SENATE BILL No. 418

April 19, 2007, Introduced by Senators JANSEN, BIRKHOLZ, BROWN, KUIPERS, GILBERT, HARDIMAN, GEORGE, CROPSEY, VAN WOERKOM, GARCIA, PAPPAGEORGE and BISHOP and referred to the Committee on Local, Urban and State Affairs.

A bill to provide for a catastrophic stop loss fund and catastrophic stop loss benefit plans; to create a board of directors of the catastrophic stop loss fund; to prescribe the conditions upon which public employers may provide certain benefits; to require the compilation and release of certain information and data; to provide certain powers and duties to certain state officials, departments, agencies, and authorities; and to provide for appropriations.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Sec. 1. This act shall be known and may be cited as the "public employees health benefit act".

Sec. 3. As used in this act:

(a) "Board" means the board of directors created under section

SENATE BILL No. 418

5.

(b) "Carrier" means a health, dental, or vision insurance company authorized to do business in this state under, and a health maintenance organization or multiple employer welfare arrangement operating under, the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302; a system of health care delivery and financing as defined in section 3573 of the insurance code of 1956, 1956 PA 218, MCL 500.3573; a nonprofit dental care corporation operating under 1963 PA 125, MCL 550.351 to 550.373; a nonprofit health care corporation operating under the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1101 to 550.1704; a voluntary employees' beneficiary association described in section 501(c)(9) of the internal revenue code, 26 USC 501(c)(9); a pharmacy benefits manager; and any other person providing a plan of health benefits, coverage, or insurance in this state.

(c) "Commissioner" means the commissioner of the office of financial and insurance services.

(d) "Consumer price index" means the percentage of change in the consumer price index for all urban consumers in the United States city average for all items for the calendar year ending prior to the June 1 effective date of the adjustment under section 7 as reported by the United States department of labor, bureau of labor statistics, and as certified by the commissioner.

(e) "Medical benefit plan" means a plan established and maintained by a carrier or 1 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.

(f) "Public employer" means 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, a public school academy, or an intermediate school district, as those terms are defined in the revised school code, 1976 PA 451, MCL 380.1 to 380.1852; or a community college or junior college described in section 7 of article VIII of the state constitution of 1963. Public employer includes the following:

(*i*) A public university that elects to come under the provisions of this act.

(*ii*) This state through the civil service commission that elects to come under the provisions of this act or any other state employer on behalf of its state employees that elects to come under the provisions of this act.

(g) "Public employer pooled plan" or "pooled plan" means a public employer pooled plan established pursuant to section 11(1)(b).

(h) "Public university" means a public university described in section 4, 5, or 6 of article VIII of the state constitution of 1963.

(i) "Public employee" means an employee of a public employer.

Sec. 5. (1) There is created a board of directors to administer the catastrophic stop loss fund. The board shall consist of 10 directors as follows:

(a) The following 9 directors appointed by the governor with

the advice and consent of the senate with not more than 1 director representing the same agency:

(*i*) Until July 1, 2008, 2 directors with some background in insurance issues representing public employers, and, effective July 1, 2008, 2 directors with some background in insurance issues representing public employers that have selected a catastrophic stop loss benefit plan and participate in the catastrophic stop loss fund.

(*ii*) Until July 1, 2008, 2 directors with some background in insurance issues representing collective bargaining organizations that represent public employees, at least 1 of whom is recommended by the Michigan state AFL-CIO, and, effective July 1, 2008, 2 directors representing collective bargaining organizations that represent public employees of public employers that have selected a catastrophic stop loss benefit plan and participate in the catastrophic stop loss fund, at least 1 of whom is recommended by the Michigan state AFL-CIO.

(*iii*) One director representing the general public.

(*iv*) One director representing the general public with expertise in health promotion and chronic care management programs that include, at a minimum, promoting nutrition and physical exercise and compliance with disease management programs and preventive service guidelines that are supported by evidence-based medical practice.

(*v*) One director representing the house of representatives with some background in insurance issues as recommended by the speaker of the house of representatives.

(*vi*) One director with some background in insurance issues representing the senate as recommended by the senate majority leader.

(*vii*) One director who is an actuary in good standing with the American academy of actuaries or the society of actuaries, who shall serve ex officio and without vote.

(b) The commissioner or his or her designee, who shall serve ex officio and without vote.

(2) The directors first appointed to the board shall be appointed within 60 days after the effective date of this act.

