HOUSE BILL No. 6586

December 2, 2010, Introduced by Reps. Dillon, Byrnes, Melton and Scripps and referred to the Committee on Public Employee Health Care Reform.

A bill to provide for consolidation of health benefits for public employees; to create a board to administer a uniform public employee health benefits program; to create the MI prescription drug plan committee; to provide for powers and duties for certain state and local government departments, agencies, boards, and officers; to require public employers and retirement boards that provide health benefits to public employees and retirees to participate in the MI health benefits program; to provide for exceptions from the requirement to participate in the program; to provide for optional participation in the program by private employers; to allocate costs to participating public and private employers; to require public employers to submit certain information concerning health benefit plans; to make an appropriation; and to create a restricted fund.

HOUSE BILL No. 6586

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

ARTICLE 1. GENERAL PROVISIONS

Sec. 101. (1) This act shall be known and may be cited as the "MI health benefits program act".

(2) For the purposes of this act, the words and phrases defined in sections 103 to 111 have the meanings ascribed to them in those sections.

Sec. 103. (1) "Beneficiary" means an individual who is entitled to health benefits under a health benefit plan under this act.

(2) "Board" means the MI health benefits board created in section 201.

(3) "Committee" means the MI prescription drug plan committee created in section 509.

(4) "Disease management" means education and support activities designed to increase beneficiaries' awareness and understanding of their disease, promote behavior change, and improve self-care, with the goal of preventing or managing complications associated with targeted chronic diseases.

(5) "Executive director" means the executive director hired by the office of the state employer under section 301.

(6) "Fund" means the MI health benefits fund created in section 715.

Sec. 105. (1) "Health benefits" means medical, dental, vision, surgical, or hospital care benefits.

(2) "Health benefit plan" means a policy, plan, certificate, or agreement to provide, deliver, arrange for, pay for, or

reimburse any of the costs of health benefits, including self-insured health benefits and includes the MI prescription drug plan.

(3) "MI health benefits program" or "program" means the health benefits program that includes multiple health benefit plans created and administered under this act.

(4) "MI prescription drug plan" means the consolidated prescription drug benefit plan established under article 5.

Sec. 107. (1) "Participating employer" means a public employer or a private employer that offers a health benefit plan that is part of the program.

(2) "Pharmacy" means a pharmacy or other business that dispenses prescription drugs at retail and is licensed under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838.

(3) "Pharmacy benefit manager or other appropriate entity" means an entity under contract to manage and administer the MI prescription drug plan.

Sec. 109. (1) "Prescriber" means that term as defined in section 17708 of the public health code, 1978 PA 368, MCL 333.17708, other than a licensed veterinarian.

(2) "Prescription drug" means that term as defined in section 17708 of the public health code, 1978 PA 368, MCL 333.17708.

(3) "Prescription drug manufacturer" means a manufacturer as defined in section 17706 of the public health code, 1978 PA 368, MCL 333.17706.

(4) "Program supplier" means an insurance provider or carrier, health care corporation, health maintenance organization, preferred

provider organization, pharmacy benefit manager, other prescription drug administrator, plan administrator, utilization review organization, third-party administrator, dental carrier, vision carrier, or any other entity that is necessary to make the health benefit plans available to employers under this act.

Sec. 111. (1) "Public employee" means an employee, officer, or elected official of a public employer. Public employee includes an employee, officer, or elected official retired from employment or service with a public employer.

(2) "Public employer" means this state; 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; a community college or junior college described in section 7 of article VIII of the state constitution of 1963; an institution of higher education described in section 4, 5, or 6 of article VIII of the state constitution of 1963; or a retirement board.

(3) "Retirement board" means the board or other administrator of any of the public employee or officer retirement systems in the following acts:

(a) The state employees' retirement act, 1943 PA 240, MCL 38.1 to 38.69.

(b) The public school employees retirement act of 1979, 1980 PA 300, MCL 38.1301 to 38.1437.

(c) The Michigan legislative retirement system act, 1957 PA 261, MCL 38.1001 to 38.1080.

(d) The judges retirement act of 1992, 1992 PA 234, MCL 38.2101 to 38.2670.

(e) The state police retirement act of 1986, 1986 PA 182, MCL 38.1601 to 38.1648.

(f) The Michigan military act, 1967 PA 150, MCL 32.501 to 32.851.

(g) The fire fighters and police officers retirement act, 1937 PA 345, MCL 38.551 to 38.562.

(h) The municipal employees retirement act of 1984, 1984 PA 427, MCL 38.1501 to 38.1555.

(i) 1851 PA 156, MCL 46.1 to 46.32.

(j) 1927 PA 339, MCL 38.701 to 38.706.

(4) "Value-based insurance design" means benefit design that focuses on the value of health services, not cost or quality alone, to increase beneficiary engagement and compliance, lower incidence of disease, reduce inefficiency and variance in care, focus on outcomes, align incentives between beneficiary decisions and delivery of care by providers, improve health outcomes per dollar expended, and produce savings.

ARTICLE 2. MI HEALTH BENEFITS BOARD

Sec. 201. (1) The MI health benefits board is created as an autonomous entity in the department of technology, management, and budget and shall exercise its powers independently of the director of the department of technology, management, and budget.

(2) The board consists of 13 members, as follows:

(a) The following members appointed at the governor's discretion from nominees submitted by the groups they will represent:

(*i*) Four members, with 1 each representing the interests of state, municipal, public education, and public safety employees.

(*ii*) One member representing interests of public employee retirees.

(*iii*) Three members, with 1 each representing the interests of municipal, public safety, and public education employers.

(b) Three subject matter experts appointed by the governor, 1 of whom shall be from a list of candidates submitted by the senate majority leader and 1 from a list of candidates submitted by the speaker of the house of representatives.

(c) The following 2 members serving by virtue of their position:

(*i*) The executive director or his or her designee.

(*ii*) The state budget director or his or her designee.

(3) Each subject matter expert appointed to the board shall be an independent member who has expertise in areas such as employee benefit design, value-based insurance design, or health care actuarial science.

(4) A member of the board or any subcommittee created by the board shall not be employed by or have a direct or indirect interest in a vendor, provider, or supplier that provides, or might reasonably be believed to have an interest in providing, services to the program.

Sec. 203. (1) The members first appointed to the board shall

be appointed within 20 days after the effective date of this act.

(2) Appointed members of the board shall serve for terms of 4 years or until a successor is appointed, whichever is later, except that of the members first appointed, 1 member appointed under section 201(2)(a)(*i*), 1 member appointed under section 201(2)(a)(*iii*), and 1 member appointed under section 201(2)(b) shall serve 2-year terms and 2 members appointed under section 201(2)(a)(*i*), 1 member appointed under section 201(2)(a)(*iii*), and 1 member appointed under section 201(2)(b) shall serve 3-year terms.

