

**HOUSE SUBSTITUTE FOR
SENATE BILL NO. 446**

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.

9 (b) By joining with other public employers and establishing

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

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

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

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

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

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

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

1 commission.

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

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

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

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

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

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

~~1 (d) The dollar amounts paid for specific and aggregate stop-~~
~~2 loss insurance.~~

~~3 (e) The dollar amount of administrative expenses incurred or~~
~~4 paid, reported separately for medical, pharmacy, dental, and~~
~~5 vision.~~

~~6 (f) The total dollar amount of retentions and other expenses.~~

~~7 (g) The dollar amount for all service fees paid.~~

~~8 (h) The dollar amount of any fees or commissions paid to~~
~~9 agents, consultants, or brokers by the medical benefit plan or by~~
~~10 any public employer or carrier participating in or providing~~
~~11 services to the medical benefit plan, reported separately for~~
~~12 medical, pharmacy, stop loss, dental, and vision.~~

~~13 (i) Other information as may be required by the commissioner.~~

14 (A) A CENSUS OF ALL COVERED EMPLOYEES, INCLUDING ALL OF THE
15 FOLLOWING:

16 (i) YEAR OF BIRTH.

17 (ii) GENDER.

18 (iii) ZIP CODE.

19 (iv) THE CONTRACT COVERAGE TYPE FOR THE EMPLOYEE, SUCH AS
20 SINGLE, DEPENDENT, OR FAMILY, AND NUMBER OF INDIVIDUALS COVERED BY
21 CONTRACT.

22 (B) CLAIMS DATA FOR THE EMPLOYEE GROUP COVERED BY THE MEDICAL
23 BENEFIT PLAN, INCLUDING AT LEAST ALL OF THE FOLLOWING:

24 (i) FOR A PLAN THAT PROVIDES HEALTH BENEFITS, INFORMATION
25 CONCERNING HOSPITAL AND MEDICAL CLAIMS UNDER THE PLAN, PRESENTED IN
26 A MANNER THAT CLEARLY SHOWS ALL OF THE FOLLOWING FOR EACH OF THE 3
27 MOST RECENT EXPERIENCE YEARS:

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

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

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

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

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

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

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

11 (B) TOTAL AMOUNT CHARGED AND AMOUNT PAID FOR BRAND
12 PRESCRIPTION DRUGS CLAIMS FOR EACH OF THE 3 MOST RECENT EXPERIENCE
13 YEARS.

14 (C) TOTAL AMOUNT CHARGED AND AMOUNT PAID FOR GENERIC
15 PRESCRIPTION DRUGS CLAIMS FOR EACH OF THE 3 MOST RECENT EXPERIENCE
16 YEARS.

17 (D) THE 50 MOST FREQUENTLY PRESCRIBED BRAND PRESCRIPTION DRUGS
18 FOR WHICH CLAIMS WERE MADE FOR THE MOST RECENT EXPERIENCE PERIOD.

19 (E) THE 50 MOST FREQUENTLY PRESCRIBED GENERIC PRESCRIPTION
20 DRUGS FOR WHICH CLAIMS WERE MADE FOR THE MOST RECENT EXPERIENCE
21 PERIOD.

22 (iii) FOR A PLAN THAT PROVIDES DENTAL BENEFITS, INFORMATION
23 CONCERNING DENTAL CLAIMS AND TOTAL EXPENDITURES FOR THESE CLAIMS
24 UNDER THE PLAN, PRESENTED IN A MANNER THAT CLEARLY SHOWS AT LEAST
25 ALL OF THE FOLLOWING FOR EACH OF THE 3 MOST RECENT EXPERIENCE
26 YEARS:

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

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

2 (C) TOTAL EXPENDITURES FOR CLAIMS SUBMITTED TO NETWORK
3 PROVIDERS.

