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BILL ANALYSIS

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Senate Bill 447 (as introduced 5-18-21)
Sponsor: Senator Dan Lauwers
Committee: Insurance and Banking

Date Completed: 10-19-21

CONTENT

The bill would amend Chapter 34 (Disability Insurance Policies) of the Insurance Code to the following:

- **Require an insurer to provide, on request, a large employer group with claims utilization and cost information on presentation of a signed nondisclosure agreement (NDA).**
- **Require an insurer to compile and make available to the large employer group, within 30 days after a request, complete and accurate claims utilization and cost information for the medical benefit plan in the aggregate and for each large employer group entitled to that information and each subgroup of employees of the large employer group if the subgroup had 100 or more employees covered by the medical benefit plan, including incurred and paid claims data for the employee group covered by the medical benefit plan and a census of all covered employees.**
- **Require a large employer group or combined large employer group to disclose the claims utilization and cost information to any carrier or administrator it solicited to provide benefits or administrative services for its medical benefit plan.**
- **Require a large employer group or combined large employer group to disclose the claims utilization and cost information on request to a carrier or administrator who requested 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, within 30 days of the request.**
- **Require an insurer to provide, on request, the tax identification number or national provider identifier of each provider rendering service or care on presentation of a signed NDA to an insurer.**
- **Prohibit an agent of record from requesting claims utilization and cost information more than once per calendar year.**
- **Specify that claims utilization and cost information required to be produced under the bill to include only health information as permitted under the Health Insurance Portability and Accountability Act (HIPAA).**

Definitions

"Carrier" would mean any of the following:

- An insurer.
- An employee welfare benefit plan as that term is defined in Section 7001 of the Code.

-- A person operating a system of health care delivery and financing.
-- A nonprofit dental care corporation.
-- A voluntary employees' beneficiary association described in Section 501(c)(9) of the Internal Revenue Code.

(Under Section 7001 of the Code, "employee welfare benefit plan" means that term as defined in Section 3 of the Employee Retirement Income Security Act: any plan, fund, or program which was or will be established or maintained by an employer or by an employee organization, or both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purpose of insurance or otherwise: a) medical, surgical, or hospital care or benefits or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal service or b) any benefits described in 29 USC 186(c) (which prescribes exceptions to the prohibition on an employer paying, lending, or delivering money or other thing of value to labor organizations) other than pensions on retirement or death, and insurance to provide such pensions.

Section 501(c)(9) exempts from Federal income tax voluntary employees' beneficiary associations providing for the payment of life, sick, accident or other benefits to their members or their dependents or designated beneficiaries, if no part of the net earnings inures (other than through such payments) to the benefit of any private shareholder or individual.)

"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.

"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. "Full-time employees" would mean the term as used in Section 3701 of the Code: the 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 for purposes of determining group size, as described in 26 USC 4980h(c)(2)(e). (Title 26 USC 4890h(c)(4) defines "full-time employee" as, with respect to any month, an employee who is employed on average at least 30 hours of service per week. Title 26 USC 4980h(c)(2), defines "applicable large employer" as, with respect to a calendar year, an employee who employed an average of at least 50 full-time employees on business days during the preceding calendar year. Under 26 USC 4980h(c)(2)(e), solely for the purposes of determining whether an employer is an applicable large employer, an employer must include, in addition to the number of full-time employees for any month otherwise determined, for such month a number of full-time employees determined by dividing the aggregate number of hours of service of employees who are not full-time employees for the month by 120.)

"Medical benefit plan" would mean a plan, established and maintained by a large employer group, that provides for the payment of medical benefits, including, but not limited to, hospital and physician services, prescription drugs, and related benefits, to its employees.

"National Provider Identifier" would mean that term as described in 45 CFR Part 162. (The National Provider Identifier is the standard unique health identifier for health care providers.)

"Provider" would mean provider of services as that term is defined in 42 USC 1395x. (A hospital, critical access hospital, rural emergency hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, hospice program, or, for certain purposes, a fund.)

"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:

-- Requires special administration including, but not limited to, inhalation or infusion.
-- Requires special delivery or special storage.
-- Requires special oversight, intensive monitoring, or care coordination with a person licensed under Article 15 (Occupations) of the Public Health Code.

