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BILL ANALYSIS

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Senate Bill 418 (Substitute S-1 as reported)
Senate Bills 419, 420, and 421 (as reported without amendment)
Sponsor: Senator Mark C. Jansen (S.B. 418)
Senator Wayne Kuipers (S.B 419)
Senator Patricia L. Birkholz (S.B. 420)
Senator Cameron S. Brown (S.B. 421)
Committee: Local, Urban and State Affairs

Date Completed: 7-3-07

RATIONALE

In Michigan, health care coverage for public employees typically takes a large share of public employers' budgets. As health care benefits become more expensive, local governments and school districts have less money to spend on public safety, education, and other public service. According to an analysis by Standard & Poor's, in 2004, 24.2% of districts' core operating spending went toward benefits, including health insurance, for public school employees in Michigan. Some people believe that a similar percentage is spent by other public employers for their employees.

It has been suggested that regional health insurance pools could allow school districts and local governments to reap cost savings. Some also suggest that schools and local governments should have greater access to information about health care providers' prices and performance, and believe that insurers as well as employers should have greater access to claims history information. In particular, many people believe that allowing public employers to form insurance pools would increase their effectiveness by allowing them to save money on health care. It has been suggested that these and other measures would enhance competition in the health care market and enable school districts and other public employers to control employee benefit costs.

CONTENT

Senate Bill 418 (S-1) would create the "Public Employees Health Benefit Act" to do the following:

-- Allow a public employer 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 a pooled plan procuring coverage or benefits from one or more carriers to solicit at least four bids when establishing a medical benefit plan and every three years when renewing or continuing a medical benefit plan.
-- Require a carrier that provided one or more medical benefit plans to a public employer, covering 100 or more of that employer's employees, or to a combination of employers that together had 100 or more employees in a medical benefit plan or had signed a letter of intent to enter them in a plan, to provide the employers with claims utilization and

-- cost information; and require the public employer or combination of public employers to disclose the information to any carrier or administrator it solicited to provide benefits.
-- Require all medical benefit plans in the State to compile and make available claims utilization and cost information for the medical benefit plan in the aggregate and for each public employer, as described in the bill.
-- Provide that claims utilization and cost information could include only de-identified health information.
-- Require a person to obtain a certificate of authority 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 authority, distributing a buyer's guide for public employers, 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.

The four bills are tie-barred to each other.

Senate Bill 418 (S-1)

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.
-- Entering into an agreement under which contributions were made to a trust fund for the purpose of providing medical, dental, or optical benefits to public employees and their dependents under a plan agreed to by their employer.
-- 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, which could pool risks with other public employers under this provision to the extent permitted under a written agreement.

A plan under any of the first three 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 trust fund under the second method could receive contributions from one or more public employers and could provide medical, dental, and optical benefits to public employees of one or more public employers.

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.

A pooled plan that procured coverage or benefits from one or more carriers would have to solicit at least four bids when establishing a medical benefit plan and every three years when renewing or continuing a medical benefit plan, including

at least one bid from a voluntary employees' beneficiary association described in a section of the Internal Revenue Code. A pooled plan that provided for administration of a medical benefit plan using 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 would have to solicit at least four bids for those administrative services when establishing a medical benefit plan and every three years when renewing or continuing a medical benefit plan.

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 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 and a State employer 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, as well as this State through the Civil Service Commission or any other State employer on behalf of its State employees that elected to come under the Act's provisions.

"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, 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 Authority

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 authority. 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, if any, of the pooled plan.
-- 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 promptly would have to examine the application and documents submitted by the applicant and could conduct any investigation that he or she considered necessary and examine, under oath, any person interested in or connected with the pooled plan.

The Commissioner would have to issue a certificate of authority to the pooled plan if he or she were satisfied that the plan was in a stable and unimpaired financial condition and that it was qualified to maintain a medical benefit plan in compliance with the proposed Act. Failure of the Commissioner to act within 60 days after the application and documents had been filed would constitute approval, and a temporary certificate of authority would have to be issued. The Commissioner would have to deny a certificate of authority to an applicant who failed to meet the requirements, and 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, within seven days of receiving the written request, would have to conduct a hearing pursuant to the Administrative Procedures Act in which the applicant would be given the 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 authority 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% of the aggregate contributions in the current fiscal year or, in the case of new applicants, 25% of the aggregate contributions projected to be collected during its first 12 months of operation, as applicable. 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 the reserve requirement through an irrevocable and unconditional letter of credit that was issued by a federally insured financial institution and was 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 (that provided 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 determined to be actuarially sound by an actuary who was approved by the Commissioner or had five or more years of experience in the field.
-- 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 in an amount equal to 0.25% of the annual self-funded contributions made to the self-insured medical benefit 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 if not disapproved within 60 days after the filing. 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% of the trustees would have to be people who were covered under the pooled plan or their collective bargaining representatives.

