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BILL ANALYSIS

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Senate Bills 418, 419, 420, and 421 (as enacted) **PUBLIC ACTS 106-109 of 2007**
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)
Senate Committee: Local, Urban and State Affairs
House Committee: Education

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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 services. 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 was suggested that regional health insurance pools could allow school districts and local governments to reap cost savings. Some also suggested that schools and local governments should have greater access to information about health care providers' prices and performance, and 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 will increase their effectiveness by enabling them to save money on health care. Many believe that these and other measures will enhance competition in the health care market and enable school districts and other public employers to control employee benefit costs.

CONTENT

Senate Bill 418 created 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 applies to become a member, agrees to make required payments, and agrees to remain in the pool for three years.
-- Prohibit a public employer that leaves a pooled plan from rejoining it for two years.
-- Require a public employer or 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 public employer that has 100 or more employees in a medical benefit plan, or a combination of employers that together have 100 or more employees in a medical benefit plan or have signed a letter of intent to enter them in a plan, to be given claims utilization and cost information.

-- Require all medical benefit plans in the State to compile claims utilization and cost information for the medical benefit plan in the aggregate and for each public employer, and make the information available to medical benefit plans with 100 or more employees.
-- Require public employers to disclose to carriers and employee representatives the claims utilization and cost information that must be provided in cases of 100 or more public employees in a plan.
-- Provide that claims utilization and cost information may 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 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.
-- Authorize the OFIS Commissioner to grant certificates of registration, examine pooled plans, and take action against pooled plans for violating the Act.

<u>Senate Bills 419, 420, and 421</u> amended various statutes to do the following:

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

The four bills were tie-barred to each other. Senate Bills 419, 420, and 421 also were tie-barred to Senate Bill 549 (Public Act 101 of 2007, which requires intermediate school districts and their constituent districts to adopt a common calendar).

Senate Bills 418 through 421 took effect on October 1, 2007, and are described below.

<u>Senate Bill 418</u>

<u>Medical Benefit Plans</u>

Under the Public Employees Health Benefit Act, subject to collective bargaining requirements, a public employer may 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 Act.
-- 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 does not constitute doing the business of insurance in the State and is not be subject to the insurance laws of the State. A pooled plan may enter into contracts and sue or be sued in its own name.

A pooled plan must accept any public employer that applies to become a member, agrees to make the required payments, agrees to remain in the pool for a three-year period, and satisfies the other reasonable provisions of the pooled plan. A public employer that leaves a pooled plan may not rejoin the plan for two years.

A public employer or a pooled plan that procures coverage or benefits from one or more carriers must solicit at least four bids when establishing a medical benefit plan and every three years when renewing or continuing a medical benefit plan. At least

one bid must be from a voluntary employees' beneficiary association described in a section of the Internal Revenue Code. A public employer or pooled plan that provides 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 must 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 Act states that it does 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 provides medical benefits must provide to covered individuals case management services that meet 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 may 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 Act.

The Act defines "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 includes a public university that elects to come under the provisions of the Act.

"Medical benefit plan" means 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" means 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 Registration

A person may not establish or maintain a public employer pooled plan in the State unless the pooled plan obtains and maintains a certificate of registration. A person wishing to establish a pooled plan must apply for a certificate on a form prescribed by the Commissioner. The completed application must 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, optical, or dental benefits under it.
-- Current financial statements of the pooled plan or, for a newly established pooled pan, three years of financial projections.
-- A statement showing in full detail the plan upon which the pooled plan proposes to transact business and a copy of all contracts or other instruments that it proposes to make with or sell to its members, together with a copy of its plan description.

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

The Commissioner must issue or deny a certificate of registration within 90 days of receiving an applicant's substantially completed application. The Commissioner may not issue a certificate of registration to the pooled plan unless he or she is satisfied that the plan is in a stable and unimpaired financial condition, that it is qualified to maintain a medical benefit plan in compliance with the Act, and that the pooled plan meets 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 must deny a certificate of registration to an applicant who fails to meet the requirements of the Act. Notice of denial must set forth in writing the basis for the denial. If the applicant submits a written request within 60 days after the notice of denial is mailed, the Commissioner promptly must conduct a hearing pursuant to the Administrative Procedures Act, in which the applicant will be given an opportunity to show compliance with the requirements of the Public Employees Health Benefit Act.

