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BILL ANALYSIS

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Senate Bills 418 through 421 (as introduced 4-19-07)
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: 5-22-07

CONTENT

Senate Bill 418 would create the "Public Employees Health Benefit Act", and Senate Bills 419, 420, and 421 would amend various statutes, to do the following:

-- Require a school board or the board of trustees of a community college that provided health benefits to employees to provide those benefits in accordance with the proposed Public Employees Health Benefit Act.
-- Require that all school medical benefit plans and public universities in the State be offered the opportunity to participate in a catastrophic stop loss (CSL) benefit plan.
-- Create a board of directors that, beginning July 1, 2007, would have to implement and administer a CSL fund that provided two or more CSL benefit plans.
-- Require the CSL fund to reimburse a participating medical benefit plan for a claim over a certain dollar threshold (of at least $50,000 per claim), as specified in the CSL benefit plan; and require the fund to assume liability for a covered claim exceeding the threshold.
-- Require a medical benefit plan to give the CSL fund information it needed to price coverages under the CSL benefit plan chosen by the medical benefit plan.
-- Allow a public employer to join with other public employers by establishing and maintaining a public employer pooled plan to provide benefits on a self-insured basis.
-- Require a person to obtain a certificate of authority before establishing or maintaining a public employer pooled plan.
-- Establish requirements for the maintenance of a public employer pooled plan, including minimum cash reserves.
-- Require a carrier that provided one or more medical benefit plans to a public employer, covering 100 or more of that employer's employees, to provide the employer with claims utilization and cost information, as long as the public employer had 100 or more public employees entered in a pooled plan or signed a letter of intent to enter them; and require a 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.
-- Assign responsibilities to the Commissioner of the Office of Financial and Insurance Services (OFIS), including granting certificates of authority, maintaining reserves, and taking action against pooled plans for violations of the proposed Act.

The bills are tie-barred.

Senate Bill 418

The bill would create a 10-member board of directors to administer the CSL fund. Nine of the members would be appointed by the Governor with the advice and consent of the Senate with not more than one representing the same agency. The appointed members would have to include the following:

-- Two with some background in insurance issues representing public employers until July 1, 2008; and, effective on that date, two with some background in insurance issues representing public employers that had selected a CSL benefit plan and were participating in the CSL fund.
-- Two with some background in insurance issues representing collective bargaining organizations that represented public employees, at least one of whom was recommended by the Michigan State AFL-CIO, until July 1, 2008; and, effective on that date, two with experience representing bargaining organizations that represented public employees of public employers that had selected a CSL benefit plan and were participating in the CSL fund, including at least one recommended by the AFL-CIO
-- One representing the general public.
-- One representing the general public with expertise in health promotion and chronic care management programs including, at least, promoting nutrition and physical exercise and compliance with disease management programs and preventative service guidelines supported by evidence-based medical practice.
-- One representing the House of Representatives with some background in insurance issues, as recommended by the Speaker of the House.
-- One representing the Senate with some background in insurance issues, as recommended by the Senate Majority Leader.
-- One who was an actuary in good standing with the American Academy of Actuaries or the Society of Actuaries, who would serve ex officio and without vote.

The 10th member of the board would be the OFIS Commissioner or his or her designee, who would serve ex officio and without vote.

The directors first appointed to the board would have to be appointed within 60 days of the bill's effective date. The board would be required to adopt rules providing for the composition and term of successor boards. The directors' terms would have to be staggered so that they did not all expire at the same time, and successive appointments would have to be made in the same manner as the initial appointments.

Except as otherwise provided, each director would have one vote on any matter that came before the board. The first meeting of the board would have to be called by the Commissioner. At the first meeting, the board would elect from among the directors a chairperson and other officers as it considered necessary or appropriate. The board would be required to meet at least quarterly, or more frequently at the call of the chairperson or if requested by three or more directors.

A majority of the directors would constitute a quorum for the transaction of business at a board meeting. A majority of the directors present and serving would be required for official board action.

Directors would serve without compensation, but could be reimbursed for expenses incurred in the performance of their duties.

The bill states that the board would not be a State board or agency and the CSL fund administered by the board would not be a State fund.

CSL Fund & CSL Benefit Plans

Beginning July 1, 2007, the board would be required to implement and administer a CSL fund that provided two or more CSL benefit plans. The fund would have to reimburse a participating medical benefit plan for a claim that exceeded the dollar threshold of the CSL benefit plan chosen by that medical benefit plan. The board would have to adopt a plan of operation for the CSL fund that would provide for the management and nonprofit operation of the fund and each CSL benefit plan consistent with the proposed Act.

(A "medical benefit plan" would be 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, but not limited to, hospital and physician services, prescription drugs, and related benefits, to public employees.

A "carrier" would include:

-- A health, dental, or vision insurance company authorized to do business in the State under the Insurance Code.
-- A health maintenance organization or multiple employer welfare arrangement operating under the Insurance Code.
-- A system of health care delivery and financing as defined in the Insurance Code.
-- A nonprofit dental care corporation operating under Public Act 125 of 1963.
-- A nonprofit health care corporation operating under the Nonprofit Health Care Corporation Reform Act (Blue Cross and Blue Shield of Michigan).
-- A voluntary employees' beneficiary association described in a section of the Internal Revenue Code.
-- A pharmacy benefits manager.
-- Any other person providing a plan of health benefits, coverage, or insurance in the State.