(3) The board shall adopt rules providing for the composition and term of successor boards to the initial board, consistent with subsection (1). Terms of the board directors shall be staggered so that the terms of all directors do not expire at the same time. The appointment of a successor director or to fill a vacancy shall be made in the same manner as the original appointment.

(4) Except as otherwise provided, each board director shall have 1 vote on any matter coming before the board.

(5) The first meeting of the board shall be called by the commissioner. At the first meeting, the board shall elect from among the directors a chairperson and other officers as it considers necessary or appropriate. After the first meeting, the board shall meet at least quarterly, or more frequently at the call of the chairperson or if requested by 3 or more directors.

(6) A majority of the directors of the board constitute a quorum for the transaction of business at a meeting of the board. A majority of the directors present and serving are required for

official action of the board.

(7) Directors of the board shall serve without compensation. However, board directors may be reimbursed for their actual and necessary expenses incurred in the performance of their official duties as board directors.

(8) The board is not a state board or agency and the catastrophic stop loss fund administered by the board is not a state fund.

Sec. 7. (1) Beginning July 1, 2007, the board shall implement and administer a catastrophic stop loss fund that provides 2 or more catastrophic stop loss benefit plans. The catastrophic stop loss fund shall reimburse a participating medical benefit plan for a claim that exceeds the dollar threshold of the catastrophic stop loss benefit plan chosen by that participating medical benefit plan. The board shall adopt a plan of operation for the catastrophic stop loss fund that shall provide for the management and nonprofit operation of the catastrophic stop loss fund and each catastrophic stop loss benefit plan consistent with this act.

(2) The board shall establish the catastrophic stop loss fund and 1 or more catastrophic stop loss benefit plans. The board shall do all of the following:

(a) Provide for reimbursement to a participating medical benefit plan for the portion of a covered medical benefit claim that exceeds a dollar threshold established by the board in the catastrophic stop loss benefit plan selected by the medical benefit plan. The minimum dollar threshold to be provided under a catastrophic stop loss benefit plan shall not be less than

$50,000.00 per individual claim. The board may provide for additional catastrophic stop loss benefit plans that provide dollar threshold levels above $50,000.00 per individual claim. A dollar threshold level established under this subdivision in a catastrophic stop loss benefit plan shall be adjusted to reflect changes in the consumer price index by June 1 of each year.

(b) Provide that each catastrophic stop loss benefit plan is subject to the following:

(*i*) Does not require any changes in the participating medical benefit plan for payment from the catastrophic stop loss fund.

(*ii*) Provides for continuity of health care treatment and providers for individuals covered under the participating medical benefit plan.

(c) Maintain relevant and accurate loss and expense data relative to all liabilities of each catastrophic stop loss benefit plan.

(d) Require each participating medical benefit plan to furnish claims data at the times and in the form and detail as may be required by the catastrophic stop loss fund.

(e) Determine a premium for each catastrophic stop loss benefit plan that is sufficient to cover expected losses and expenses that the catastrophic stop loss fund will likely incur during the period for which the premium is applicable. The premium shall include an amount to cover incurred but not reported losses for the period and may be adjusted for any excess or deficient premiums from previous periods. Excesses or deficiencies from previous periods may be fully adjusted in a single period or may be

adjusted over several periods.

(f) Receive and distribute all sums required for the operation of the catastrophic stop loss fund.

(g) Adopt an investment policy for investing and reinvesting the assets of the catastrophic stop loss fund that complies with investment limitations governing the investment of assets of public employee retirement systems under the public employee retirement system investment act, 1965 PA 314, MCL 38.1132 to 38.1140m.

(h) Provide a comprehensive program of case management services that shall be offered to a participating medical benefit plan for a covered individual whose claim is covered under, or is likely to become covered under, the catastrophic stop loss fund.

(i) Provide 1 or more incentives to participating medical benefit plans to provide health promotion, case management, and chronic care management programs to covered individuals of a participating medical benefit plan for the purpose of improving or maintaining the health of covered individuals and reducing unnecessary or excessive medical expenses. Incentives may 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. Health promotion and chronic care management programs shall meet, if applicable, nationally recognized accreditation standards. If nationally recognized accreditation standards are not applicable, health promotion and chronic care management programs shall meet standards established by the board which shall include, at a minimum, complete health risk assessments.