(3) If a vacancy occurs on the board, an appointment for the unexpired term of an appointed member shall be made in the same manner as the original appointment.

(4) The governor may remove a member of the board appointed by the governor for incompetence, dereliction of duty, malfeasance, misfeasance, or nonfeasance in office, or any other good cause.

Sec. 205. (1) The first meeting of the board shall be called by the executive director or his or her designee within 10 days after the members are appointed. The executive director or his or her designee shall serve as chairperson. After the first meeting, the board shall meet as necessary at the call of the chair, but at least monthly.

(2) A majority of the members of the board constitute a quorum for the transaction of business at a meeting of the board. A majority vote of the members serving is required for official action of the board.

Sec. 207. Members of the board shall serve without compensation for their service on the board. However, members of

the board may be reimbursed for their actual and necessary expenses incurred in the performance of their official duties as members of the board.

Sec. 209. The board shall initially do all of the following:

(a) Review current public employee health benefit plans in this state to determine the types and levels of health benefits provided.

(b) Provide information and guidance, such as desired plan features, to the office of the state employer to be used in developing an array of health benefit plans and plan options to be offered through the program. This information shall be provided within 15 days after the first board meeting and at continuing intervals as established by the board.

(c) Consider the array of health benefit plans and plan options developed by the office of the state employer and presented to the board as described in section 303.

(d) Consider the design and cost of health benefit plans provided to public and private employees in this state and similar states using available data, such as the medical expenditure panel survey published by the agency for health care research and quality, the annual Kaiser family foundation health research and educational trust (Kaiser/HRET) employer health benefits survey, and other reputable published sources of information when evaluating and approving the total premium cost of each health benefit plan and the expected average premium cost for all health benefit plans that are offered as part of the program. The board shall utilize these sources annually to analyze health benefit

plans under the program.

(e) Approve, or revise and approve, an array of health benefit plans and plan options with different levels of health benefits adapted to the interests of various classes of public employees that meets the requirements of articles 4 and 5 and specifies any out-of-pocket costs to be paid by beneficiaries. The board shall submit the approved plans to the office of the state employer no later than 105 days after the effective date of this act.

Sec. 211. The board shall have the following additional and continuing duties in overseeing the program after implementation:

(a) Review recommendations of the office of the state employer as to health benefit plans and total premium cost for each plan to be adopted as part of the MI health benefits program to be offered to public employees or other beneficiaries.

(b) Approve, or revise and approve, the benefit plan designs recommended by the office of the state employer based on the efficiency and effectiveness of the design in improving the health of beneficiaries and the features and the criteria listed in sections 405, 407, and 503. The design shall include an array of health benefit plans and plan options with different levels of health benefits adapted to the interests of various classes of public employees that meets the requirements of articles 4 and 5 and specifies any out-of-pocket costs to be paid by beneficiaries. The board shall submit the approved plans to the office of the state employer within 60 days after receipt of recommendations from the office of the state employer.

(c) Issue directions to the office of the state employer as to

changes to be researched, developed, included, and resubmitted for any rejected recommendation.

(d) Assess the financial stability of the health benefit plans proposed for adoption as part of the MI health benefits program.

(e) Approve, or revise and approve, the annual operating budget for the MI health benefits program and assess the financial stability of the program not less than annually after adoption and implementation.

(f) Monitor the fund investments.

(g) Determine whether the purchase of reinsurance for the MI health benefits program is in the state's best interest.

(h) Approve, or revise and approve, the plan documents as developed by the office of the state employer.

(i) Conduct periodic beneficiary satisfaction surveys.

(j) Review on a quarterly basis the results of voluntary appeals, including the reason for the appeal and the resolution, to ensure that the program is being properly and fairly administered.

(k) Approve or request revisions for all government filings.

(*l*) Monitor and approve or disapprove the executive director's expense reports.

(m) Deliver an annual status report to the legislature no later than February 28 of each year with appropriate updates on the MI health benefits program including the information indicated in sections 411 and 513.

(n) After successful implementation of the program for public employees, develop methods to extend the option to participate in the MI health benefits program to the private sector.

(o) Any other activity necessary to carry out the board's duties under this act.

Sec. 213. The board shall approve or reject the recommendations from the office of the state employer as to proposed contracts with program suppliers based on the standards and criteria as specified in section 413 within 15 days after receipt.

Sec. 215. The board shall develop performance metrics and evaluate the performance of program suppliers on an ongoing basis, including, but not limited to, the review and resolution of significant operational or service issues.

Sec. 217. State departments and agencies shall cooperate with the board and provide assistance necessary to allow it to perform its duties under this act.

Sec. 219. (1) After the first evaluation of the implemented program is completed, if the program meets the savings requirements of section 313, the board may form subcommittees in distinct subject areas as necessary to assist and support the board in performing its duties under this act. The subcommittees shall investigate and make nonbinding recommendations to the board for plan designs and program improvements to keep the program competitive, current, efficient, cost-effective, and relevant. A subcommittee may be formed for a limited time or as a standing subcommittee.

(2) A subcommittee shall be composed of up to 7 members, consisting of 1 subject matter expert and an equal number of representatives of public employees and public employers. A minimum

of 2 board members and a minimum of 2 nonboard members shall serve on each subcommittee. The subject matter expert may be a board member. A subcommittee member may be removed at any time by the board.

(3) Board members may nominate individuals to serve on a subcommittee. The board shall vote on the confirmation of each subcommittee member. A vacancy on the subcommittee shall be filled in the same manner as the original appointment.

(4) Two board members shall serve as co-chairs of the subcommittee, 1 representing public employers and 1 representing public employees.

(5) A subject matter expert shall be an independent member of a subcommittee with expertise in areas such as employee benefit design, value-based insurance design, or health care actuarial science. The subject matter expert shall serve as a resource to the subcommittee and have no vote, except when necessary to break a tie.

(6) A subcommittee member shall serve without compensation for service on the subcommittee. However, a subcommittee member may be reimbursed for actual and necessary expenses incurred in the performance of official duties as a member of the subcommittee.

Sec. 221. A subcommittee formed under section 219 shall meet at least once each quarter for as long as the subcommittee is needed to perform its duties as assigned by the board. The subcommittee shall submit reports and recommendations to the board.

ARTICLE 3. OFFICE OF THE STATE EMPLOYER

Sec. 301. (1) The office of the state employer shall have all

of the following general powers, duties, and responsibilities in carrying out its duties under this act:

(a) Implementing and administering the MI health benefits program and ensuring that health benefits are delivered efficiently to beneficiaries.

(b) Communicating with and educating beneficiaries concerning the program and ensuring that program plan information is current and accessible.