Upon receiving its initial certificate of registration, which will be a temporary certificate, a pooled plan must proceed to complete organization of the proposed pooled plan. A pooled plan is required to open its books to the Commissioner. The Commissioner may not issue a final certificate of registration until the pooled plan collects cash reserves (as described below).

Requirements of Pooled Plans

A public employer pooled plan established on or after October 1, 2007, must 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; or not less than 35% of the claims paid in the preceding fiscal year, whichever is greater. Reserves must be maintained in a separate, identifiable account and may not be commingled with other funds of the pooled plan. The pooled plan must 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 may satisfy up to 100% of the reserve requirement in the first year of operation, up to 75% of the reserve requirement in the second year of operation, and up to 50% of the reserve requirement in the third and subsequent years of operation, through an irrevocable and unconditional letter of credit. The letter of credit must be issued by a federally insured financial institution and upon such terms and in a form as approved by the Commissioner. It also is 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 is unable to pay claims as they come due.

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

Within 60 days after the end of each fiscal quarter, a pooled plan must 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 maintains reserves that are sufficient to meet its contractual obligations, and that it maintains coverage for excess loss as required under the Act.

A pooled plan also must provide for administration of the plan by using its personnel, provided that the plan has 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 is 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 finds that a pooled plan's reserves are not sufficient to meet the requirements described above, he or she must order the pooled plan immediately to collect from any public employer that is or has been a member of the plan appropriately proportionate contributions sufficient to restore reserves to the required level.

The Commissioner may take action he or she considers necessary, including ordering the suspension or dissolution of a pooled plan, if the pooled plan does any of the following:

-- Consistently fails to maintain required reserves.
-- Uses methods and practices that render further transaction of business hazardous or injurious to its members, employees, or beneficiaries, or to the public.
-- Fails, after written request by the Commissioner, to remove or discharge an officer, director, trustee, or employee who has been convicted of any crime involving fraud, dishonesty, or moral turpitude.
-- Fails or refuses to furnish any report or statement required under the Act.
-- Conducts business fraudulently or does not meet its contractual obligations in good faith (as determined by the Commissioner upon investigation).

Proceedings under these provisions are 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, may examine the affairs of any pooled plan, and for such purposes, must have free access to all of the books, records, and documents that relate to the business of the plan, and may 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 must 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% of the annual self-funded contributions made to the pooled plan for that year. The assessments must be appropriated to OFIS to cover the additional costs it incurs in the examination and regulation of pooled plans under the Act.

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

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

The powers of a pooled plan, except as otherwise provided, must be exercised by the board of trustees chosen to carry out the purposes of the trust agreement. At least 50% of the trustees must be people who are covered under the pooled plan or their collective bargaining representatives. No trustee may 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 has 100 or more employees in a medical benefit plan must be provided with claims utilization and cost information, as described below. A public employer that is in an arrangement with one or more other public employers, which together have 100 or more employees in a

medical benefit plan or have signed a letter of intent to enter together 100 or more public employees into a medical benefit plan, must be provided with claims utilization and cost information aggregated for all the public employees together of those public employers, as described below.

All medical benefit plans in the State must compile, and 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 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 must be compiled on an annual basis and cover a relevant period, which means the 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 has been in effect for less than 36 months, the relevant period is that shorter period.

All claims utilization and cost information described in these provisions must be compiled beginning 60 days after October 1, 2007. Claims utilization and cost information that already was being compiled on October 1, 2007, is subject to the requirements on that date.

A public employer or combination of public employers must disclose the claims utilization and cost information required to be provided in cases of 100 or more public employees in a medical benefit plan, to any carrier or administrator it solicits 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 requests 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 must make the information available at cost and within a reasonable period of time.

The claims utilization and cost information required under these provisions may include only de-identified health information as permitted under, and may 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 amended 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 provides medical, optical, or dental benefits to employees and their dependents, the board must provide those benefits in accordance with the Public Employees Health Benefit Act and must comply with that Act.