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 described below. A public employer that was in an arrangement with one or more other public employers, and together had 100 or more employees in a medical benefit plan or had signed a letter of intent to enter together 100 or more public employees into a medical benefit plan, would have to be provided with aggregate claims utilization and cost information.

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 in the aggregate and for each public employer as follows:

-- 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 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 a relevant period, which would be a 36-month period ending not more than 120 days before the effective date or renewal date of the medical benefit plan under consideration. If the medical benefit plan had been in effect for less than 36 months, the relevant period would be that shorter 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.

A public employer or combination of public employers would have to disclose the claims utilization and cost information required to be provided in cases of 100 or more public employees in a pooled plan, to any carrier or administrator it solicited to provide benefits or administrative services for its medical benefit plan, and to the employee representative of employees covered under the medical benefit plan, and upon request to any carrier or administrator who requested the opportunity to submit a proposal to provide benefits or administrative services for the medical benefit plan at the time of the request for bids. The public employer would have to make the information available at cost and within a reasonable period of time.

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.

Comparison of Services

To encourage and facilitate informed decisions concerning medical benefit plan design, the administration of plans, the selection of medical service providers, and the planning of medical care, the Commissioner would have to gather data evaluating and comparing the cost, efficiency, and performance of administrative services provided to medical benefit plans, including claims payment timeliness and accuracy, and make available easily accessible comparative ratings and descriptions of those plan administrators on a regular basis.

Also, working with other State departments and agencies, the Commissioner would have to ensure access on a regular basis for public employers, medical benefit plans, and covered public employees to information concerning cost and performance of Michigan hospitals, medical clinics, and other health care facilities, including licensure, accreditation, and performance measures for those facilities; and information concerning cost and performance of Michigan physicians and other health care providers, including medical training, years in practice, board certification, verified licensure information, patient experience, and the results of at least two clinical performance measures of physicians and other health care providers.

At least annually, the Commissioner would have to prepare and make available for distribution to public employers and other interested people a buyer's guide for public employers that provided information necessary to make informed decisions concerning medical benefit plan design, the administration of medical benefit plans, the selection of medical service providers, and the planning of medical care similar to information provided to assist buyers in making informed decisions in the buyer's guide to auto insurance in Michigan, the buyer's guide to home and renter's insurance in Michigan, and the HMO consumer's guide.

Senate Bill 419

The bill would amend the Revised School Code 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 (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 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.

MCL 380.632 et al. (S.B. 419)
124.5 (S.B. 420)
389.123 & 389.124 (S.B. 421)

ARGUMENTS

(Please note: The arguments contained in this analysis originate from sources outside the Senate Fiscal Agency. The Senate Fiscal Agency neither supports nor opposes legislation.)

Supporting Argument

The cost of providing health care benefits has risen dramatically in recent years. According to a 2006 survey by the Kaiser Family Foundation and the Health Research and Educational Trust, premiums for employer-sponsored health care coverage rose an average 7.7% in 2006 from the prior year, less than the 9.2% increase recorded in 2005 and the recent peak of 13.9% in 2003, but more than twice the rise in workers' wages (3.8%) and overall inflation (3.5%). In the previous six years, according to the survey, premiums rose 87%. Like

other employers that pay for health care coverage, public employers are subject to these cost increases. When the employer is a public entity, however, taxpayers and residents also pay the price.

According to Standard and Poor's, in 2004, 19% of an average school district's core spending went to employee benefits. In Michigan, a greater amount, 24.2% or $2,165 per student, was spent on employee benefits. If the percentage for other public employers is comparable, then a significant amount of tax revenue is used for this purpose.

The bills would reduce the cost of health benefits for public employers in the State through pooled risk, competitive bidding, and health management without reducing benefits for public employees. Insurance pools have been shown to reduce costs in other states, and in 2005 the Ottawa Area Intermediate School District and other school districts created the West Michigan Insurance Pool, which expects to produce significant savings for its participants. The West Michigan Insurance Pool, however, faced significant regulatory obstacles in an approval process that took almost three years to complete. The bills would offer a more straightforward process for establishing such pools.

When employers form and join large insurance pools, those pools spend less on administrative costs and risk management both for certain individuals and on average for the pool. Rather than each employer having to manage its own plan, an insurance pool can be administered centrally, reducing costs and operating more efficiently. In addition, a large pool can negotiate for better insurance rates based on the number of participants. Insurance companies typically offer discounts for large groups. Combining several employers into one pool allows the participants to qualify for lower rates.

