Legislative Analysis

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PROVISION AND NONDISCLOSURE OF LARGE EMPLOYER GROUP CLAIMS UTILIZATION AND COST INFORMATION

Senate Bill 447 (S-3) as reported from House committee
Sponsor: Sen. Dan Lauwers
House Committee: Insurance
Senate Committee: Insurance and Banking
Complete to 6-7-22

SUMMARY:

Senate Bill 447 would amend Chapter 34 (Disability Insurance Policies) of the Insurance Code to require an insurer to provide certain claims utilization and cost information to a large employer group that requests it, as long as the large employer group signs a nondisclosure agreement (NDA) by which it agrees to keep information received under the bill confidential.

Under the bill, upon the request of a ***large employer group*** and within 30 days after that request, an insurer in Michigan would have to compile accurate and complete claims utilization and cost information for the medical benefit plan in the aggregate and for each large employer group entitled to the information under the bill and each subgroup of 100 or more employees of the large employer group who are covered by the plan. The information would have to be made available to a large employer group in an electronic, spreadsheet-compatible format. However, a large employer group that is part of a ***combined large employer group*** would have to be provided with information that is aggregated for all the employees enrolled in the combined large employer group, and the information could not be separated out for any of those employers included in the combined large employer group.

Large employer group would mean an employer that is issued a policy by a ***carrier*** under Chapter 34 with enrollment of 100 or more ***full-time employees***.

Carrier would mean any of the following:

- An insurer that offers a ***medical benefit plan***.
- An employee welfare benefit plan as defined in section 3 of the federal Employee Retirement Income Security Act, 29 USC 1002.[1]
- A person operating a system of health care delivery and financing under section 3573 of the Insurance Code.
- A voluntary employees' beneficiary association described in section 501(c)(9) of the federal Internal Revenue Code, 26 USC 501.[2]

Full-time employees would mean that term as calculated in 26 USC 4890h(c)(4), including application of the special rules for determining group size as defined in 26 USC 4980h(c)(2) and the specification that full-time equivalents are treated as full-time employees in determining group size, as described in 26 USC 4980h(c)(2)(e).[3]

[1] https://www.law.cornell.edu/uscode/text/29/1002
[2] https://www.law.cornell.edu/uscode/text/26/501
[3] https://www.law.cornell.edu/uscode/text/26/4980H

Medical benefit plan would mean a plan established and maintained by a large employer group that provides for the payment to its employees of medical benefits such as hospital and physician services, prescription drugs, and related benefits. Medical benefit plan would not include either of the following:

- A medical benefit plan as defined in section 3 of the Public Employees Health Benefit Act that is required to compile and make available claims utilization and cost information under section 15 of that act.
- A plan that covers only a specified accident, accident only, credit, dental, disability income, long-term care, or vision benefits.

Combined large employer group would mean either of the following:

- Two or more employers that are in an arrangement and together have 100 or more employees in medical benefit plans or have a signed letter of intent to enter together 100 or more employees into medical benefit plans.
- A medical benefit plan in which the employees of two or more employers are enrolled.

Required information

The information provided under the bill would have to include all of the following:

- Incurred and paid claims data for the employee group covered by the medical benefit plan, including at least all of the following:
  - Information about hospital and medical claims under a plan providing medical benefits, presented in a way that clearly shows all of the following:
    - The number and total expenditures for inpatient claims for each month.
    - The number and total expenditures for outpatient claims for each month.
    - The number and total expenditures for all other medical claims for equipment, devices, and services, including services rendered in the private office of a health professional, for each month.
    - The tax identification number or ***national provider identifier*** of each ***provider*** rendering service or care.
  - Information about prescription drug claims under a plan providing prescription drug benefits, presented in a way that clearly shows all of the following:
    - The amount paid for prescription drug claims for each month.
    - The amount paid for brand prescription drug claims for each month.
    - The amount paid for generic prescription drug claims for each month.
    - The amount paid for ***specialty prescription drug*** claims for each month.
    - The 50 prescription drugs for which claims were paid most frequently.
    - The 50 prescription drugs for which expenditures were the largest.
  - In addition to the above, information concerning ***covered individuals*** with total medical or prescription drug claims, under a plan providing the applicable benefits, exceeding $25,000 for any 12-month period for which claims utilization and cost information are provided, presented in a way that clearly shows all of the following separately for each covered individual:
    - The total medical expenditures for the individual.
    - The total prescription drug expenditures for the individual.
    - Whether the covered individual is currently covered by the plan.
    - The covered individual's diagnoses.