(3) All medical benefit plans in this state shall be offered the opportunity to select a catastrophic stop loss benefit plan and participate in the catastrophic stop loss fund. A medical benefit plan shall provide to the catastrophic stop loss fund all information necessary for the catastrophic stop loss fund to price coverage under the catastrophic stop loss benefit plan chosen by the medical benefit plan, including, but not limited to, medical benefit plan coverage limits. A public university and a state employer shall be offered the opportunity to select a catastrophic stop loss benefit plan and participate in the catastrophic stop loss fund.

(4) The catastrophic stop loss fund shall do all of the following:

(a) Assume 100% of all liability for any covered claim exceeding the dollar threshold under the applicable catastrophic stop loss benefit plan.

(b) Maintain relevant and accurate loss and expense data relative to all liabilities of the catastrophic stop loss fund.

(c) Maintain reserves as are required by the commissioner as being necessary in the exercise of sound and prudent actuarial judgment for the preservation, maintenance, and operation of the catastrophic stop loss fund.

Sec. 9. (1) The board may do any of the following:

(a) Sue and be sued in the name of the catastrophic stop loss fund. A judgment against the board shall not create any direct liability against the participating medical benefit plans or public employers.

(b) Purchase coverage to cede all or any portion of its potential liability with an insurer licensed to transact insurance in this state or otherwise approved by the commissioner.

(c) Provide for appropriate housing, equipment, and personnel as may be necessary to assure the efficient operation of the catastrophic stop loss fund.

(d) Adopt reasonable rules for the administration of the catastrophic stop loss fund, enforce those rules, and delegate authority, as the board considers necessary to assure proper administration and operation.

(e) Contract for goods and services, including independent claims management and actuarial, investment, and legal services to assure the efficient operation of the catastrophic stop loss fund.

(f) Perform other acts that are necessary or proper to accomplish the purposes of the catastrophic stop loss fund.

(2) The board shall hear and determine complaints concerning the operation of the catastrophic stop loss fund.

Sec. 11. (1) Subject to collective bargaining requirements, a public employer may provide medical, optical, or dental benefits to public employees and their dependents by any of the following methods:

(a) By establishing and maintaining a plan on a self-insured basis. A plan under this subdivision does not constitute doing the business of insurance in this state and is not subject to the insurance laws of this state.

(b) By joining with other public employers and establishing and maintaining a public employer pooled plan to provide medical,

optical, or dental benefits to not fewer than 250 public employees on a self-insured basis as provided in this act. A pooled plan shall accept any public employer that applies to become a member of the pooled plan, agrees to make the required payments, and satisfies the other reasonable provisions of the pooled plan. A pooled plan under this subdivision does not constitute doing the business of insurance in this state and is not subject to the insurance laws of this state. A pooled plan under this subdivision may enter into contracts and sue or be sued in its own name.

(c) By entering into an agreement under which contributions are 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 the public employer. A trust fund under this subdivision may receive contributions from 1 or more public employers and may provide medical, dental, and optical benefits to public employees of 1 or more public employers. A plan under this subdivision does not constitute doing the business of insurance in this state and is not subject to the insurance laws of this state.

(d) By procuring coverage or benefits from 1 or more carriers, either on an individual basis or with 1 or more other public employers. Public employers may pool risks with other public employers under this subdivision to the extent permitted under a written agreement.

(2) A pooled plan procuring coverage or benefits from 1 or more carriers shall solicit 4 or more bids when establishing, renewing, or continuing a medical benefit plan, including at least

1 bid from a voluntary employees' beneficiary association described in section 501(c)(9) of the internal revenue code, 26 USC 501(c)(9). A 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 shall solicit 4 or more bids for those administrative services when establishing, renewing, or continuing a medical benefit plan.

(3) This act 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.

(4) A medical benefit plan participating in a catastrophic stop loss benefit plan that elects not to participate in a program of case management under section 7(2)(h) shall 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.

(5) 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 set forth in this section.

Sec. 12. (1) A person shall not establish or maintain a public employer pooled plan in this state unless the pooled plan obtains and maintains a certificate of authority pursuant to this act.

(2) A person wishing to establish a pooled plan shall apply for a certificate of authority on a form prescribed by the commissioner. The application shall be completed and submitted to the commissioner along with all of the following:

(a) 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 the pooled plan.

(b) Current financial statements, if any, of the pooled plan.

(c) 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.

(3) The commissioner shall promptly examine the application and documents submitted by the applicant and may conduct any investigation that the commissioner considers necessary and examine under oath any person interested in or connected with the pooled plan.