Insurance pools also smooth risk by minimizing the impact of expensive outliers (i.e., individuals with long or frequent hospital stays and serious chronic illnesses) and combining groups with relatively high risk (e.g., older populations) with groups that are exceptionally healthy.

In addition, the availability of claims information can enable employers to focus on wellness and preventive care, which may produce long-term cost savings as participants live healthier lives. Most health care plans today focus only on treating illnesses once they have reached a critical stage. At that point, the treatment can be much more costly than preventive care would have been.

These bills represent a positive step in the right direction to bring health care costs under control without compromising the collective bargaining process. Reduced health care costs would allow local governments to spend more on essential public services such as law enforcement, and would allow school districts to put more money directly into the classroom.

Supporting Argument

Currently, insurance purchasers have access to limited information. Insurance companies do not always provide specific data on the quality of service or the costs of particular services that a purchaser needs to make the best decision. Senate Bill 418 (S-1) would provide greater transparency in Michigan health services by requiring medical benefit plans to supply public employers with claims utilization and cost information, including aggregated claims amounts and types, administrative expenses, and fees paid. In addition, the OFIS Commissioner would have to compile data regarding the performance of administrative services provided to medical benefit plans, and the cost and performance of health care facilities and providers. These requirements would enable public employers to make more informed choices regarding health care. Transparency would enable a public employer to save money by assessing the health problems of its employees and implementing effective and targeted health management and preventive programs. The increased available information also would allow purchasers to seek competitive bids from providers based on cost and performance, increasing competition and lowering prices.

At the same time, many carriers are not experienced in bidding school or other public employee health benefits, especially at large group rates. By requiring public employers to disclose claims utilization and cost information to carriers and plan

administrators, the bill would ensure that they had the information necessary to offer accurate quotes to make the lowest and most competitive bids, which in turn would lower the cost for employers.

Opposing Argument

The key methods of providing health care coverage under the bills are already available to public employers. The proposed insurance pools are currently permitted under the laws regulating multiple employer welfare arrangements. The West Michigan Insurance Pool was developed and approved by the State under existing law. If public employers are interested in creating insurance pools, they can establish MEWAs modeled after the West Michigan pool. The two or three years it took to create the pool were not unreasonable in view of its significance and newness. Also, the Michigan Education Special Services Association (MESSA), which covers about 55% of the State's public school and community college employees, currently offers the benefits and cost savings of insurance pooling. The bills, however, would remove the consumer protections offered under these plans, allowing the creation of insurance pools that would not be regulated as MEWAs or otherwise subject to the Insurance Code. Pools operated without proper oversight and regulation could be underfunded and financially unstable.

Response: Senate Bill 418 (S-1) would establish cash reserve requirements for public employer pooled plans, require them to submit financial statements and have excess loss insurance, and authorize the Commissioner to take action against a noncompliant plan.

Opposing Argument

Because the pools created under the bills would be voluntary, school districts and other public employers would be able to jump in and out of the system, based on whether they could get a better rate within a pool or on their own.

The bills would compound this problem by requiring the release of claims experience data for each employer. A pool then could select only employers with low health costs to join the pool, leaving other employers with higher costs to face higher health premiums. Such selective "cherry picking" violates a basic principal of insurance: that the risks are spread equally across as many people as possible. If pools were able to pick and choose the employers with lower claims histories, the health insurance market in Michigan could be destabilized, reducing costs for some while driving up insurance premiums for others.

The release of employees' claims histories also could violate the individuals' privacy. Health information is very sensitive and personal, and even if all identifying markers were removed from the data, employers might be able to tell which employee had a particular condition, particularly in small local units or districts or in cases involving unusual illnesses or conditions.

Response: Senate Bill 418 (S-1) would curb cherry picking by requiring a pooled plan to accept any public employer that applied to become a member and agreed to make required payments and remain in the pooled plan for at least three years. Also, an employer would not be able to rejoin a plan for two years after leaving it.

Opposing Argument

According to the Office of Financial and Insurance Services, the agency does not have the expertise or experience to comply with several of the requirements of Senate Bill 418 (S-1). The bill would require the Commissioner to ensure access to information regarding cost and performance of medical providers, who are not regulated by OFIS. Specifically, OFIS does not have expertise in areas of physician performance information, clinical measures, hospital performance information, case management techniques, or best practices and program accreditation involving health care. According to the agency, duties in these areas "would be better assigned to a department or agency that is more familiar with the standard used to determine quality of care and treatment".

Also, according to OFIS, the proposed regulatory assessment would not cover the costs of the responsibilities that would be assigned to the Commissioner.