(c) Developing and administering a voluntary appeals process that meets all legal requirements and assures that benefits are delivered in accordance with plan requirements.

(d) Managing relationships with program suppliers, consultants, actuaries, and regulatory agencies.

(e) Supporting and participating in public forums focused on health care reform and health benefit study groups.

(f) Maintaining relationships with various consultants and organizations representing both public and private employers in this state and other states to identify emerging practices, trends, and issues.

(g) Working with participating employers to validate beneficiary eligibility and ensure all eligibility records are accurate and updated on a timely basis, including both of the following:

(*i*) Performing or contracting for beneficiary eligibility and reconciliation audits at intervals of no longer than every 3 years.

(*ii*) Establishing enrollment criteria to be used for all public employers, using information from the audits performed under

subparagraph (*i*) or other audits.

(h) Providing financial oversight of the program, including, but not limited to, developing an annual program budget; accounting; financial forecasting, analysis, and reporting; trend analysis; internal controls; performance analytics; internal and external audits; and payments to program suppliers.

(i) Ensuring all aspects of the program meet all governmental and legal requirements, including, but not limited to, legal compliance, audit compliance, plan documentation, financial reporting, and communications such as regulatory required notices and summary plan descriptions.

(j) Performing or contracting for audits of program suppliers as necessary to ensure compliance with contract terms and program requirements.

(2) The office of the state employer shall hire an executive director to serve as the chief executive officer of the program and may hire staff and incur expenses as necessary to assist the office of the state employer in performing its duties under this act. The executive director position shall be only an interim position unless the program meets the conditions required for implementation in section 313. The executive director shall be selected based on the following qualifications:

(a) A record of service as a benefits executive demonstrating sophisticated understanding of health benefit plans and extensive experience in the strategic development, design, and administration of a large employee benefit program.

(b) Ability to manage and build program supplier

relationships.

(c) Demonstrated effectiveness in negotiating and managing contractual benefit arrangements.

(d) Strong interpersonal and communication skills, combined with the ability to work effectively with a wide range of constituencies at all levels in the public sector, including board members and legislators.

(e) Strong financial background with analytical and problem-solving skills.

Sec. 303. (1) The office of the state employer shall have the following duties in developing an array of health benefit plans and plan options and recommendations for the MI health benefits program during the initial review and assessment period and annually as necessary:

(a) Develop an array of health benefit plans and plan options with different structures and features adapted to the interests of various classes of public employees for presentation to the board for consideration as described in article 2. The health benefit plans and plan options may be structured to include out-of-pocket costs to be paid by the beneficiaries, including, but not limited to, annual deductibles, copayment amounts, and coinsurance amounts, each of which may be different for services obtained within the provider network or outside of the provider network as specified by the program supplier.

(b) Include structures, features, and implementation for health benefit plans based on the criteria in this article and articles 4 and 5.

(c) When developing the initial health benefit plans, consult with the office of the governor for information on plans developed or proposed by the executive branch.

(d) When developing the initial health benefit plans, consult with a representative group of public employers, collect data on their existing plan designs, and consider those plans and the existing state plan to facilitate timely design.

(e) Consult with appropriate agencies, entities, and resources to coordinate the program's health benefit plans with the implementation of the patient protection and affordable care act, Public Law 111-148, and the health care and education reconciliation act of 2010, Public Law 111-152.

(f) Both as input to the initial health benefit plans and periodically after the program is implemented, review available benefit plan design and cost data on public employee health benefit programs in similar states and for private employee health benefit programs in this state, using sources such as the medical expenditure panel survey published by the agency for health care research and quality, the annual Kaiser family foundation health research and educational trust (Kaiser/HRET) employer health benefits survey, and other reputable published sources of information.

(g) Confer with the board before and during the design of the initial array of health benefit plans and plan options and on an ongoing basis after the program is implemented.

(2) The office of the state employer shall present the initial array of health benefit plans and plan options and recommendations

for consideration by the board no later than 60 days after the effective date of this act. After the program is implemented, the office of the state employer shall present an array of health benefit plans and plan options for consideration by the board no later than 10 months before the beginning of each succeeding plan year.

(3) After the program is implemented, the office of the state employer shall, on an ongoing basis, do all of the following:

(a) Working with consultants and actuaries, periodically review the approved health benefit plan designs offered through the program using research, surveys, and analysis of benefit trends to ensure that plans are competitive, current, efficient, cost-effective, and relevant.

(b) Periodically collect data and analyze current health benefit plan designs from various public employers to determine the types, levels, and costs of health benefits provided outside the program.

(c) Develop, annually or as requested by the board, an array of health benefit plans and plan options with different levels of health benefits adapted to the interests of various classes of public employees, considering the information collected under subdivisions (a) and (b).

(d) Present recommendations on plan design changes for board approval and modify plan designs as appropriate based on board input.

(e) As the board approves plan design changes, work with consultants and actuaries to develop and distribute requests for

proposals to implement those modifications to the program offerings.

(f) Evaluate proposals submitted by potential program suppliers and develop recommendations for program suppliers based on standards and criteria as specified in section 413.

(g) Present recommendations to the board as to program suppliers, modify recommendations based on board input, and negotiate contracts, as appropriate, based on board approval.

Sec. 305. (1) The office of the state employer shall prepare and issue requests for proposals for the initial array of health benefit plans and plan options no later than 30 days after receiving the approved array of health benefit plans from the board. The requests for proposals shall seek quotations for several specified participation levels of public employees. If the board has not submitted its approved array of health benefit plans to the office of the state employer by 105 days after the effective date of this act, the initial array of health benefit plans developed by the office of the state employer and submitted to the board shall be considered to be the approved array of health benefit plans for preparing the requests for proposals issued under this subsection if the array meets the requirements of article 4. The deadline for responses to the requests for proposals to implement the approved health benefit plans shall be within 30 days after the requests for proposals are issued.

(2) For years after the program is implemented, the office of the state employer shall prepare and issue requests for proposals no later than 30 days after receiving the array of health benefit

plans approved by the board. If the board has not submitted its approved array of health benefit plans by 60 days after receiving plan recommendations from the office of the state employer, the office of the state employer's recommendations shall be considered to be the approved array of health benefit plans for preparing the request for proposals if the array meets the requirements of article 4.

Sec. 307. The office of the state employer shall develop the form for submitting the report required under article 6 and post the form on a website accessible to public employers by 5 days after the effective date of this act.

Sec. 309. The office of the state employer shall contract with an actuary to do the following:

(a) Analyze data submitted by public employers under article 6.

(b) Assist in analyzing the responses to the initial request for proposals to determine whether implementing the approved array of health benefit plans would yield the savings required under section 313 to proceed with the contracts.

(c) Develop minimum enrollment levels required of each prospective program supplier, as appropriate, if necessary to ensure that the program is actuarially creditable and each program supplier is administratively viable.