Claims Utilization & Cost Information

Under the bill, on request of a large employer group, an insurer would have to provide the large employer group with claims utilization and cost information on presentation of a signed NDA to the insurer. In signing the NDA, the large employer group would have to agree to keep confidential all information received under the bill.

A large employer group that was part of a combined large employer group would have to be provided with claims utilization and cost information that was 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.

An insurer in the State would have to compile, and make available to a large employer group 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 large employer group entitled to that information and each subgroup of employees of the large employer group if the subgroup had 100 or more employees covered by the medical benefit plan, as described below.

Incurred and paid claims data for the employee group covered by the medical benefit plan, including at least all of the following:

-- For a plan that provided medical benefits, information concerning hospital and medical claims under the plan, presented in a manner that clearly showed all of the following: a) number and total expenditures for inpatient claims for each month, b) number and total expenditures for outpatient claims for each month, c) 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, and d) the tax identification number or National Provider Identifier of each provider rendering service or care.
-- For a plan that provided prescription drug benefits, information concerning prescription drug claims under the plan, presented in a manner that clearly showed all of the following: a) amount charged and amount paid for prescription drug claims for each month, b) amount charged and amount paid for brand prescription drug claims for each month, c) amount charged and amount paid for generic prescription drug claims for each month, d) amount charged and amount paid for specialty prescription drug claims for each month, e) the 50 prescription drugs for which claims were most frequently paid, and f) the 50 prescription drugs for which expenditures were the largest.
-- For a plan that provided medical or prescription drug benefits, in addition to the information required above, as applicable, information concerning covered individuals with total medical or prescription drug claims, or both, exceeding $25,000 for any 12-month

period for which claims utilization and cost information were provided, presented in a manner that clearly showed 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 currently was covered by the medical benefit plan, and d) the covered individual's diagnoses.

-- 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 showed at least all of the following: a) the dollar amounts paid for specific and aggregate stop-loss insurance, b) the dollar amount of administrative expenses incurred or paid, reported separately for medical and pharmacy, c) the total dollar amount of retentions and other expenses, and d) the dollar amount for all service fees paid.
-- 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.
-- For medical and prescription drug plans, a benefit summary for the current year's plan and, if benefits had 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.

The claims utilization and cost information also would have to include a census of all covered employees, including all of the following:

-- Year of birth and gender of each employee.
-- Zip code in which each employee resided.
-- The contract coverage type for each employee, such as single, two-person, or family, and number of individuals covered by 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 provided prescription drug benefits, information concerning enrollment and prescription drugs claims under the plan, presented in a manner that clearly showed 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, b) for each month, the total number of covered individuals and the number of covered individuals in each contract coverage type, and c) other information as required by the Director.

Except as otherwise provided, claims utilization and cost information required to be compiled under the bill would have to be compiled at the large employer group's request. The large employer group could not request claims utilization and cost information more than once per calendar year. Claims utilization and cost information compiled on the large employer group's request would have to be compiled within 30 days after the request.

Claims utilization and cost information compiled under the bill would have to cover a relevant period. For purposes of this provision, "relevant period" would mean the 24-month period ending no more than 60 days before the compilation of the information for the medical benefit plan under consideration. However, if the medical benefit plan had been in effect for less than 24 months, the relevant period would be that shorter period.

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 solicited to provide benefits or administrative services for its medical benefit plan, and on request to any carrier or administrator who requested 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 agent of record would have to make the claims utilization and cost information available within 30 days after the request.

On a large employer group's or combined large employer group's request, an insurer would have to provide the tax identification number or National Provider Identifier of each provider rendering service or care on presentation of a signed NDA to the insurer.

The claims utilization and cost information required to be produced under the bill would have to include only health information as permitted under HIPAA or regulations promulgated under that Act, and could not include any protected health information as defined in HIPAA or regulations promulgated under that Act.

An insurer that delivered, issued for delivery, or renewed in the State a health insurance policy that provided information in response to a large employer group's request 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.

Proposed MCL 500.3471 Legislative Analyst: Stephen Jackson

FISCAL IMPACT

The bill would have no fiscal impact on State or local government.

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