(4) The commissioner shall issue a certificate of authority to the pooled plan if the commissioner is satisfied that the pooled plan is in a stable and unimpaired financial condition and that the pooled plan is qualified to maintain a medical benefit plan in compliance with this act. Failure of the commissioner to act within 30 days after the application and documents required under subsection (2) have been filed with the commissioner constitutes approval, and a temporary certificate of authority under subsection

(5) shall be issued. The commissioner shall deny a certificate of authority to an applicant who fails to meet the requirements of this act. Notice of denial shall be in writing and shall set forth the basis for the denial. If the applicant submits a written request within 30 days after mailing of the notice of denial, the commissioner shall conduct a hearing within 7 days of receiving the written request pursuant to the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, in which the applicant shall be given an opportunity to show compliance with the requirements of this act.

(5) The pooled plan, upon receipt of its initial certificate of authority, which shall be a temporary certificate, shall proceed to the completion of organization of the proposed pooled plan.

(6) A pooled plan shall open its books to the commissioner, and a final certificate of authority shall not be issued by the commissioner to a pooled plan until the pooled plan has collected cash reserves as provided in section 13.

Sec. 13. (1) In addition to other requirements as provided in this act, a public employer pooled plan established on or after the effective date of this act shall do all of the following:

(a) Establish and maintain minimum cash reserves of not less than 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 established pursuant to this section shall be maintained in a separate, identifiable account and shall not be commingled with other funds of the pooled plan. The

pooled plan shall invest the required reserve in the types of investments allowed under section 910, 912, or 914 of the insurance code of 1956, 1956 PA 218, MCL 500.910, 500.912, and 500.914. The pooled plan may satisfy the reserve requirement through an irrevocable and unconditional letter of credit. As used in this subdivision, "letter of credit" means a letter of credit that meets all of the following requirements:

(*i*) Is issued by a federally insured financial institution.

(*ii*) Is subject to draw by the commissioner, upon giving 5 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.

(b) Within 90 days after the end of each fiscal year, file with the commissioner financial statements audited by a certified public accountant. An actuarial opinion regarding reserves for known claims and associated expenses and incurred but not reported claims and associated expenses, in accordance with subdivision (d), shall be included in the audited financial statement. The opinion shall be rendered by an actuary approved by the commissioner or who has 5 or more years of experience in this field.

(c) Within 60 days after the end of each fiscal quarter, file with the commissioner unaudited financial statements, affirmed by an appropriate officer or agent of the pooled plan.

(d) Within 60 days after the end of each fiscal quarter, file with the commissioner a report certifying that the pooled plan maintains reserves that are sufficient to meet its contractual obligations, and that it maintains coverage for excess loss as

required in this act.

(e) File with the commissioner a schedule of premium contributions, rates, and renewal projections.

(f) Possess a written commitment, binder, or policy for excess loss insurance issued by an insurer authorized to do business in this state or from the catastrophic stop loss fund under this act, in an amount determined to be actuarially sound by an actuary approved by the commissioner or who has 5 or more years of experience in this field. The binder or policy shall provide not less than 30 days' notice of cancellation to the commissioner.

(g) Establish a procedure, to the satisfaction of the commissioner, for handling claims for benefits in the event of dissolution of the pooled plan.

(h) Provide for administration of the plan using personnel of the pooled plan, provided that the pooled 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.

(2) If the commissioner finds that a pooled plan's reserves are not sufficient to meet the requirements of subsection (1)(a), the commissioner shall order the pooled plan to immediately collect from any public employer that is or has been a member of the pooled plan appropriately proportionate contributions sufficient to restore reserves to the required level. The commissioner may take

such action as he or she considers necessary, including, but not limited to, ordering the suspension or dissolution of a pooled plan, if the pooled plan is consistently failing to maintain reserves as required in this section, is using methods and practices that render further transaction of business hazardous or injurious to its members, employees, beneficiaries, or to the public, has failed, 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, has failed or refused to furnish any report or statement required under this act, or if the commissioner, upon investigation, determines that it is conducting business fraudulently or is not meeting its contractual obligations in good faith. Any proceedings by the commissioner under this subsection shall be governed by the requirements and procedures of sections 7074 to 7078 of the insurance code of 1956, 1956 PA 218, MCL 500.7074 to 500.7078.