- 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 large employer group or carrier participating in or providing services to the medical benefit plan, reported separately for medical, prescription drug, and stop-loss.
- Fees and administrative expenses for the most recent experience year, reported separately for medical and prescription drug plans and presented in a manner that clearly shows at least all of the following:
  - The dollar amounts paid for specific and aggregate stop-loss insurance.
  - The dollar amount of administrative expenses incurred or paid, reported separately for medical and pharmacy.
  - The total dollar amount of retentions and other expenses.
  - The dollar amount for all service fees paid.
- For medical and prescription drug plans, a benefit summary for the current year's plan and, if benefits have changed during any of the two most recent 12-month periods for which claims utilization and cost information are provided, a brief benefit summary for each of those periods for which the benefits were different.

- A census of all covered employees, including all of the following:
  - Year of birth of each employee.
  - Gender of each employee.
  - Zip code in which each employee resides.
  - The contract coverage type for each employee, such as single, two-person, or family, and the number of individuals covered by the contract.
  - For each month, the total number of covered employees and the number of covered employees in each contract coverage type.
  - For each month, the total number of covered individuals and the number of covered individuals in each contract coverage type.
  - 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:
    - For each month, the total number of covered employees and the number of covered employees in each contract coverage type.
    - For each month, the total number of covered individuals and the number of covered individuals in each contract coverage type.
    - Other information as required by the director.

National provider identifier would mean that term as described in 45 CFR part 162.[4]

Provider would mean "provider of services" as that term is defined in 42 USC 1395x.[5]

Specialty prescription drug would mean a prescription drug used to treat a rare, complex, or chronic medical condition that meets any of the following requirements:

- It requires special administration such as inhalation or infusion.
- It requires special delivery or special storage.
- It requires special oversight, intensive monitoring, or care coordination with a person licensed under Article 15 of the Public Health Code.

[4] https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-C/part-162
[5] https://www.law.cornell.edu/uscode/text/42/1395x

Covered individual would mean an employee covered under a medical benefit plan.

Confidentiality and privacy

As noted above, the information would have to be provided to the large employer group upon presentation to the insurer of a signed NDA. In signing the NDA, the large employer group would have to agree to keep all information received under the bill confidential. The required information could include only health information as permitted under the federal Health Insurance Portability and Accountability Act (HIPAA) or regulations promulgated under it and could not include any protected health information as defined in HIPAA or its regulations.[6]

Relevant period

A large employer group could not request claims utilization and cost information more than once per calendar year. Claims utilization and cost information compiled under the bill would have to cover the 24-month period ending no more than 60 days before the compilation of the information, unless the medical benefit plan under consideration has been in effect for less than 24 months, in which case the information would have to cover that shorter period.

Additional information

Upon request of a large employer group or combined large employer group, and upon presentation of a signed NDA, an insurer would have to provide the tax identification number or national provider identifier of each provider rendering service or care.

Disclosure by employer group

A large employer group or combined large employer group would have to disclose the claims utilization and cost information required to be provided under the bill to any carrier or administrator it solicits to provide benefits or administrative services for its medical benefit plan and, upon request, to any carrier or administrator that 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 large employer group or combined large employer group would have to make the information available within 30 days after the request.

Civil immunity

An insurer that delivers, issues for delivery, or renews a health insurance policy in Michigan and that provides information in response to a request from a large employer group under the bill would be immune from civil liability for complying with the request and for the acts or omissions of any person's subsequent use of the data or information.

The bill would take effect 90 days after being enacted.

Proposed MCL 500.3471

FISCAL IMPACT:

Senate Bill 447 would not have a fiscal impact on any units of state or local government.

[6] See https://www.hhs.gov/hipaa/index.html

POSITIONS:

Representatives of the following entities testified in support of the bill (4-28-22):

- Michigan Association of Health Plans
- Michigan Association of Health Underwriters

The following entities indicated support for the bill:

- Health Alliance Plan (HAP) (4-28-22)
- Upper Peninsula Health Plan (5-19-22)

Legislative Analyst: Rick Yuille
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■ This analysis was prepared by nonpartisan House Fiscal Agency staff for use by House members in their deliberations and does not constitute an official statement of legislative intent.