THE INSURANCE CODE OF 1956 (EXCERPT)
Act 218 of 1956

500.3471 Provision and nondisclosure of large employer group claims utilization and cost information; civil liability immunity; definitions.

Sec. 3471.

(1) On request of a large employer group, an insurer shall provide the large employer group with claims utilization and cost information as provided in subsection (3) on presentation of a signed nondisclosure agreement to the insurer. In signing the nondisclosure agreement described in this subsection, the large employer group shall agree to keep confidential all information received under this section other than the information required to be disclosed under subsection (6).

(2) A large employer group that is part of a combined large employer group must be provided with claims utilization and cost information as provided in subsection (3)(a) that is aggregated for all the employees enrolled in the combined large employer group, and the information must not be separated out for any of those employers included in the combined large employer group.

(3) An insurer in this state shall compile, and shall 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 under subsection (1) or (2) and each subgroup of employees of the large employer group if the subgroup has 100 or more employees covered by the medical benefit plan, as follows:

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

(i) For a plan that provides medical benefits, information concerning hospital and medical claims under the plan, presented in a manner that clearly shows 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.

(D) The tax identification number or national provider identifier of each provider rendering service or care.

(ii) For a plan that provides prescription drug benefits, information concerning prescription drug claims under the plan, presented in a manner that clearly shows all of the following:

(A) Amount paid for prescription drug claims for each month.

(B) Amount paid for brand prescription drug claims for each month.

(C) Amount paid for generic prescription drug claims for each month.

(D) Amount paid for specialty prescription drug claims for each month.

(E) The 50 prescription drugs for which claims were most frequently paid.

(F) The 50 prescription drugs for which expenditures were the largest.

(iii) For a plan that provides medical or prescription drug benefits, in addition to the information required under subparagraphs (i) and (ii), as applicable, information concerning covered individuals with total medical or prescription drug claims, or both, exceeding $25,000.00 for any 12-month period for which claims utilization and cost information are provided, presented in a manner that clearly shows 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 is currently covered by the medical benefit plan.

(D) The covered individual's diagnoses.

(iv) 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:

(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.

(D) The dollar amount for all service fees paid.

(v) 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.

(vi) For medical and prescription drug plans, a benefit summary for the current year's plan and, if benefits have changed during any of the 2 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.

(b) A census of all covered employees, including all of the following:

(i) Year of birth of each employee.

(ii) Gender of each employee.

(iii) Zip code in which each employee resides.

(iv) The contract coverage type for each employee, such as single, 2-person, or family, and number of individuals covered by contract.

(v) For each month, the total number of covered employees and the number of covered employees in each contract coverage type.

(vi) For each month, the total number of covered individuals and the number of covered individuals in each contract coverage type.

(vii) 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:

(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.

(C) Other information as required by the director.

(4) Except as otherwise provided in subsection (3) and subject to subsection (5), claims utilization and cost information required to be compiled under this section must be compiled at the request of a large employer group. The large employer group may not request claims utilization and cost information more than once per calendar year. Claims utilization and cost information compiled on the request of a large employer group must be compiled within 30 days after the request.

(5) Claims utilization and cost information compiled under this section must cover a relevant period. For purposes of this subsection, "relevant period" means the 24-month period ending not more than 60 days before the compilation of the information for the medical benefit plan under consideration. However, if the medical benefit plan has been in effect for less than 24 months, the relevant period is that shorter period.

(6) A large employer group or combined large employer group shall disclose the claims utilization and cost information required to be provided under subsections (2) and (3) to any carrier or administrator it solicits to provide benefits or administrative services for its medical benefit plan. A large employer group or combined large employer group shall make the claims utilization and cost information required under this section available within 30 days after the request. In addition, a large employer group or combined large employer group may disclose the claims utilization and costs information required to be provided under subsections (2) and (3) to any carrier or administrator who requests the opportunity to submit a proposal to provide benefits or administrative services for the medical benefit plan during the request for bids or proposals.

(7) On request of a large employer group or combined large employer group, an insurer shall provide the tax identification number or national provider identifier of each provider rendering service or care on presentation of a signed nondisclosure agreement to the insurer.

(8) The claims utilization and cost information required to be produced under subsection (3) must include only health information as permitted under the health insurance portability and accountability act of 1996, Public Law 104-191, or regulations promulgated under that act, 45 CFR parts 160 and 164, and must not include any protected health information as defined in the health insurance portability and accountability act of 1996, Public Law 104-191, or regulations promulgated under that act, 45 CFR parts 160 and 164.

(9) An insurer that delivers, issues for delivery, or renews in this state a health insurance policy that provides information in response to a request from a large employer group under this section is 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.

(10) As used in this section:

(a) "Carrier" means any of the following:

(i) An insurer that offers a medical benefit plan.

(ii) An employee welfare benefit plan as that term is defined in section 7001.

(iii) A person operating a system of health care delivery and financing under section 3573.

(iv) A voluntary employees' beneficiary association described in section 501(c)(9) of the internal revenue code of 1986, 26 USC 501.

(b) "Combined large employer group" means either of the following:

(i) 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.

(ii) A medical benefit plan in which the employees of 2 or more employers are enrolled.

(c) "Covered individual" means an employee covered under a medical benefit plan.

(d) "Full-time employees" means the term as used in section 3701.

(e) "Large employer group" means an employer that is issued a policy by a carrier under this chapter with

enrollment of 100 or more full-time employees.

(f) "Medical benefit plan" means 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. Medical benefit plan does not include either of the following:

(i) A medical benefit plan as defined in section 3 of the public employees health benefit act, 2007 PA 106, MCL 124.73, that is required to compile and make available claims utilization and cost information under section 15 of the public employees health benefit act, 2007 PA 106, MCL 124.85.

(ii) A plan that covers only a specified accident, accident only, credit, dental, disability income, long-term care, or vision benefits.

(g) "National provider identifier" means that term as described in 45 CFR part 162.

(h) "Provider" means provider of services as that term is defined in 42 USC 1395x.

(i) "Specialty prescription drug" means a prescription drug used to treat a rare, complex, or chronic medical condition that meets any of the following requirements:

(i) Requires special administration including, but not limited to, inhalation or infusion.

(ii) Requires special delivery or special storage.

(iii) Requires special oversight, intensive monitoring, or care coordination with a person licensed under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838.

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