Legislative Analyst: Craig Laurie

FISCAL IMPACT

Senate Bill 418 (S-1)

The bill would result in new administrative costs to the State. Specific State costs

include the examination and regulation of pooled plans by the Office of Financial and Insurance Services within the Department of Labor and Economic Growth. The bill would allow OFIS to collect an assessment on each pooled plan in the amount of 0.25% of the annual self-funded contributions made to the medical benefit plan each year, although OFIS testified that the amount of these assessments would be insufficient to cover the estimated oversight costs. The State also would incur information technology costs pertaining to the collection and manipulation of necessary data. In addition, OFIS would be required to collect and ensure access to data on the cost efficiency and performance of administrative service providers and health care facilities and providers, and to prepare and make available a buyer's guide with information on medical benefit plan design, administration, selection of providers, and medical care planning. It appears that these costs would not be recovered via the assessments charged to participating public employers.

Regarding local costs, according to "A Model for Saving Public School Health Care Dollars Through Large Claim Pooling, Increased Competition and Improving Health Care Quality", an August 10, 2005, report sponsored by the Michigan Federation of Teachers (MFT) and School Related Personnel and the International Union of Operating Engineers Local 547, the estimated savings to schools are $156 million (7.20% of the total cost of school employee health care) in the first year, based upon a model that includes:

-- State-sponsored catastrophic stop loss coverage.
-- Competitive health care purchasing by local school districts through regional group-purchasing pools.
-- State-of-the-art programs to improve employee health.
-- Disclosure of hospital and physician performance on quality measures.
-- Efficient administrative services that leverage industry standards, competition and information technology.
-- Transparent health care information for purchasers and consumers.

Since Senate Bill 418 (S-1) does not include the State-sponsored catastrophic stop loss (CSL) coverage, it is unknown how the estimated savings in the MFT's report would change, though the report does estimate that the State-sponsored CSL coverage made up 0.17% of the 7.20% total estimated savings. It is possible that the report's assumption that 75% of fully insured groups would move to self-funding could be overstated due to the unavailability of statewide CSL coverage, which would yield lower total estimated savings.

Other estimated savings found in the August 10, 2005, report include frequent updates of employer eligibility, more aggressive checks of students' eligibility for benefits, negotiated administrative fees, provider access fees, and pharmacy carve-out (savings estimated to equal 4.88% out of the 7.20% cited above of total school employer health care costs). The bill itself would not force these savings; instead, if a public employer did regionally pool and self-insure, it would be in the best interests of that employer to undertake these activities and generate the possible savings.

Again, however, this bill would not force or guarantee those stated savings, but could make it easier for a self-funded, pooled benefit arrangement to occur due to the availability of health care claims data, though without State-sponsored CSL coverage, as mentioned above, it is unknown how that factor would affect the willingness and ability of public employers to pool and self-insure.

The report and potential savings listed above relate only to school districts. This bill would allow all public employers to petition to become a pooled plan. It is unknown what the fiscal impact would be on all public employers due to a lack of detailed information on the vast array of current plans offered, actuarial assumptions used, employees covered, benefits offered, employee payments toward health care, and other information. Pooled plan participants would pay assessments to OFIS of 0.25% of the annual self-funded contributions made to the self-insured medical benefit plan for a given year.

Senate Bills 419 and 421

The bills would have no fiscal impact on the State.

The bills would require school districts, public school academies, urban high school

academies, strict discipline academies, intermediate school districts, and community colleges that offered medical, optical, or dental benefits to employees and their dependents to provide those benefits in accordance with the proposed Public Employees Health Benefit Act. The only local mandate under that Act would require a public employer to be furnished with complete and accurate claims utilization and cost information with respect to the employer's claims and benefits so long as the public employer had 100 or more public employees entered into a pooled plan, or had signed a letter of intent for such pooling. Therefore, the fiscal impact on public employers under the bills would be zero (unless a benefits provider under contract with a public employer chose to increase the premiums charged to cover any costs associated with providing claims data), though the availability of claims data could lead to different benefit choices.

Senate Bill 420

The bill would have no fiscal impact on the State.

The bill would allow municipal corporations to group self-insure if the benefits were provided under the Public Employees Health Benefit Act. Therefore, the fiscal impact under the bill is indeterminate and would depend upon how many municipal corporations used the bill's provisions and any resulting changes the provisions would make in the cost of providing insurance. The bill would expand the circumstances under which municipal corporations are allowed to pool group self-insurance, but would not mandate such activities. The availability of this type of arrangement could lead to changes in the provision of benefits, and corresponding differences in costs, but the bill itself would not require those benefit changes.

Fiscal Analyst: Kathryn Summers-Coty

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