4 (iv) FOR A PLAN THAT PROVIDES OPTICAL BENEFITS, INFORMATION
5 CONCERNING OPTICAL CLAIMS AND TOTAL EXPENDITURES FOR THESE CLAIMS
6 UNDER THE PLAN, PRESENTED IN A MANNER THAT CLEARLY SHOWS AT LEAST
7 ALL OF THE FOLLOWING FOR EACH OF THE 3 MOST RECENT EXPERIENCE
8 YEARS:

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

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

11 (C) TOTAL EXPENDITURES FOR CLAIMS SUBMITTED TO NETWORK
12 PROVIDERS.

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

17 (i) THE DOLLAR AMOUNTS PAID FOR SPECIFIC AND AGGREGATE STOP-
18 LOSS INSURANCE.

19 (ii) THE DOLLAR AMOUNT OF ADMINISTRATIVE EXPENSES INCURRED OR
20 PAID, REPORTED SEPARATELY FOR MEDICAL, PHARMACY, DENTAL, AND
21 VISION.

22 (iii) THE TOTAL DOLLAR AMOUNT OF RETENTIONS AND OTHER EXPENSES.

23 (iv) THE DOLLAR AMOUNT FOR ALL SERVICE FEES PAID.

24 (v) THE DOLLAR AMOUNT OF ANY FEES OR COMMISSIONS PAID TO
25 AGENTS, CONSULTANTS, THIRD PARTY ADMINISTRATORS, OR BROKERS BY THE
26 MEDICAL BENEFIT PLAN OR BY ANY PUBLIC EMPLOYER OR CARRIER
27 PARTICIPATING IN OR PROVIDING SERVICES TO THE MEDICAL BENEFIT PLAN,

1 REPORTED SEPARATELY FOR MEDICAL, PHARMACY, STOP-LOSS, DENTAL, AND
2 VISION.

3 (vi) OTHER INFORMATION AS MAY BE REQUIRED BY THE COMMISSIONER.

4 (D) FOR HEALTH, DENTAL, AND OPTICAL PLANS, A BENEFIT SUMMARY
5 FOR THE CURRENT YEAR'S PLAN AND, IF BENEFITS HAVE CHANGED DURING
6 ANY OF THE 3 MOST RECENT EXPERIENCE YEARS, A BRIEF BENEFIT SUMMARY
7 FOR EACH OF THOSE EXPERIENCE YEARS FOR WHICH THE BENEFITS WERE
8 DIFFERENT.

9 (4) ~~The~~ EXCEPT AS OTHERWISE PROVIDED IN SUBSECTION (3), claims
10 utilization and cost information required to be compiled under this
11 section shall be compiled on an annual basis and shall cover a
12 relevant period. For purposes of this subsection, the term
13 "relevant period" means the 36-month period ending no more than 120
14 days prior to the effective date or renewal date of the medical
15 benefit plan under consideration. However, if the medical benefit
16 plan has been in effect for a period of less than 36 months, the
17 relevant period shall be that shorter period.

18 (5) A public employer or combination of public employers shall
19 disclose the claims utilization and cost information required to be
20 provided under subsections (1) and (2) to any carrier or
21 administrator it solicits to provide benefits or administrative
22 services for its medical benefit plan, and to the employee
23 representative of employees covered under the medical benefit plan,
24 and upon request to any carrier or administrator who requests the
25 opportunity to submit a proposal to provide benefits or
26 administrative services for the medical benefit plan at the time of
27 the request for bids. The public employer shall make the claims

1 utilization and cost information required under this section
2 available at cost and within a reasonable period of time.

3 (6) The claims utilization and cost information required under
4 this section shall include only de-identified health information as
5 permitted under the health insurance portability and accountability
6 act of 1996, Public Law 104-191, or regulations promulgated under
7 that act, 45 CFR parts 160 and 164, and shall not include any
8 protected health information as defined in the health insurance
9 portability and accountability act of 1996, Public Law 104-191, or
10 regulations promulgated under that act, 45 CFR parts 160 and 164.

11 (7) All claims utilization and cost information described in
12 this section is required to be compiled beginning 60 days after the
13 effective date of this act. However, claims utilization and cost
14 information already being compiled on the effective date of this
15 act is subject to this section on the effective date of this act.

16 Enacting section 1. This amendatory act takes effect October
17 1, 2011.