"Public employer" would mean a city, village, township, county, or other political subdivision of the State; any intergovernmental, metropolitan, or local department, agency, or authority, or other local political subdivision; a school district, a public school academy, or an intermediate school district; or a community college or junior college. A public employer would include a public university that elected to come under the provisions of the proposed Act; the State, through the Civil Service Commission, that elected to come under the Act, or any other State employer on behalf of its State employees that elected to come under the Act. "Public employee" would mean an employee of a public employer.)

The board would be required to establish the CSL fund and one or more CSL benefit plans. The board would have to provide for reimbursement to a participating medical benefit plan for the portion of a covered claim that exceeded a dollar threshold established by the board in the CSL plan selected by the medical benefit plan. The threshold could not be less than $50,000 per claim. The board could provide additional plans that provided higher thresholds. A dollar threshold established under this provision would have to be adjusted to reflect changes in the U.S. consumer price index by June 1 of each year.

The board also would have to determine a premium for each CSL benefit plan that would be sufficient to cover expected losses and expenses that the CSL fund likely would incur during the period for which the premium applied. The premium would have to include an amount to cover losses incurred but not reported for the period, and could be adjusted for any excess or deficient premiums from previous periods. Adjustments could be made in a single period or over several periods.

The board would have to provide one or more incentives to participating medical benefit plans to provide health promotion and chronic care management programs to covered individuals for the purpose of improving or maintaining their health and reducing unnecessary or excessive medical expenses. Incentives could include an appropriate rebate of contributions paid for a demonstrated maintenance or improvement of members' health status as determined by assessments of agreed upon health status indicators. The programs would have to meet, if applicable, nationally recognized accreditation standards. If no such standards applied, the programs would have to meet standards established by the board, which would have to include, at a minimum, complete health risk assessments.

In establishing a CSL benefit plan, the board would have to do all of the following:

-- Provide that each benefit plan would not require any changes in the participating medical benefit plan, and would provide for continuity of health care treatment and providers for individuals covered under the participating medical benefit plan.
-- Maintain relevant and accurate loss and expense data relative to all liabilities of each CSL plan.
-- Require each participating medical benefit plan to furnish claims data at the

times and in the form and detail that the CSL fund required.
-- Receive and distribute all sums required for the operation of the CSL fund.
-- Adopt an investment policy for investing and reinvesting the assets of the CSL fund that complied with investment limitations governing the investment of assets of public employee retirement systems under the Public Employee Retirement System Investment Act.
-- Provide a comprehensive program of case management services that would be offered to a participating medical benefit plan for a covered individual whose claim was covered under, or was likely to become covered under, the CSL fund.

All medical benefit plans in the State would have to be offered the opportunity to select a CSL benefit plan and participate in the CSL fund. A medical benefit plan would have to provide to the CSL fund all information necessary for it to price coverage under the CSL benefit plan chosen by the medical benefit plan, including coverage limits. A public university and a State employer also would have to be offered the opportunity to select a CSL benefit plan and participate in the CSL fund.

The CSL fund would have to do all of the following:

-- Assume all of the liability for any covered claim that exceeded the dollar threshold under the applicable CSL benefit plan.
-- Maintain relevant and accurate loss and expense data relative to all liabilities of the CSL fund.
-- Maintain reserves as required by the Commissioner as necessary for the preservation, maintenance, and operation of the CSL fund.

Authorized Activities of the Board

The board would have the authority to do any of the following:

-- Purchase coverage to cede all or any portion of its potential liability with an insurer licensed to transact insurance in the State or otherwise approved by the Commissioner.
-- Provide for appropriate housing, equipment, and personnel as necessary to ensure the efficient operation of the CSL fund.
-- Adopt reasonable rules for the administration of the fund, enforce those rules, and delegate authority as the board considered necessary to assure proper administration and operation.
-- Contract for goods and services, including independent claims management, actuarial, investment, and legal services to assure the efficient operation of the fund.
-- Perform other acts that were necessary or proper to accomplish the purposes of the fund.

The board would be required to hear and determine complaints concerning the operation of the fund.

The board could sue and be sued in the name of the CSL fund. A judgment against the board could not create any direct liability against the participating medical benefit plans or public employers.

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, who 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 provisions 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, and satisfied the other reasonable provisions of the pooled plan. A pooled plan that procured coverage or benefits from one or more carriers would have to solicit at least four bids when establishing, 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, 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 participating in a CSL benefit plan that elected not to participate in a program of case management 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.

Certificate of Authority for a Public Employer Pooled Plan

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 excepted 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 30 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 30 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 for establishment under 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 collected the required cash reserves (described below).

Requirements of Public Employer 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 that 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).

The reserve requirement could be satisfied 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 experiences 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. The pooled plan also would have to file 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.