(d) Assist in completing the analysis and review of the responses to the requests for proposals. The actuary shall aid in preparing a report that indicates the potential savings and includes recommendations for program suppliers for presentation to

the board by 30 days after receipt of the responses to the request for proposals.

(e) Assist in determining the illustrative average annual premiums described in section 311.

(f) Assist in any review and analysis required to administer the program after implementation.

Sec. 311. (1) Upon completion of the initial request for proposals and annually thereafter, the office of the state employer shall work with an actuary to determine the comprehensive illustrative average annual program premium for single, 2-party, employee and children, and full-family coverage categories using the lowest cost full coverage plan, including all medical and prescription drug benefits, but excluding any high deductible health plan with a health savings account component. Based on an actuarial review, an illustrative average annual program premium for each category may be determined by separate geographical areas. The expected total cost and expected total enrollment shall initially be based on 50% participation of public employees in the program and shall be adjusted in subsequent plan years, based on experience. The expected total cost shall include, but is not limited to, expected claims charges, program administration fees, consulting and other administration fees, and payments required for stop-loss coverage or program reserves.

(2) The office of the state employer shall also work with an actuary to determine separate illustrative annual premiums for prescription drug benefits and other health benefits that comply with the following:

(a) The illustrative average annual premiums for health benefits other than prescription drug benefits shall be calculated for single, 2-party, employee and children, and full-family coverage categories and shall include all benefits except prescription drug benefits, excluding any high deductible health benefit plan with a health savings account component, and taking into consideration cost differences attributable to different geographic areas.

(b) The illustrative average annual prescription drug benefit premiums shall be calculated for single, 2-party, employee and children, and full-family coverage categories and shall include only prescription drug benefits, excluding any high deductible health benefit plan with a health savings account component and taking into consideration cost differences attributable to different geographic areas.

Sec. 313. (1) If the actuarial analysis of the responses to the initial request for proposals and the calculation of illustrative average annual premiums indicates that 2.0% or more savings over current public employer expenditures for health benefits can be obtained, the office of the state employer shall do the following to implement and administer the MI health benefits program:

(a) Negotiate contracts with program suppliers under this act within 60 days after board approval of the report described in section 309(d). If the board has not rejected or approved the report, or submitted alternative recommendations by 15 days after receipt, the report and recommendations shall be considered

approved.

(b) Communicate plan designs, expected premiums, and the identity of program suppliers to employers within 15 days after the contracts necessary to implement and administer the program are entered into.

(c) Obtain additional bids and negotiate and enter into contracts as necessary to implement and administer the program, if the additional bids and contracts would continue to yield the minimum required savings.

(2) The powers granted under this section do not include the authority to bind the state or any public employer to expend funds for an approved health benefit plan. Any contract resulting from the initial solicitations to implement the approved array of health benefit plans shall include a provision that makes the contract conditional on receipt of an actuarial opinion that the contract will achieve the minimum required savings and limits the contract to beneficiaries of participating employers.

Sec. 315. The office of the state employer shall prepare and submit an annual status report to the board no later than January 31 of each year with appropriate updates on the MI health benefits program as described in sections 411 and 513.

Sec. 317. State departments and agencies shall cooperate with the office of the state employer and provide assistance necessary to allow it to perform its duties under this act.

ARTICLE 4. HEALTH BENEFIT PLANS

Sec. 401. As used in this article:

(a) "Best practice" means translating evidence-based care into

practice. The goals of best practices are to derive the greatest value in purchasing health benefits and to improve the health of beneficiaries.

(b) "Clinical advocates" means health care experts who represent the beneficiary's best interest and are solely focused on obtaining the right diagnosis and the best treatment plan specific to the exact situation of the beneficiary so as to ensure that the beneficiary has the best outcome. Clinical advocates do not use cost criteria when making recommendations on beneficiary care; the right diagnosis and treatment for each beneficiary is the sole focus.

(c) "Evidence-based care" means a medically necessary procedure, process, activity, or treatment plan that has demonstrated greater effectiveness than competing alternatives in producing positive clinical outcomes, as recommended by review bodies such as the national guideline clearinghouse that have examined the published scientific literature and made recommendations to providers based on the quality and strength of the evidence.

(d) "Wellness or healthy lifestyle program" means a combination of activities designed to increase awareness, assess risks, educate, and promote behavior change to improve health, encourage modifications of health status, and enhance personal well-being and productivity of an individual, with the goal of preventing illness and injury.

Sec. 403. The office of the state employer and the board shall consider all of the following in developing, recommending, and

approving health benefit plans:

(a) A variety of structures for the health benefit plan designs, including, but not limited to, offering benefits through preferred provider organizations, health maintenance organizations, high deductible health plan options combined with health savings accounts, or self-insurance.

(b) Features and plan options that are tailored to address grouping of employees by geographic location, risk, or service requirements.

(c) Various combinations of health benefit plan types with plan options that utilize contracts with program suppliers.

(d) Incentives that increase beneficiary engagement at all stages of wellness maintenance and acute and chronic health care.

Sec. 405. (1) The health benefit plans developed or implemented and administered by the office of the state employer and developed or approved by the board shall include all of the following:

(a) Features that maximize cost-containment while ensuring access to quality health care.

(b) Streamlined processes that maximize administrative efficiencies and minimize administrative costs.

(c) Wellness or healthy lifestyle programs, disease management, and prevention incentives for beneficiaries, such as smoking cessation, injury and accident prevention, reduction of alcohol misuse or abuse, weight management, exercise, automobile and motorcycle safety, blood cholesterol management, nutrition education, and other methods that focus on strategies to improve

health and meet the needs of beneficiaries.

(d) Appropriate networks to allow beneficiaries easy access to the health benefits offered through the program.

(e) Evidence-based care and best practices.

(f) Provisions to evaluate the cost and effectiveness of the use of clinical advocates to review diagnoses and care and to make recommendations to promote correct treatment in coordination with a beneficiary's medical providers. If the evaluation determines it is cost-effective, the health benefit plan shall include confidential access to clinical advocates at the beneficiary's discretion.

(g) Coordination of care for beneficiaries across the various benefit providers, including a health plan and a pharmacy benefit manager or other appropriate entity.

(h) Coordination of benefits with any other available policy, certificate, contract, or plan as provided in the coordination of benefits act, 1984 PA 64, MCL 550.251 to 550.255.

(i) Value-based insurance designs.

(j) Incentives to beneficiaries to encourage enrollment in high deductible health plans that are offered through the program. Working with an actuary, the office of the state employer shall make recommendations for those incentives. The board shall approve the incentives or offer alternative suggestions for incentives that shall be adopted if an actuarial assessment determines the alternative incentives are actuarially equivalent to those recommended by the office of the state employer.

