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BILL ANALYSIS

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Senate Bill 446 (as reported without amendment) *(as enrolled)*
Sponsor: Senator Phil Pavlov
Committee: Education

CONTENT

The bill would amend the Public Employees Health Benefit Act to clarify the health care claims utilization and cost information required to be provided by medical benefit plans to public employers. In addition, the bill would add the phrase "from independent entities" to the requirement that a public employer or pooled plan solicit at least four bids ("from independent entities") when establishing or renewing medical benefit plans, or when establishing or renewing administrative services of a medical benefit plan.

Specifically, the bill would add employee job classification to the list of information required of medical benefit plans, along with numerous clarifications and requirements for detailed claims data. The language in the bill would replace existing language requiring 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; the number of claims paid over $50,000 and the total of those claims; amounts paid for specific and aggregate stop-loss insurance; amount of administrative expenses for medical, pharmacy, dental, and vision; amount of retentions and other expenses; amount for all service fees paid; amount of any fees or commissions paid to agents, consultants, or brokers; and other information required by the Commissioner of Financial and Insurance Regulation. The following paragraphs itemize the proposed data requirements.

Health Benefits. For a plan providing health benefits, information about claims would have to show all of the following for each of the three most recent experience years:

-- Number and total expenditures for hospital claims and for medical claims.
-- Number of hospital claims and number of medical claims exceeding $50,000.
-- Total expenditures for claims exceeding $50,000.
-- Provider discounts received versus charged amount.
-- Network access fee.

Prescription Drug Benefits. For prescription drug benefit plans, the data would have to show all of the following for each of the three most recent experience years:

-- Amount charged and amount paid for prescription drug claims.
-- Total amount charged and amount paid for brand prescription drug claims, and for generic prescription drug claims.
-- Rebates received by the carrier or pharmacy benefits manager.

The data also would have to show the top 50 brand prescriptions and top 50 generic prescriptions for which claims were made for the most recent experience period.

Dental Benefits. For a plan that provides dental benefits, the data would have to show at least all of the following for each of the three most recent experience years:

-- Number of claims submitted and total charged.
-- Number of and total expenditures for claims paid.
-- Total expenditures for claims submitted to network providers.
-- Total savings realized by network providers.
-- Network access fee.

Optical Benefits. For a plan that provides optical benefits, information concerning optical claims and total expenditures for the claims would have to show at least all of the following for each of the three most recent experience years:

-- Number of claims submitted and total charged.
-- Number of and total expenditures for claims paid.
-- Total expenditures for claims submitted to network providers.
-- Total savings realized by network providers.
-- Network access fee.

Other Requirements. Each plan provider also would be required to report fees and administrative expenses for the most recent experience year, reported separately for health, dental, and optical plans, showing at least all of the following:

-- Total dollar amount of fees and administrative expenses for the current rating year.
-- Commissions or fees paid to agents, brokers, or consultants, and any stop-loss insurance commission.
-- Administration fees charged by an insurance carrier or third party administrator, including claim administration, risk, nongroup conversion subsidy, and taxes.
-- Specific stop-loss insurance charges and attachment point.
-- Aggregate stop-loss insurance charges and attachment point.
-- Additional fees for case management, precertification, or other claim services.
-- Other fees.

Finally, the bill would require a summary plan description or certificate for the current year's plan and, if benefits had changed during any of the three most recent experience years, a brief benefit summary for each of those experience years for which the benefits were different. This summary plan would be required for health, dental, and optical plans.

MCL 124.75 & 124.85

FISCAL IMPACT

The bill would have no fiscal impact on the State.

If the bill resulted in a district having more specific health care claims data for its employees, it is possible that the district could engage in a more informed competitive bidding process when purchasing health insurance. However, whether this additional information would lead to increased savings or costs is indeterminate.

It is possible that "healthy" districts with relatively low health care claims could secure lower-cost health care coverage once those districts had more specific and detailed claims data, but it is also possible that less healthy districts could end up paying more as the healthier districts changed insurers and left group pooling. However, either of these possibilities is simply conjecture, since it is unknown how each district would fare when seeking bids for health insurance, given the additional claims data that would be provided.

Date Completed: 6-16-11 Fiscal Analyst: Kathryn Summers

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