# Legislative Analysis

Mitchell Bean, Director
Phone: (517) 373-8080
http://www.house.mi.gov/hfa

**PUBLIC EMPLOYEE HEALTH POOLS**

**Senate Bill 418 as passed by the House**
**Sponsor: Sen. Mark C. Jansen**

**Senate Bill 420 as passed by the House**
**Sponsor: Sen. Patricia L. Birkholz**

**Senate Bill 419 as passed by the House**
**Sponsor: Sen. Wayne Kuipers**

**Senate Bill 421 as passed by the House**
**Sponsor: Sen. Cameron S. Brown**

**House Committee: Education**
**Senate Committee: Local, Urban, and State Affairs**

**Complete to 9-24-07**

***BRIEF SUMMARY:*** The bills would allow the creation of public employer pooled medical plans under certain conditions. The bills are tie-barred to each other, and also to Senate Bill 549 (which establishes a common school calendar within intermediate school district regions), so that none could take effect unless all were enacted.

Senate Bill 418 (H-3) would create the "Public Employees Health Benefit Act" to do the following:

- Allow a public employer (except the State of Michigan) to join with other public employers and establish and maintain a public employer pooled plan to provide medical, optical, or dental benefits to at least 250 public employees on a self-insured basis.
- Require a pooled plan to accept any public employer that applied to become a member, agreed to make required payments, and agreed to remain in the pool for three years.
- Prohibit a public employer that left a pooled plan from rejoining it for two years.
- Require all medical benefit plans in the state to compile and make available electronically, claims utilization and cost information for the medical benefit plan for the most recent rate renewal period and under the same basis by which the public employer has been pooled or rated.
- Provide that claims utilization and cost information could include only de-identified health information.
- Require a person to obtain a certificate of registration before establishing or maintaining a public employer pooled plan.
- Require each authorized pooled plan to pay an annual assessment equal to 0.25% of the annual self-funded contributions made to the medical benefit plan, for regulatory costs of the Office of Financial and Insurance Services (OFIS).
- Require a pooled plan to maintain minimum cash reserves; file audited financial statements; and have excess loss insurance.

- Assign responsibilities to the OFIS Commissioner, including granting certificates of registration and taking action against pooled plans for violating the proposed act.

Senate Bills 419, 420, and 421 would amend various statutes to do the following:

- Require a school board, if it provided medical, optical, and dental benefits to employees and their dependents, to provide those benefits in accordance with the proposed act.
- Allow a municipal corporation to provide medical benefits as permitted under the proposed act.
- Require the board of trustees of a community college that provided medical, optical, or dental benefits to employees and their dependents, to provide those benefits in accordance with the proposed act.

**HOUSE COMMITTEE ACTION:**

The House Education Committee reported out Substitute H-3 of Senate Bill 418. That bill made *four changes* to the Senate-passed version of Senate Bill 418, as follows:

- *First*, the bill changed the definition of "public employer" to eliminate the State of Michigan and the Civil Service Commission from the proposed act.
- *Second*, the bill eliminated the requirement that a public employer solicit at least four bids every three years when establishing a medical benefit plan.
- *Third*, the bill eliminated the requirement that a public employer provide claims utilization and cost information aggregated for all public employees and for each public employee for the past 36 months (and instead requires complete and accurate claims utilization and cost information for the most recent rate renewal period and under the same basis by which the employer had been pooled or rated).
- *Fourth*, the bill eliminated the requirement that a public employer disclose claims utilization and cost information to any carrier at the time of the request for bids.

NOTE: All of the bills—Senate Bills 418, 419, 420, and 421—were also amended on the House floor to tie bar each to Senate Bill 549, which would establish a common school calendar for winter and spring break within an intermediate school district region.