(k) Methods of disease management that improve coordination of care and identify beneficiaries best served through use of a

disease management model that uses predictive modeling based on claims or other health risk information.

(2) The array of health benefit plans and plan options shall comply with the health insurance portability and accountability act of 1996, Public Law 104-191, and regulations promulgated under that act, 45 CFR parts 160 and 164.

Sec. 407. The office of the state employer and the board may include provisions in health benefit plans that provide incentives for beneficiaries or program suppliers that do any of the following:

(a) Reward improvements in health outcomes for beneficiaries with chronic diseases, increased utilization of appropriate preventive health services, or reductions in medical errors.

(b) Increase the adoption and use of information technology that contributes to improved health outcomes, better coordination of care, or decreased medical errors.

(c) Through purchasing, reimbursement, or pilot program strategies, promote and increase the adoption of health information technology systems, such as electronic medical records, electronic prescribing, and integrated delivery systems, that do any of the following:

(*i*) Facilitate diagnosis or treatment.

(*ii*) Reduce unnecessary duplication of medical tests.

(*iii*) Promote efficient electronic physician order entry.

(*iv*) Increase access to health information for beneficiaries and their health care providers.

(*v*) Improve health outcomes.

(*vi*) Reward or encourage review of diagnosis and care by clinical advocates to ensure appropriate treatment.

(d) Reward increases in participation in wellness or healthy lifestyle programs, disease management, and regular preventive care.

Sec. 409. The office of the state employer and the board shall do all of the following:

(a) Review aggregate data on health trends of the beneficiaries, including diagnosis and treatment, when considering the array of health benefit plans to ensure that they include features that drive better health outcomes while controlling costs, including but not limited to appropriate, targeted, evidence-based care; prevention programs; identification of excessive costs; and development of pharmacy management programs.

(b) Direct program suppliers to submit an analysis of clinical performance of health care facilities and analyze each health care provider's efficiency and quality relative to the care provider's peers.

(c) Request that program suppliers submit a design for benefit plans with incentives for beneficiaries to use better-performing health care providers and facilities.

Sec. 411. The office of the state employer shall prepare an annual status report on the MI health benefits program, excluding the MI prescription drug plan that is reported separately under section 513. The report shall be presented to the board not later than January 31 for review, approval, and delivery to the legislature not later than February 28 of each year. The report

shall include, but is not limited to, the following:

(a) Enrollment and average premium cost by category of coverage, plan type, public employer type, and program supplier; average employee premium share; effectiveness of the features described in section 405; information on features designed to improve the health of beneficiaries while containing cost, including, but not limited to, type of feature, cost/investment, return on investment, and success in improving the health of beneficiaries; cost of the program; year-over-year total cost and cost trend comparisons in which cost trend is calculated by contract adjusted for those beneficiaries who enter and exit the program; the benefit plan designs and costs for the program as compared to the private sector in this state, public employers in this state who opt out of the program, and public employers in similar states; an analysis of the overall accumulated estimated savings or cost avoidance achieved by the program; major milestones achieved by the program in the preceding year; changes scheduled to the program in the current year; aggregate information on public employers that opt out of the program; and other information at the request of the legislature or as deemed appropriate by the board or office of the state employer.

(b) Tables and charts as appropriate to best convey the information.

(c) Recommendations on legislation necessary to improve the MI health benefits program.

Sec. 413. The office of the state employer shall set standards for use in evaluating proposals submitted by potential program

suppliers, and the board shall set standard criteria to be used in approving or rejecting the recommendations from the office of the state employer on proposed contracts with program suppliers. These standards and criteria shall be set before sending a request for proposals to any potential program supplier and the standards and criteria for evaluating a proposal shall be included in each request for proposals. The standards used by the office of the state employer and the board shall include, but are not limited to, all of the following:

(a) The impact on the financial interests and stability of public employers.

(b) The financial stability of the proposed program supplier, including, but not limited to, actuarial assessments and other financial reviews and expected enrollment through the program that is great enough to ensure continued financial viability.

(c) Objective data for quality, cost, service, administrative practices, and provider networks, including, but not limited to, all of the following:

(*i*) Accreditation by appropriate nationally recognized accreditation standards agencies and organizations.

(*ii*) Track record of providing high-quality, patient-centered care.

(*iii*) Proven effectiveness as a long-term strategic partner in developing and delivering innovative programs to control health benefits costs.

(*iv*) Competitive pricing, premiums, and administrative costs.

(*v*) Simplified administrative practices and ease of access for

beneficiaries to health benefits.

(*vi*) Access to efficient, cost-effective, competitive provider networks that meet the needs of a variety of beneficiaries with limited disruptions.

(*vii*) Common performance metrics based on evidence-based care.

(d) The expected ability and willingness of the program supplier to meet minimum standards for successful delivery of the program, including, but not limited to, all of the following:

(*i*) Objectives for wellness, prevention, and care management to improve the health of beneficiaries.

(*ii*) Promotion of evidence-based care and compliance with best practices.

(*iii*) Outstanding customer service.

(*iv*) Seamless coordination with other program suppliers and federal and state health care programs, such as medicare.

(*v*) Compliance with all other requirements of the program as specified in this article or article 5.

(*vi*) Incentives for beneficiaries to make health care decisions and providers to deliver care that improves health outcomes using value-based insurance design at all stages of wellness maintenance and acute and chronic health care.

(e) Other criteria necessary to efficiently and effectively implement the program.

(f) The additional value of contracting with Michigan-based businesses to implement and administer the program.

(g) A requirement that a program supplier allow bids from Michigan-based businesses for any subcontract under a contract to

implement the program.

ARTICLE 5. MI PRESCRIPTION DRUG PLAN

Sec. 501. (1) The board shall adopt and, if consistent with the savings requirement in section 313, the office of the state employer shall implement and administer a consolidated prescription drug benefit plan known as the MI prescription drug plan that employers may participate in, either separate from or as part of another health benefit plan under the program.

(2) The MI prescription drug plan is a payer of last resort for the provision of outpatient prescription drug benefits for beneficiaries. The MI prescription drug plan shall cover only outpatient prescription drug costs not covered by any other state or federal program or third-party payer. This subsection does not require payment by a local prescription drug discount program or a local emergency prescription drug assistance program for a prescription drug covered under the MI prescription drug plan.

Sec. 503. (1) The office of the state employer shall administer the MI prescription drug plan under this article in an actuarially sound manner. The board and the office of the state employer shall take all steps necessary to ensure that the MI prescription drug plan is structured and administered in a way that maximizes savings, efficiencies, affordability, benefits, coverage, patient safety, and health outcomes of the beneficiaries.

