House
Legislative
Analysis
Section

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**HEALTH INSURANCE CLAIM INFORMATION**

**House Bill 4756**
**Sponsor: Rep. Andrew Richner**

**House Bill 4757**
**Sponsor: Rep. Marc Shulman**

**House Bills 4758 and 4759**
**Sponsor: Rep. Doug Hart**

**Committee: Family and Civil Law**

**Complete to 6-4-99**

## A SUMMARY OF HOUSE BILLS 4756 - 4759 AS INTRODUCED 6-3-99

The bills would amend various acts to require health care benefit providers to provide certain specified information, including all pertinent information that would be necessary for the person paying for the insurance to obtain competitive bids for other health care coverage.

House Bill 4756 would amend the Third Party Administrator Act (MCL 550.934-935) as it applies to third party administrators. House Bill 4757 would amend the Nonprofit Health Care Corporation Reform Act (MCL 550.1406-1406a) as it applies to those Blue Cross and Blue Shield of Michigan (BCBSM). House Bill 4758 would amend the Public Health Code (MCL 333.21046) as it applies to health maintenance organizations (HMOs). House Bill 4759 would amend the Insurance Code (MCL 500.3633) as it applies to commercial insurance companies who deliver, issue for delivery, or renew a group expense-incurred hospital, medical, or surgical policy or certificate in this state.

The information would have to be provided, upon written request, to any person who was paying, either directly or indirectly (in the case of third party administrators and nonprofit health care corporations), or primarily (in the case of HMOs and insurers providing a group expense-incurred hospital, medical, or surgical policy or certificate). The benefit provider could require the payment of a reasonable charge for the information, but would be required to supply the required information within 30 days after receiving the request.

In response to a request, the benefit provider would be required to provide the following information regarding the policy, certificate, benefit plan or contract for the previous 12-month period:

-- The total number of individuals covered.

-- The total number of claims paid or, for HMOs, services provided.

-- The total number of claims pending or, for HMOs, services pending.

-- The total number of claims or, for HMOs, services, that exceeded $50,000 and the amount of each of those claims or services. However, such information would have to be provided in a manner that did not disclose the identity of a covered individual.

-- The claims experience data by coverage component or, for HMOs, the utilization and cost per service data by covered component.

-- All other pertinent information that would be necessary for the person seeking the information to obtain competitive bids.



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