**FISCAL IMPACT:**

The bills would have an indeterminate fiscal impact on school districts, municipalities and community colleges. An actuarial analysis would be necessary to estimate any savings that could be achieved through self-insured pools for providing medical, optical, and dental benefits, and savings would vary depending on the pool. Creating pools could produce savings through self-funding, better eligibility management, and purchasing coalitions. In the past few years, two studies by both the Hay Group and by the Michigan Federation of Teachers & School Related Personnel, in conjunction with the International Union of Operating Engineers Local 547, have suggested that savings could reach 6.5%

to 7.0% in the first year if such pools take advantage of the ability to move to a self-funded system and leverage their purchasing power to reduce administrative fees, provider access fees, and pharmacy costs.

The bill would result in increased administrative costs to the State related to data collection and the examination and regulation of the new pools by the Office of Financial and Insurance Services (OFIS) in the Department of Labor and Economic Growth. OFIS estimates the cost increases at approximately $300,000 per year. While SB 418 would allow OFIS to collect an assessment from each pool equal to .25% of the annual self-funded contributions made to the pooled plan, they do not expect collections to compensate for the added costs.

**DETAILED SUMMARY OF BILLS:**

Senate Bill 418 (H-3)

***Medical Benefit Plans.*** Subject to collective bargaining requirements, a public employer could provide medical, optical, and dental benefits to its employees and their dependents by any of the following methods:

- Establishing and maintaining a plan on a self-insured basis.
- Joining with other public employers by establishing and maintaining a public employer pooled plan to provide medical, optical or dental benefits to at least 250 public employees on a self-insured basis as provided in the bill.
- Procuring coverage or benefits from one or more carriers, either on an individual basis or with one or more other public employers.

A plan under either of the first two methods would not constitute doing the business of insurance in the state and would not be subject to the insurance laws of the state.

A pooled plan would have to accept any public employer that applied to become a member, agreed to make the required payments, agreed to remain in the pool for a three-year period, and satisfied the other reasonable provisions of the pooled plan. A public employer that left a pooled plan could not rejoin the plan for two years. A pooled plan could enter into contracts and sue or be sued in its own name.

The bill states that the proposed act would not prohibit a public employer from participating, for the payment of medical benefits and claims, in a purchasing pool or coalition to procure insurance, benefits, or coverage, or health care plan services, or administrative services.

A medical benefit plan that provided medical benefits would have to provide to covered individuals case management services that met the case management accreditation standards established by the National Committee on Quality Assurance, the Joint

Commission on Health Care Organizations, or the Utilization Review Accreditation Commission.
A public university could establish a medical benefit plan to provide medical, dental, or optical benefits to its employees and their dependents by any of the methods described in the bill.

The bill would define "public employer" as a city, village, township, county, or other political subdivision of this state; any intergovernmental, metropolitan, or local department, agency, or authority, or other local political subdivision; a school district, public school academy, or intermediate school district; or a community college or junior college. The term would include a public university that elected to come under the provisions of the proposed act.

"Medical benefit plan" would mean a plan, established and maintained by a carrier or one or more public employers, that provides for the payment of medical, optical, or dental benefits, including hospital and physician services, prescription drugs, and related benefits, to public employees.

"Carrier" would mean a health, dental, or vision insurance company authorized to do business in this state under the Insurance Code, and a health maintenance organization (HMO) or multiple employer welfare arrangement (MEWA) operating under the Insurance Code; a system of health care delivery and financing as defined in Section 3573 of the Code (which provides for systems similar to HMOs that do not meet requirements of the Code); a nonprofit dental care corporation; a nonprofit health care corporation (Blue Cross and Blue Shield of Michigan); a voluntary employees' beneficiary association; a pharmacy benefits manager; and any other person providing a plan of health benefits, coverage, or insurance in Michigan.