(2) The MI prescription drug plan shall include options with different levels of benefits adapted to the interests and needs of participating employers and the beneficiaries of the MI prescription drug plan. The MI prescription drug plan shall include

an option for a participating employer that offers its employees a health savings account as described in section 223 of the internal revenue code of 1986, 26 USC 223, in combination with a high deductible health plan, all of which comply with federal statutes and regulations. The MI prescription drug plan options may be structured to include a variety of benefits or features, including, but not limited to, out-of-pocket costs to be paid by the beneficiaries, such as annual deductibles, copayment amounts, and coinsurance amounts, each of which may be different for services obtained within or outside of the provider network as specified by the program supplier.

(3) The office of the state employer shall do all of the following:

(a) Establish the premium cost for the MI prescription drug plan that is offered to participating employers under the program for board approval.

(b) Assess the financial stability of the MI prescription drug plan.

(c) Employ and enter into board-approved contracts with program suppliers as necessary to implement and administer the MI prescription drug plan.

(d) Administer the formulary and the preferred drug list as developed by the committee.

(e) Perform drug utilization reviews.

(f) Develop medical and disease management programs that support beneficiaries with special medical conditions or chronic conditions in coordination with health benefit plans or other

coverage programs with respect to those beneficiaries.

(g) Cooperate, coordinate, and share data with health benefit plans or other coverage programs in a timely manner to ensure that beneficiaries are receiving appropriate medication therapy and are adhering to medication regimes.

(h) Share prescription drug out-of-pocket deductible, copayment, and coinsurance data with health benefit plans or other coverage programs as necessary to satisfy requirements, if any, relative to a health savings account as described in section 223 of the internal revenue code of 1986, 26 USC 223, in combination with a high deductible health plan.

(i) Measure the quality and outcomes of pharmacy services.

(j) Work with the MI prescription drug plan committee to develop and present to the board cost-containment measures, including, but not limited to, prior authorization requirements, pill splitting, step therapy, dose optimization, quantity limits, and refill-too-soon supply limits.

(k) Work with an outside consultant to conduct periodic studies of all of the following:

(*i*) Medicare part-D operations or other federal plans for prescription drug benefits for medicare participants, and financial data to assess the costs and risks of having eligible beneficiaries in authorized options, such as the retiree drug subsidy or medicare employer group waiver program prescription drug plan.

(*ii*) The effectiveness of plan copayment levels in terms of both the behavioral and financial impact to the MI prescription drug plan.

(*iii*) New techniques to best manage drug usage while controlling costs.

(*l*) Administer the MI prescription drug plan in compliance with all applicable state and federal laws, rules, regulations, and guidelines applicable to the security and confidentiality of medical and personally identifiable information relating to beneficiaries in the plan.

Sec. 505. (1) With board approval, the office of the state employer may enter into a competitively procured contract with a pharmacy benefit manager or other appropriate entity to manage and administer pharmacy benefits under the MI prescription drug plan. Subject to the terms of the contract, a pharmacy benefit manager or other appropriate entity may do the following:

(a) Negotiate and execute contracts with pharmacies.

(b) Serve as intermediary between the MI prescription drug plan, prescription drug manufacturers, and pharmacies.

(c) Administer cost-containment measures approved by the board.

(d) Process, pay, and adjudicate claims.

(e) Manage pharmacy network claims.

(f) Provide customer service.

(g) Collect and report data.

(h) Assist the office of the state employer with drug utilization review.

(i) Provide enrollment services.

(j) Provide billing services.

(k) Provide any other functions necessary to manage and

administer benefits under the MI prescription drug plan as required in this article.

(2) A contract with a pharmacy benefit manager or other appropriate entity under subsection (1) shall include all of the following in the contract:

(a) Drug substitution restrictions to prevent the substitution of or switching to higher-cost drugs without proper authority, approval, and notice.

(b) A requirement that the entity account for and remit to the program any compensation or rebates paid to the entity from a prescription drug manufacturer or other entity, including any of the following:

(*i*) Compensation derived from market share incentives, drug-switch programs, educational support, commissions, mail service purchase discounts, administrative or management fees, or other forms of compensation attributable to the contract.

(*ii*) Compensation for sales of utilization or claims data that the entity possesses due to the contract.

(*iii*) Rebates based upon prescription drugs dispensed pursuant to the contract.

(c) Limitations on prescription drug charges to the MI prescription drug plan relative to drug reimbursement to the pharmacy to prevent spread pricing.

(d) Unlimited access by the board and the office of the state employer to information relating to contracts entered into by the entity under the contract, including, but not limited to, prescription drug manufacturer arrangements and contracts with

pharmacies. Information disclosed by an entity under this subdivision is confidential and is exempt from disclosure under the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246.

(e) Any other provision the office of the state employer determines necessary to administer the MI prescription drug plan under this article.

Sec. 507. The board and the office of the state employer shall not do any of the following:

(a) Establish prices for any particular prescription drugs available under the MI prescription drug plan.

(b) Establish a state-managed wholesale or retail drug distribution or dispensing system.

(c) Require pharmacies to maintain or allocate separate inventories for prescription drugs dispensed through the MI prescription drug plan.

Sec. 509. (1) The MI prescription drug plan committee is created as an autonomous entity in the office of the state employer. The committee shall consist of the executive director or his or her designee and 10 members appointed by the governor as follows:

(a) Three prescribers whose practice, after program implementation, includes patients who are enrolled in the plan. A prescriber appointed under this subdivision may include, but is not limited to, a prescriber with expertise in mental health, a prescriber who specializes in obstetrics and gynecology, and a prescriber with experience as an internist or general practitioner.

(b) Two prescribers who have earned a research doctorate from

a 4-year doctorate-granting university in the United States and who have expertise in evidence-based prescribing or pharmacoeconomics.

(c) Three pharmacists. A pharmacist appointed under this subdivision may include, but is not limited to, a pharmacist with expertise in mental health drugs, a pharmacist who specializes in obstetrics and gynecology, and a pharmacist with experience in internal medicine or general practice.

(d) Two pharmacists who have earned a doctorate in pharmacy from a 4-year doctorate-granting university in the United States and who have expertise in evidence-based prescribing or pharmacoeconomics.

(2) To avoid a conflict of interest, a member of the committee shall not be any of the following:

(a) Employed by a prescription drug manufacturer or have any interest directly or indirectly in the business of a prescription drug manufacturer.

(b) Employed by a pharmacy benefit manager or other entity under contract with the MI prescription drug plan under section 505 or have any interest directly or indirectly in the business of a pharmacy benefit manager or other entity under contract with the plan under section 505.

(3) A member of the committee shall disclose any financial relationship with a medical supply vendor, health care provider organization, or any other commercial interest that may give rise to a conflict of interest. The committee shall require that a member of the committee with a direct or indirect interest in any matter before the committee disclose the member's interest to the

committee and recuse himself or herself before the committee takes any action on the matter.