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 or from the CSL fund, 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.
-- Provide for administration of the plan by using personnel of the pooled plan, 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.

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 such action as 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 was not meeting 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 multiple employer welfare arrangements).

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 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 the 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 of its amendments would have to be filed with and presumed approved by the Commissioner if not disapproved within 30 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

Beginning on the bill's effective date, a carrier that provided one or more medical benefit plans to a public employer, which plans covered in the aggregate 100 or more of that public employer's employees, would have to provide to that public employer complete and accurate claims utilization and cost information for that public employer's claims and benefits under those medical benefit plans so long as the public employer had 100 or more public employees entered into a pooled plan or had signed a letter of intent to enter 100 or more employees into a pooled plan.

Beginning on the bill's effective date, all medical benefit plans in the State would have to compile, and would have to make available as described above, complete and accurate claims utilization and cost information for the medical benefit plan in the aggregate and for each public employer as follows:

-- The number of people covered under the medical benefit plan.
-- If applicable, the number of people covered under a policy, certificate, or contract issued by a carrier.
-- The number of claims paid.
-- The dollar amounts of claims paid and of claims incurred but not reported.
-- The number of claims paid over $100,000 and their total dollar amount.
-- The claims experience, by coverage component and by provider.
-- The dollar amount of premiums or fees paid, if any.

-- The dollar amount of administrative expenses incurred or paid.
-- The dollar amount of retentions.
-- The dollar amount of provider, network, case management, and precertification fees, and other service fees paid.
-- The dollar amount of any fees paid or commissions paid to agents or brokers by the medical benefit plan or by any public employer or carrier participating in or providing services to that plan.
-- 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 no 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.

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 person who requested the opportunity to submit a proposal to provide benefits or administrative services for the medical benefit plan. 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, Public Law 104-191, or regulations promulgated under that Act, 45 CFR parts 160 and 164.

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 timelines 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, an urban high school, or a strict discipline academy, or the school board of a school district or an intermediate school district provided medical, optical, and 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 add an exception from 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 a 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, and 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, and 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)

Legislative Analyst: Craig Laurie

FISCAL IMPACT

Senate Bill 418

State: The State would see new administrative costs associated with the creation of a catastrophic stop loss fund and the creation of a board of directors for oversight and management of the fund, and in the examination and regulation of pooled plans under this bill. Specific State costs could include the hiring of skilled actuaries trained in determining the stop loss premiums charged to participating public employers, and information technology costs pertaining to the collection and manipulation of necessary data. However, costs the State would incur in creating and overseeing the fund should be included in the premiums charged to participating public employers, thereby resulting in zero net State costs, once the premium fees were collected and used to pay for start-up and maintenance. Other responsibilities imposed by the bill and associated with the examination and regulation of pooled plans would increase the administrative costs of the Office of Financial and Insurance Services within the Department of Labor and Economic Growth. These costs probably would be recovered via an assessment on each pooled plan in the amount of 0.25% of the annual self-funded contributions made to the plan each year. In addition to the activities listed above, 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 premiums or assessments charged to participating public employers.

The State Civil Service currently self-insures and does not purchase catastrophic stop-loss insurance. If the costs to purchase CSL

insurance from the new fund were cheaper than what the State currently pays in excessive claims, the State civil service could see savings under this bill.

Local: 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 and School Related Personnel and the International Union of Operating Engineers Local 547, the estimated savings to schools for the proposed model partially contained within the bill are $156 million in the first year, representing savings of 7.20% of the total cost of school employee health care. Some of the savings in this report (2.77% due to the self-funding, or "pay-as-you-go", of medical claims, rather than the purchase of policies) assume that because of the creation of a statewide catastrophic stop loss fund available to participating employers and complete availability of health care claims data, 75% of groups that are currently fully insured would move to self-funding through purchasing coalitions or pools, and the report uses HayGroup assumptions found in the July 13, 2005, paper, "Report on the Feasibility and Cost-Effectiveness of a Consolidated State-wide Health Benefits System for Michigan Public School Employees".

Two of the assumptions used in the above report are contained within Senate Bill 418: the creation of a statewide catastrophic stop loss fund and the provision of health care claims data for public employers with 100 or more public employees, or for a pooled plan with 100 or more pooled employees.

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% 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 likely would make it easier for a self-funded, pooled benefit arrangement to occur due to the availability of a statewide catastrophic stop loss fund and the potential availability of health care claims data.

The report and potential savings listed above relate only to school districts. This bill would allow all public employers to use the catastrophic stop loss fund and/or 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.

Participants in the statewide catastrophic stop loss fund would pay premiums based on the expected losses and expenses of the catastrophic stop loss fund. Premiums could be adjusted for any excess or deficient premiums from previous periods. Pooled plan participants also 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

State: The bills would have no fiscal impact on the State.

Local: 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

State: The bill would have no fiscal impact on the State.

Local: The bill would allow municipal corporations to group self-insure if the benefits were provided as permitted 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 circumstance 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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This analysis was prepared by nonpartisan Senate staff for use by the Senate in its deliberations and does not constitute an official statement of legislative intent.