Legislative Analysis

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SCHOOL MEDICAL BENEFIT PLANS

House Bill 4700 (Proposed Substitute H-1)
Sponsor: Rep. Deb Shaughnessy
Committee: Education

Complete to 6-14-11

A SUMMARY OF HOUSE BILL 4700 (PROPOSED COMMITTEE SUBSTITUTE H-1)

House Bill 4700 (H-1) would amend the Revised School Code (MCL 380.1255a) to prohibit the board of a school district, intermediate school district, or charter school from entering into a contract for a medical benefit plan described in Section 15 of the Public Employee Health Benefits Act, unless the contract provides for one of the following:

- That the board or board of directors is a policyholder for the medical benefit plan and, at all times during the period of the contract, the board or board of directors will have access by electronic means to at least all of the claims utilization and cost information described in Section 15 of the Public Employee Health Benefits Act; or

- That, within two business days after making a written request, the board would be given access by electronic means to at least all of the claims utilization and cost information described in Section 15 of the Public Employee Health Benefits Act.

Section 15 of that act would be amended by House Bill 4752 to require that the following information be provided to the public employer. (A separate summary is also available for House Bill 4752.)

- A census of all covered employees, including all of the following: year of birth, gender, zip code, the contract coverage type (single, dependent, or family, and number of covered individuals) and employee job classification.

- Claims data for the employee group covered by the medical benefit plan, including all of the following:

    - For a *plan that provided health benefits*, information about hospital and medical claims presented in a manner that clearly shows all of the following for each of the three most recent experience years: number and total expenditures for hospital and medical claims, as well as the number of those claims exceeding $50,000, the total expenditures for claims exceeding $50,000, provider discounts received versus charged amount, and network access fee.

    - For a *plan that provided prescription drug benefits*, information concerning prescription drugs claims under the plan, presented in a

manner that clearly shows all of the following: the amount charged and the amount paid for prescription drugs claims, brand prescription drugs, and generic prescription drugs for each of the three most recent experience years; the top 50 brand and generic prescriptions for which claims were made for the most recent experience period; and rebates received by the carrier or pharmacy benefits manager for each of the three most recent experience years;

- For a *plan that provided dental benefits and for a plan that provided optical benefits*, information concerning claims and total expenditures for these claims, presented in a manner that clearly showed at least all of the following for each of the three most recent experience years: number of claims submitted and total charge; the number of and total expenditures for claims paid; total expenditures for claims submitted to network providers; total savings realized by network providers; and network access fee.

Section 15, as amended by House Bill 4752, also specifies that the plans make available electronically information about the fees and administrative expenses for the most recent experience year, reported separately for health, dental, and optical plans, and presented in a manner that clearly shows at least all of the following: (1) the total dollar amount of fees and administrative expenses for the current rating year; (2) commissions or fees paid to agents, brokers, or consultants (including an stop loss insurance commission); (3) administration fees charged by an insurance carrier or third party administrator, including but not limited to claim administration, risk, non-group conversion subsidy, and taxes; (4) specific stop loss insurance charges and attachment point; (5) aggregate stop loss insurance charges and attachment point; (6) additional fees for case management, precertification, or other claim services; and (7) other fees.

FISCAL IMPACT:

House Bill 4700 (H-1), together with House Bill 4752, would have no fiscal impact on the State, but would have an indeterminate fiscal impact on local and intermediate school districts.

To the extent that the bills would require that school districts have more complete access to health care claims and experience data, they could create potential savings for certain districts with a history of low health care costs by allowing them to more competitively bid out their health insurance. Districts with a history of higher health care costs would not likely achieve the same benefit from the bills and may see their health care costs increase if they participate in a pool whose membership decreases and is largely made up of similar districts with high health care cost experience.

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