(4) Members of the committee shall serve a term of 2 years. Except as otherwise provided in this subsection, a member of the committee shall serve until a successor is appointed and qualified. The governor shall designate 1 member of the committee to serve as the chairperson, who shall serve as chairperson at the pleasure of the governor. An individual appointed to serve as a prescriber or pharmacist member of the committee shall serve only while maintaining his or her professional license in good standing. An individual prescriber's or pharmacist's failure to maintain his or her professional license in good standing immediately terminates that individual's membership on the committee. For purposes of this subsection, a prescriber or pharmacist is not maintaining a professional license in good standing if the department of community health imposes a sanction under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838, on the prescriber or pharmacist committee member. A vacancy on the committee shall be filled in the same manner as the original appointment. An individual appointed to fill a vacancy created other than by expiration of a term shall be appointed for the unexpired term of the member whom he or she is to succeed in the same manner as the original appointment. A member may be reappointed for additional terms.

(5) Members of the committee shall serve without compensation for their service on the committee. However, members of the committee may be reimbursed for necessary expenses incurred in the

performance of their official duties as members of the committee.

(6) A majority of the members of the committee serving constitute a quorum for the transaction of business. The committee shall approve a final action of the committee by a majority vote of the serving members. A member of the committee must be present at a meeting of the committee to vote. A member shall not delegate his or her responsibilities to another individual.

(7) The committee shall meet at the call of the chairperson. The committee may meet at any location within this state. A meeting of the committee is subject to the open meetings act, 1976 PA 267, MCL 15.261 to 15.275. The committee shall post a notice of the meeting on the office of the state employer's website and the board's website, if any, 14 days before each meeting date. By January 31 of each year, the committee shall make available the committee's regular meeting schedule and meeting locations for that year on the office of the state employer's website and the board's website, if any. The committee may make inquiries, conduct studies and investigations, hold hearings, and receive comments from the public.

Sec. 511. (1) The committee shall do all of the following:

(a) Develop a formulary of prescription drugs covered by the MI prescription drug plan.

(b) Develop a preferred drug list that identifies preferred choices of prescription drugs within therapeutic classes for particular diseases and conditions, including generic alternatives, for use in the MI prescription drug plan.

(c) Develop drug utilization management programs for the drugs

included in the preferred drug list developed under subdivision (b).

(d) As required in section 509, have open committee meetings with a standard agenda for public comment.

(e) Establish procedures to evaluate independent evidence-based reviews of prescription drugs to assist in the development of the preferred drug list under subdivision (b). The committee shall only utilize an independent evidence-based review of a prescription drug if the review is based upon the evidence of safety, efficacy, and effectiveness available at the time of the review and includes a rigorous assessment of the scientific evidence.

(f) Work with the office of the state employer to develop cost-containment measures for presentation to the board under section 503(3)(j).

(2) In developing the preferred drug list under subsection (1), the committee shall do all of the following:

(a) Use independent evidence-based reviews on the effectiveness of prescription drugs within drug classes.

(b) Identify the most clinically effective and cost-effective prescription drug or drugs from among the drugs in the reviewed drug class, including generic alternatives, or determine that there is sufficient evidence of similar safety, efficacy, and effectiveness for the prescription drugs in a drug class to allow therapeutic interchange of the drugs within that drug class.

(c) Base its development of the list only upon available evidence and, if more than 1 drug in a drug class is identified as the most clinically effective or determined to be of similar

safety, efficacy, and effectiveness under subdivision (b), upon cost considerations.

Sec. 513. The office of the state employer shall prepare an annual report on the MI prescription drug plan. The report shall be presented to the board not later than January 31 for review, approval, and delivery to the legislature not later than February 28 of each year. The report shall outline in specific detail all of the following:

(a) A status report on the MI prescription drug plan. The report shall contain a chart that includes, but is not limited to, the following performance measures for all claims, listed by generic claims, preferred (formulary) brand claims, nonformulary brand claims, and specialty claims: claims volume/total number of claims; number of eligible beneficiaries; total drug costs, including plan and beneficiary share of costs; average cost per beneficiary per year (PBPY), including the PBPY cost paid by the plan and the PBPY cost paid by beneficiaries; and dispensing rate.

(b) Plan information, including, but not limited to, the following: rebates; administrative costs; major milestones achieved by the plan in the preceding calendar year; costs and savings from cost-containment measures such as those developed under section 503(3)(j); an analysis of mail order pharmacy use, including mail order utilization rate, drug delivery times, and costs and savings of mail order utilization; an analysis of the overall accumulated estimated savings or cost avoidance achieved by the MI prescription drug plan; the results of studies conducted periodically by the board under section 503(3)(k); and other information at the request

of the legislature.

(c) Recommendations on legislation necessary to improve the MI prescription drug plan.

ARTICLE 6. DATA COLLECTION

Sec. 601. As used in this article:

(a) "Carve-out program" means a plan in which some health benefits are purchased and administered separately from the benefits in the main health benefit plan. Benefits under a carve-out program may include mental health, laboratory and imaging, foot care, or other similar benefits.

(b) "Coverage type" means individual, 2-party, employee and children, or full family coverage.

Sec. 603. A public employer that has 5 or more employees in a health benefit plan on the effective date of this act shall file a report and provide other requested information on its health benefit plan design, population demographics, claims data, and bargaining unit provisions with the office of the state employer by 45 days after the effective date of this act. The public employer shall file the report electronically in a format determined by the office of the state employer.

Sec. 605. The report required under this article shall include all of the following information regarding health benefits that the public employer provides on the effective date of this act:

(a) A list of the birth date; gender; home zip code; employment class as salaried, hourly, executive, bargaining unit, etc.; status, such as active, disabled, participating through federally permitted purchasing, or retired; benefits elected, such

as medical, dental, vision, or prescription drug; and coverage type.

(b) Monthly claims by provider type and service category reported by the providers.

(c) Number of claims paid over $50,000.00 and the total dollar amount of those claims.

(d) Dollar amounts paid for specific and aggregate stop-loss insurance.

(e) Dollar amount of administrative expenses incurred or paid, reported separately for medical, prescription drug, dental, and vision.

(f) Total dollar amount of retentions and other expenses.

(g) Dollar amount for all administrative costs and service fees, including, but not limited to, administrative service fees and access fees, paid to insurance providers or third-party administrators, pharmacy benefit managers, other prescription drug administrators, plan administrators, consultants, insurance agents, and other outside administrators, including those costs and fees that are billed and paid as part of the premium or as part of the cost for health benefit services, and a description of the costs and fees.