***Certificate of Registration.*** A person could not establish or maintain a public employer pooled plan in the state unless the pooled plan obtained and maintained a certificate of registration. A person wishing to establish a pooled plan would have to apply for a certificate on a form prescribed by the Commissioner. The completed application would have to be submitted to the Commissioner along with all of the following:

- Copies of all articles, bylaws, agreements, or other documents or instruments describing the rights and obligations of employers, employees, and beneficiaries with respect to the pooled plan and the expected number of public employees to be covered for medical benefits under it.
- Current financial statements of the pooled plan or, for a newly established pooled plan, three years of financial projections.
- A statement showing in full detail the plan upon which the pooled plan proposed to transact business and a copy of all contracts or other instruments that it proposed to make with or sell to its members, together with a copy of its plan description.

The Commissioner would have to examine the application and documents for completeness and would have to notify the applicant within 30 days after receiving the application of any additional information needed. The Commissioner could conduct any investigation that he or she considered necessary or examine under oath any person interested in or connected with the pooled plan.

The Commissioner would have to issue or deny a certificate of registration within 90 days of receiving a substantially completed application. The Commissioner could not issue a certificate of registration to the pooled plan unless he or she were satisfied that the plan was in a stable and unimpaired financial condition, that it was qualified to maintain a medical benefit plan in compliance with the proposed act, and that the pooled plan met requirements pertaining to cash reserves; a schedule of premiums, rates, and renewal projections; excess loss insurance; a procedure for handling claims in the event of dissolution; and administration of the plan (described below).

The Commissioner would have to deny a certificate of registration to an applicant who failed to meet the requirements of the proposed act. Notice of denial would have to set forth in writing the basis for the denial. If the applicant submitted a written request within 60 days after the notice of denial was mailed, the Commissioner promptly would have to conduct a hearing pursuant to the Administrative Procedures Act, in which the applicant would be given an opportunity to show compliance with the requirements of the proposed act.

Upon receiving its initial certificate of authority, which would be a temporary certificate, a pooled plan would have to proceed to complete organization of the proposed pooled plan. A pooled plan would be required to open its books to the Commissioner. The Commissioner could not issue a final certificate of registration until the pooled plan had collected cash reserves (as described below).

***Requirements of Pooled Plans.*** A public employer pooled plan established on or after the bill's effective date would have to establish and maintain minimum cash reserves of at least 25 percent of the aggregate contributions in the current fiscal year or, in the case of new applicants, 25 percent of the aggregate contributions projected to be collected during its first 12 months of operation, as applicable; or not less than 35 percent of the claims paid in the preceding fiscal year, whichever was greater. Reserves would have to be maintained in a separate, identifiable account and could not be commingled with other funds of the pooled plan. The pooled plan would have to invest the required reserve in the types of investments allowed under the Insurance Code (including certificates of deposit or depository receipts issued by a bank, trust company, or savings and loan association; bonds or other evidences of indebtedness of the U.S., Canada, or certain subdivisions of them; and government securities of the U.S. or any foreign government or subdivisions and certain authorities of them).

A pooled plan could satisfy up to 100 percent of the reserve requirement in the first year of operation, up to 75 percent of the reserve requirement in the second year of operation, and up to 50 percent of the reserve requirement in the third and subsequent years of

operation, through an irrevocable and unconditional letter of credit. The letter of credit would have to be issued by a federally insured financial institution and upon such terms and in a form as approved by the Commissioner. It also would be subject to draw by the Commissioner, upon giving five business days' written notice to the pooled plan, or by the pooled plan for the member's benefit if the pooled plan were unable to pay claims as they came due.

Within 90 days after the end of each fiscal year, a pooled plan would have to file with the Commissioner financial statements audited by a certified public accountant. The audited financial statements would have to include an actuarial opinion regarding reserves for known claims and associated expenses and incurred but not reported claims and associated expenses. The opinion would have to be rendered by an actuary who was approved by the Commissioner or who had at least five years of experience in the field.

Within 60 days after the end of each fiscal quarter, a pooled plan would have to file with the Commissioner unaudited financial statements, affirmed by an appropriate officer or agent of the pooled plan, as well as a report certifying that it maintained reserves that were sufficient to meet its contractual obligations, and that it maintained coverage for excess loss as required under the proposed act.