Senate Bill 420

The bill amended 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 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 makes another exception to that prohibition for a municipal corporation that is providing hospital, medical, surgical, or dental benefits as permitted under the Public Employees Health Benefit Act.

Senate Bill 421

The bill amended the Community College Act to require the board of trustees of a community college that provides medical benefits to employees to provide those benefits in accordance with the Public Employees Health Benefit Act.

Specifically, the bill authorizes the board of trustees of a community college to select and employ administrative officers, teachers, and other employees it finds necessary to operate the community college district and establish the terms and conditions of their service or employment. If the board provides medical, optical, or dental benefits to employees and their dependents, the board must provide those benefits in accordance with the Act and must comply with it.

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 added that if the chief executive officer provides medical, optical, or dental benefits to employees and their dependents, he or she must provide those benefits in accordance with the Public Employees Health Benefit Act and comply with it.

MCL 124.71-124.85 (S.B. 418)
380.506a 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 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 will 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 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 by 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 will allow local governments to spend more on essential public services such as law enforcement, and will enable school districts to put more money directly into the classroom.

Supporting Argument

Traditionally, insurance purchasers have had 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 provides 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. These requirements will enable public employers to make more informed choices regarding health care, and to save money by assessing the health problems of their employees and implementing effective and targeted health management and preventive programs. The increased available information also will 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 will ensure that they have the information necessary to offer accurate quotes to make the lowest and most competitive bids, which in turn will lower the cost for employers.

Opposing Argument

The key methods of providing health care coverage under the bills were already available to public employers. The insurance pools already were 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 were interested in creating insurance pools, they could establish MEWAs modeled after the West Michigan pool. The two or three years it took to create that 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, already offered the benefits and cost savings of insurance pooling. The bills, however, omit the consumer protections offered under these plans, allowing the creation of insurance pools that will not be regulated as MEWAs or otherwise subject to the Insurance Code. Pools operated without proper oversight and regulation may be underfunded and financially unstable.

Response: Senate Bill 418 contains cash reserve requirements for public employer pooled plans, requires them to submit financial statements and have excess loss insurance, and authorizes the Commissioner to take action against a noncompliant plan.

Opposing Argument

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

The bills compound this problem by requiring the release of claims experience data for each employer. A pool then can

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. Because pools may pick and choose the employers with lower claims histories, the health insurance market in Michigan may be destabilized, reducing costs for some while driving up insurance premiums for others.

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

Response: Senate Bill 418 will curb cherry picking by requiring a pooled plan to accept any public employer that applies to become a member and agrees to make required payments and remain in the pooled plan for at least three years. Also, an employer may not rejoin a plan for two years after leaving it.

Legislative Analyst: Craig Laurie

FISCAL IMPACT

Senate Bill 418

The bill will 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 allows OFIS to collect an assessment on each pooled plan in the amount of 0.25% of the annual self-funded contributions made to the pooled plan each year, although OFIS testified that the amount of these assessments will be insufficient to cover the estimated oversight costs.

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 does not include the State-sponsored catastrophic stop loss (CSL) coverage, it is unknown how the estimated savings in the MFT's report will 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 will 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 will not force these savings; instead, if a public employer does regionally pool and self-insure, it will be in the best interests of that employer to undertake these activities and generate the possible savings.

Again, however, this bill will not force or guarantee those stated savings, but may 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 will 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 allows all public employers to petition to become a pooled plan. It is unknown what the fiscal impact will 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 will 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.

One other provision in the bill requires all public employers or pooled plans to seek four or more bids when establishing or renewing a medical benefit plan, and when using an authorized third party administrator. The fiscal impact of this requirement is indeterminate.

Senate Bills 419 and 421

The bills will have no fiscal impact on the State.

The bills require school districts, public school academies, urban high school academies, strict discipline academies, intermediate school districts, and community colleges that offer medical, optical, or dental benefits to employees and their dependents to provide those benefits in accordance with the Public Employees Health Benefit Act. The only local mandate under that Act requires 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 has 100 or more public employees entered into a pooled plan, or has signed a letter of intent for such pooling. Therefore, the fiscal impact on public employers under the bills is zero (unless a benefits provider under contract with a public employer chooses 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 will have no fiscal impact on the State.

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

Fiscal Analyst: Kathryn Summers-Coty

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