

SENATE BILL No. 446

June 15, 2011, Introduced by Senator PAVLOV 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:

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

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

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

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

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

1 501(c)(9) of the internal revenue code, 26 USC 501(c)(9). A public
2 employer or pooled plan that provides for administration of a
3 medical benefit plan using an authorized third party administrator,
4 an insurer, a nonprofit health care corporation, or other entity
5 authorized to provide services in connection with a noninsured
6 medical benefit plan shall solicit **FROM INDEPENDENT ENTITIES** 4 or
7 more bids for those administrative services when establishing a
8 medical benefit plan. A public employer or pooled plan that
9 provides for administration of a medical benefit plan using an
10 authorized third party administrator, an insurer, a nonprofit
11 health care corporation, or other entity authorized to provide
12 services in connection with a noninsured medical benefit plan shall
13 solicit **FROM INDEPENDENT ENTITIES** 4 or more bids for those
14 administrative services every 3 years when renewing or continuing a
15 medical benefit plan.

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

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

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

1 health care organizations, or the utilization review accreditation
2 commission.

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

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

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

21 ~~—— (a) For persons covered under the medical benefit plan, census~~
22 ~~information, including date of birth, gender, zip code, and medical~~
23 ~~tier, such as single, dependent, or family.~~

24 ~~—— (b) Monthly claims by provider type and service category~~
25 ~~reported by the total number and dollar amounts of claims paid and~~
26 ~~reported separately for in-network and out-of-network providers.~~

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

~~dollar amount of these 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

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

3 (A) NUMBER AND TOTAL EXPENDITURES FOR HOSPITAL CLAIMS.

4 (B) NUMBER AND TOTAL EXPENDITURES FOR MEDICAL CLAIMS.

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

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

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

8 (F) PROVIDER DISCOUNTS RECEIVED VERSUS CHARGED AMOUNT.

9 (G) NETWORK ACCESS FEE.

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

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

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

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

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

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

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

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

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

5 (A) NUMBER OF CLAIMS SUBMITTED AND TOTAL CHARGED.

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

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

9 (D) TOTAL SAVINGS REALIZED BY NETWORK PROVIDERS.

10 (E) NETWORK ACCESS FEE.

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

16 (A) NUMBER OF CLAIMS SUBMITTED AND TOTAL CHARGED.

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

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

20 (D) TOTAL SAVINGS REALIZED BY NETWORK PROVIDERS.

21 (E) NETWORK ACCESS FEE.

22 (C) FEES AND ADMINISTRATIVE EXPENSES FOR THE MOST RECENT
23 EXPERIENCE YEAR, REPORTED SEPARATELY FOR HEALTH, DENTAL, AND
24 OPTICAL PLANS, AND PRESENTED IN A MANNER THAT CLEARLY SHOWS AT
25 LEAST ALL OF THE FOLLOWING:

26 (i) TOTAL DOLLAR AMOUNT OF FEES AND ADMINISTRATIVE EXPENSES FOR
27 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

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

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

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