A pooled plan also would have to provide for administration of the plan by using its personnel, provided that the plan had within its own organization adequate facilities and competent personnel to service the medical benefit plan, or by awarding a competitively bid contract to an authorized third party administrator, an insurer, a nonprofit health care corporation, or other entity authorized to provide services in connection with a noninsured medical benefit plan.

In addition, a public employer pooled plan would be required to do all of the following:

- File with the Commissioner a schedule of premium contributions, rates, and renewal projections.
- Possess a written commitment, binder, or policy (providing at least 30 days' notice of cancellation to the Commissioner) for excess loss insurance issued by an insurer authorized to do business in the state in an amount approved by the Commissioner.
- Establish a procedure, to the satisfaction of the Commissioner, for handling claims for benefits in the event of dissolution of the pooled plan.

If the Commissioner found that a pooled plan's reserves were not sufficient to meet the requirements described above, he or she would have to order the pooled plan immediately to collect from any public employer that was or had been a member of the plan appropriately proportionate contributions sufficient to restore reserves to the required level.

The Commissioner could take action he or she considered necessary, including ordering the suspension or dissolution of a pooled plan, if the pooled plan did any of the following:

- Consistently failed to maintain required reserves.
- Used methods and practices that rendered further transaction of business hazardous or injurious to its members, employees, or beneficiaries, or to the public.
- Failed, after written request by the Commissioner, to remove or discharge an officer, director, trustee, or employee who had been convicted of any crime involving fraud, dishonesty, or moral turpitude.
- Failed or refused to furnish any report or statement required under the proposed act.
- Conducted business fraudulently or did not meet its contractual obligations in good faith (as determined by the Commissioner upon investigation).

Proceedings under these provisions would be governed by Sections 7074 to 7078 of the Insurance Code (which pertain to proceedings that involve MEWAs).

The Commissioner, or any person appointed by the Commissioner, could examine the affairs of any pooled plan, and for such purposes, would have free access to all of the books, records, and documents that related to the business of the plan, and could examine under oath its trustees, officers, agents, and employees in relation to the affairs, transactions, and condition of the pooled plan. Each authorized pooled plan would have to pay an assessment annually to the Commissioner to be deposited into the Insurance Bureau Fund created in the Insurance Code, in an amount equal to 0.25 percent of the annual self-funded contributions made to the pooled plan for that year. The assessments would be appropriated to OFIS to cover the additional costs incurred by it in the examination and regulation of pooled plans under the proposed act.

The articles, bylaws, and trust agreement of a pooled plan and all amendments to them would have to be filed with and presumed approved by the Commissioner before becoming operative. The trust agreement would have to be filed on a form prescribed by the Commissioner.

Each member employer of a pooled plan would have to be given notice of every meeting of the members and would be entitled to an equal vote, either in person or by proxy in writing.

The powers of a pooled plan, except as otherwise provided, would have to be exercised by the board of trustees chosen to carry out the purposes of the trust agreement. At least 50 percent of the trustees would have to be people who were covered under the pooled plan or their collective bargaining representatives. No trustee could be an owner, officer, or employee of a third party administrator providing services to the pooled plan.

***Disclosure of Benefit Plan Information.*** A public employer that had 100 or more employees in a medical benefit plan would have to be provided with claims utilization and cost information, as provided in the proposed act.

All medical benefit plans in the state would have to compile, and would have to make available electronically as provided above, complete and accurate claims utilization and cost information for the medical benefit plan for the most recent rate renewal period and under the same basis by which the public employer had been pooled or rated, including:

- For people covered under the medical benefit plan, census information, including date of birth, gender, zip code, and medical tier, such as single, dependent, or family.
- 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 their total dollar amount.
- The dollar amounts paid for specific and aggregate stop-loss insurance.
- The dollar amount of administrative expenses incurred or paid, reported separately for medical, pharmacy, dental, and vision.
- The total dollar amount of retentions and other expenses.
- The dollar amount for all service fees paid.
- The dollar amount of any fees or commissions paid to agents, consultants, or brokers by the medical benefit plan or by any public employer or carrier participating in or providing services to that plan, reported separately for medical, pharmacy, stop-loss, dental, and vision.
- Other information as required by the Commissioner.

