUMBER OF COVERED INDIVIDUALS IN EACH CONTRACT COVERAGE

TYPE INCLUDED IN THE CENSUS UNDER SUBDIVISION (A)(*iv*).

(C) ~~(A)~~ Amount charged and amount paid for prescription drugs claims for each ~~of the 3 most recent experience years.~~**MONTH.**

(D) ~~(B)~~ Total amount charged and amount paid for brand prescription drugs claims for each ~~of the 3 most recent experience years.~~**MONTH.**

(E) ~~(C)~~ Total amount charged and amount paid for generic prescription drugs claims for each ~~of the 3 most recent experience years.~~**MONTH.**

(F) TOTAL AMOUNT CHARGED AND AMOUNT PAID FOR SPECIALTY PRESCRIPTION DRUG CLAIMS FOR EACH MONTH.

(G) ~~(D)~~ The 50 ~~most frequently prescribed brand~~ prescription drugs for which claims were ~~made for the~~ most ~~recent experience period.~~**FREQUENTLY PAID.**

(H) ~~(E)~~ The 50 ~~most frequently prescribed generic~~ prescription drugs ~~for which claims were made for the most recent experience period.~~**FOR WHICH EXPENDITURES WERE THE LARGEST.**

(*iii*) FOR A PLAN THAT PROVIDES MEDICAL OR PRESCRIPTION DRUG BENEFITS, IN ADDITION TO THE INFORMATION REQUIRED UNDER SUBPARAGRAPHS (*i*) AND (*ii*), AS APPLICABLE, INFORMATION CONCERNING COVERED INDIVIDUALS WITH TOTAL MEDICAL OR PRESCRIPTION DRUG CLAIMS, OR BOTH, EXCEEDING $25,000.00 FOR ANY 12-MONTH PERIOD FOR WHICH CLAIMS UTILIZATION AND COST INFORMATION ARE PROVIDED, PRESENTED IN A MANNER THAT CLEARLY SHOWS ALL OF THE FOLLOWING SEPARATELY FOR EACH COVERED INDIVIDUAL:

(A) TOTAL MEDICAL EXPENDITURES FOR THE INDIVIDUAL.

(B) TOTAL PRESCRIPTION DRUG EXPENDITURES FOR THE INDIVIDUAL.

(C) WHETHER THE COVERED INDIVIDUAL IS CURRENTLY COVERED BY THE MEDICAL BENEFIT PLAN.

(D) THE COVERED INDIVIDUAL'S DIAGNOSES.

(*iv*) ~~*(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.

(*v*) ~~*(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.

(c) Fees and administrative expenses for the most recent experience year, reported separately for ~~health,~~ **MEDICAL, PRESCRIPTION DRUG,** dental, and optical plans, and presented in a manner that clearly shows at least all of the following:

(*i*) The dollar amounts paid for specific and aggregate stop-loss insurance.

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

(*iii*) The total dollar amount of retentions and other expenses.

(*iv*) The dollar amount for all service fees paid.

(*v*) The dollar amount of any fees or commissions paid to agents, consultants, third party administrators, 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,~~ **PRESCRIPTION DRUG**, stop-loss, dental, and vision.

(*vi*) Other information as may be required by the commissioner.

(d) For ~~health,~~ **MEDICAL, PRESCRIPTION DRUG**, dental, and optical plans, a benefit summary for the current year's plan and, if benefits have changed during any of the ~~3~~ **2** most recent ~~experience years,~~ **12-MONTH PERIODS FOR WHICH CLAIMS UTILIZATION AND COST INFORMATION ARE PROVIDED**, a brief benefit summary for each of those ~~experience years~~ **PERIODS** for which the benefits were different.

(4) Except as otherwise provided in subsection (3) **AND SUBJECT TO SUBSECTION (5)**, claims utilization and cost information required to be compiled under this section ~~shall~~ **MUST** be compiled ~~on an~~ **AS FOLLOWS:**

(A) ON AN annual basis.

(B) AT THE REQUEST OF A PUBLIC EMPLOYER. A PUBLIC EMPLOYER MAY NOT REQUEST CLAIMS UTILIZATION AND COST INFORMATION MORE THAN 4

TIMES PER CALENDAR YEAR. CLAIMS UTILIZATION AND COST INFORMATION COMPILED UPON THE REQUEST OF A PUBLIC EMPLOYER MUST BE COMPILED WITHIN 30 DAYS AFTER THE REQUEST. ~~and shall~~

(5) CLAIMS UTILIZATION AND COST INFORMATION COMPILED UNDER THIS SECTION MUST cover a relevant period. For purposes of this subsection, the term "relevant period" means the ~~36-month~~ **24-MONTH** period ending no more than ~~120~~ **60** days ~~prior to~~ **BEFORE** the ~~effective date or renewal date of~~ **COMPILATION OF THE INFORMATION FOR** the medical benefit plan under consideration. However, if the medical benefit plan has been in effect for a period of less than ~~36~~ **24** months, the relevant period shall be that shorter period.

(6) ~~(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.

(7) ~~(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.~~

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