Sec. 14. The commissioner, or any person appointed by the commissioner, may examine the affairs of any pooled plan, and for such purposes shall have free access to all 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 shall pay an assessment annually to the commissioner in an amount equal to 1/4 of 1% of the annual self-funded contributions made to the self-insured medical benefit plan for that year. The assessments paid under this section shall

be appropriated to the office of financial and insurance services to cover the additional costs incurred by the office of financial and insurance services in the examination and regulation of pooled plans under this act.

Sec. 15. (1) The articles, bylaws, and trust agreement of the pooled plan and all amendments thereto shall be filed with and presumed approved by the commissioner if not disapproved by the commissioner within 30 days after the filing. The trust agreement shall be filed on a form prescribed by the commissioner.

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

(3) The powers of a pooled plan, except as otherwise provided, shall be exercised by the board of trustees chosen to carry out the purposes of the trust agreement. Not less than 50% of the trustees shall be persons who are covered under the pooled plan or the collective bargaining representatives of those persons.

Sec. 16. (1) Beginning on the effective date of this act, a carrier that provides 1 or more medical benefit plans to a public employer, which plans cover in the aggregate 100 or more of that public employer's employees, shall provide to that public employer complete and accurate claims utilization and cost information as provided in subsection (2) for that public employer's claims and benefits under those medical benefit plans so long as the public employer has 100 or more public employees entered into a pooled plan or has signed a letter of intent to enter 100 or more public employees into a pooled plan.

(2) Beginning on the effective date of this act, all medical benefit plans in this state shall compile, and shall make available as provided in subsection (1), complete and accurate claims utilization and cost information for the medical benefit plan in the aggregate and for each public employer as follows:

(a) The number of persons covered under the medical benefit plan.

(b) If applicable, the number of persons covered under a policy, certificate, or contract issued by a carrier.

(c) The number of claims paid.

(d) The dollar amount of claims paid and the dollar amount of claims incurred but not reported.

(e) The number of claims paid over $100,000.00 and the total dollar amount of those claims.

(f) The claims experience, by coverage component and by provider.

(g) The dollar amount of premiums or fees paid, if any.

(h) The dollar amount of administrative expenses incurred or paid.

(i) The dollar amount of retentions.

(j) The dollar amount for each of the following fees: provider; network; case management; and precertification, and other service fees paid.

(k) The dollar amount of any fees 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 the medical benefit plan.

(*l*) Other information as may be required by the commissioner.

(3) The claims utilization and cost information required to be compiled under this section shall be compiled on an annual basis and shall cover a relevant period. For purposes of this subsection, the term "relevant period" means the 36-month period ending no more than 120 days prior to the effective date or renewal date of the medical benefit plan under consideration. However, if the medical benefit plan has been in effect for a period of less than 36 months, the relevant period shall be that shorter period.

(4) A public employer or combination of public employers shall disclose the claims utilization and cost information required to be provided under subsection (1) 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 person who requests the opportunity to submit a proposal to provide benefits or administrative services for the medical benefit plan. The public employer shall make the claims utilization and cost information required under this section available at cost and within a reasonable period of time.

(5) The claims utilization and cost information required under this section shall include only de-identified health information as permitted under the health insurance portability and accountability act of 1996, Public Law 104-191, or regulations promulgated under that act, 45 CFR parts 160 and 164, and shall not include any protected health information as defined in the health insurance portability and accountability act of 1996, Public Law 104-191, or

regulations promulgated under that act, 45 CFR parts 160 and 164.

Sec. 17. To encourage and facilitate 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, the commissioner shall do all of the following:

(a) Gather data that evaluate and compare 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.

(b) Working with other state departments and agencies, ensure access on a regular basis for public employers, medical benefit plans, and covered public employees to all of the following information:

(*i*) Information concerning cost and performance of Michigan hospitals, medical clinics, and other health care facilities, including, but not limited to, licensure, accreditation, and performance measures for those facilities as recommended by national organizations such as the national quality forum.

(*ii*) Information concerning cost and performance of Michigan physicians and other health care providers, including, but not limited to, medical training, years in practice, board certification, verified licensure information, patient experience, and the results of at least 2 clinical performance measures of physicians and other health care providers recommended by national organizations such as the national quality forum.

(c) At least annually, prepare and make available for distribution to public employers and other interested persons a buyer's guide for public employers that provides 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.

Enacting section 1. This act does not take effect unless all of the following bills of the 94th Legislature are enacted into law:

(a) Senate Bill No. 419.

(b) Senate Bill No. 420.

(c) Senate Bill No. 421.