The claims utilization and cost information would have to be compiled on an annual basis and cover the most recent rate renewal period.

All claims utilization and cost information described in these provisions would have to be compiled beginning 60 days after the bill's effective date. Claims utilization and cost information that already was being compiled on the effective date would be subject to the requirements on that date.

The claims utilization and cost information required under these provisions could include only de-identified health information as permitted under, and could not include any protected health information as defined in, the Federal Health Insurance Portability and Accountability Act (HIPAA), or regulations promulgated under that act.

Senate Bill 419

The bill would amend the Revised School Code (MCL 380.632 et al) to state that if the board of directors of a public school academy, an urban high school academy, or a strict discipline academy, or the board of a school district or an intermediate school district provided medical, optical, or dental benefits to employees and their dependents, the board

would have to provide those benefits in accordance with the proposed Public Employees Health Benefit Act and would have to comply with that act.

Senate Bill 420

The bill would amend Public Act 35 of 1951 (MCL 124.5), which authorizes intergovernmental contracts between municipal corporations, to allow a municipal corporation to provide medical benefits as permitted under the proposed Public Employees Health Benefit Act.

Public Act 35 specifies that a group self-insurance pool may not provide for hospital, medical, surgical, or dental benefits to the employees of the member municipalities in the pool except when those benefits arise from the obligations and responsibilities of the pool in providing automobile insurance coverage. The bill would make another exception to that prohibition if the municipal corporation were providing hospital, medical, surgical, or dental benefits as permitted under the proposed Public Employees Health Benefit Act.

Senate Bill 421

The bill would amend the Community College Act (MCL 389.123 and 389.124) to require the board of trustees of a community college that provided medical benefits to employees to provide those benefits in accordance with the proposed Public Employees Health Benefit Act.

Specifically, the bill would authorize the board of trustees of a community college to select and employ administrative officers, teachers, and other employees it found necessary to operate the community college district and establish the terms and conditions of their service or employment. If the board provided medical, optical, or dental benefits to employees and their dependents, the board would have to provide those benefits in accordance with the proposed act and would have to comply with that act.

Under the Community College Act, a board of trustees may delegate to the chief executive officer the authority to select and employ personnel of the community college. The bill would add that if the chief executive officer provided medical, optical, or dental benefits to employees and their dependents, he or she would have to provide those benefits in accordance with the proposed act and comply with it.

***POSITIONS:***

The following organizations testified in opposition to Senate Bill 418 on 9-11-07: Michigan Education Services Association (MESSA) and the Municipal Employees Retirement System.

The following organizations testified in support of the Senate-passed version of the bills on 9-11-07: the AFL-CIO; the American Federation of Teachers; the Michigan Professional Firefighters Union; the Michigan Elementary and Middle School Principals Association; Oakland Schools; Wayne RESA; Northern Michigan Schools Legislative Association; Michigan Small Rural Schools; the Michigan Association of School Boards; and Ottawa, Kalamazoo, & Muskegon Intermediate School District.

Earlier in the legislative session, the Office of Financial and Insurance Services (OFIS) offered testimony in opposition to Senate Bill 418 (5-22-07).

Also, on 6-30-07 during a hearing before the House Education Committee, the following organizations expressed support either for the bills themselves or for the concept of insurance pooling for medical care benefits: the Michigan Chamber of Commerce; the Service Employees International Union; and the International Union of Operating Engineers.

Legislative Analyst: J. Hunault
Fiscal Analyst: Mary Ann Cleary
Bethany Wicksall

■ This analysis was prepared by nonpartisan House staff for use by House members in their deliberations, and does not constitute an official statement of legislative intent.