(h) Dollar amounts of any fees or commissions paid to agents, consultants, or brokers by the health benefit plan or by any public employer or carrier participating in or providing services to the health benefit plan, reported separately for medical, prescription drug, stop-loss, dental, vision, or other carve-out program, including fees and commissions that are billed and paid as part of

the premium or part of the cost for health benefit services.

(i) Renewal rates for each health benefit plan and benefit plan design.

(j) Number of eligible employees who opt out of coverage and the annual amount an employee may receive as payment to opt out of coverage for each plan offered and each coverage type.

(k) Number of employees who are not eligible for coverage.

(*l*) Average annual premium cost information for each plan offered and for each coverage type, including all of the following:

(*i*) Average total dollar cost per employee.

(*ii*) Average total dollar cost paid by employer per employee.

(*iii*) Average dollar cost paid by employee.

(*iv*) Average percent of total dollar cost per employee paid by employee.

(m) Internal administrative costs and any other administrative costs not included in subdivisions (a) to (*l*).

Sec. 607. A public employer shall include in the report required under this article all of the following information regarding health benefits that the public employer provides as of the effective date of this act upon request from the office of the state employer:

(a) Summary plan descriptions for all health benefits that the public employer provides, including health benefits provided through any carve-out plan.

(b) Information regarding other programs, such as those promoting wellness and prevention, including all of the following:

(*i*) Types of program offerings.

(*ii*) Cost share information, such as deductibles, copayments, or coinsurance that is not reported as part of another plan.

(c) Relevant language from all bargaining unit contracts, including, but not limited to, the contract term with both effective and ending dates, numbers and classifications of individuals covered by the contract, and details of all health benefit plan provisions.

(d) Vendor contact information such as business name, individual contact, address, telephone number, and electronic mail address.

Sec. 609. The claims utilization and cost information in the report required under this article shall be for the most recently available 36-month period, or if the health benefit plan has been in effect for a shorter period, that shorter period. The report 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. 611. Information provided by a private entity upon request by a public employer to enable the public employer to comply with the requirements of this article is exempt from disclosure under the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246. A public employer and the office of the state employer shall limit public access to information that is collected

under this act as necessary to protect the privacy of any personal health information that might be identified to an individual.

ARTICLE 7. HEALTH BENEFIT PLANS IMPLEMENTATION

Sec. 701. (1) If the responses to the request for proposals issued under section 305 and the results of the actuarial analysis indicate the savings required under section 313 can be achieved, the board shall make the MI health benefits program available to public employers for purchase on terms that fully support the costs within 240 days after the effective date of this act.

(2) The board may establish minimum participation periods for public employers as necessary to support the financial stability and viability of the program. The board may authorize exceptions to the minimum participation periods only in financially exigent circumstances.

Sec. 703. (1) If health benefits are made available to employers under this act and subject to section 711, a public employer shall offer a health benefit plan only through participation in the MI health benefits program or on the terms indicated in subsections (2) to (6).

(2) A public employer may offer public employees health benefit plans that are not part of the program if any of the following circumstances exist:

(a) The health benefits are required under a contract in effect on the two hundred fortieth day after the effective date of this act. This exception expires with the expiration of the contract and does not apply to a contract entered into, revised, or renewed on or after 210 days after the effective date of this act.

(b) The public employer presents sufficient evidence, if requested by the board, that it can provide, independently or through a pooling arrangement, comparable benefits to public employees at lower cost.

(c) The public employer, at its sole discretion, elects to opt out of all or part of the program for its nonrepresented employees and provides health benefits under the conditions indicated in subsection (3).

(d) The public employer and any unit of the employer's exclusively represented employees agree to opt out of all or part of the program, and the public employer provides health benefits under the conditions indicated in subsection (3). Each individual bargaining unit shall determine separately with the public employer whether or not that bargaining unit will opt out of the program.

(3) If a public employer or a public employer and its exclusively represented employees elect to opt out of all or part of the program under subsection (2)(c) or (d), the public employer shall pay no more than the illustrative average annual program premium by category of enrollment in the applicable geographic area, as calculated under section 311, for any health benefits that the public employer offers to its public employees through any new contract or contract extension for any health benefits that are not provided through the program. The public employee shall bear any costs above the illustrative average annual premium costs for the program for costs incurred by the public employer to provide alternative health benefit plans. For purposes of this subsection, the costs to the public employer include all overhead and

administrative costs and fees, including costs, paid by the public employer to design, purchase, manage, and administer the health benefit plans. The public employer may pay the full amount for health benefits that the public employer establishes are at a lower cost than the same type of health benefits that are available under the MI health benefits program. The board may require verification and audit of costs and benefit plan designs for public employers opting out of the program for lower cost.

(4) If health benefit plans are available to public employees under this act, a public employer shall notify the board at least 6 months before the start of a new contract period as to whether it will participate in all or part of the MI health benefits program. This subsection does not limit the ability of the board to establish minimum participation periods under section 701.

(5) A public employer may opt out of participation under the conditions established in this section as to the entire program or separately as to either the MI prescription drug plan or the other health benefits made available through the program.

Sec. 705. The costs of the benefits and the administration of the health benefit plans under the program shall be fully supported by the participating employers. A participating employer shall remit the share of the costs allocated to its employees. All costs and administrative fees charged by program suppliers shall be included in the health benefit plan premiums. A participating employer shall pay a surcharge on health benefit plan premiums to support the state's expenses of implementing and administering the program. The office of the state employer shall establish the

amount of the surcharge at not more than 1.0% of the premium if 50% or more of public employees participate in the program, and not more than 2.0% of the premium if participation is less than 50%, and shall remit the surcharge payments to the state treasurer for deposit into the fund.

Sec. 707. Payments for health benefit plans under the program that are remitted by participating employers are not state funds, but are held in trust in the fund to support the contractual obligation for health benefits for beneficiaries.

Sec. 709. Participation in the program does not restrict the right of a public employer to select, subject to collective bargaining, any of the following in relation to health benefit plans:

(a) Which of the program's health benefit plans the public employer will offer.

(b) The share of the premium cost of a program health benefit plan that will be allocated to the public employer and the public employee.

(c) Which of the public employer's employees are eligible to receive health benefits under the program.

Sec. 711. (1) If a collective bargaining agreement or other binding agreement, such as an agreement specifying a vesting schedule, that affects a health benefit plan for retirees of a public employer is in effect on June 1, 2011, retirement health benefits shall be administered in accordance with the terms of the collective bargaining agreement or other binding agreement until the agreement expires or is revised or renewed.

(2) This act does not modify terms relating to retiree health benefits in contractual agreements under which a public employee retired before the effective date of this act.

Sec. 713. The office of the state employer shall make information concerning the health benefit plans under the program and the procedure for participation in the program available to public employers within 15 days after the contracts necessary to implement and administer the program are entered into.

Sec. 715. (1) The MI health benefits fund is created in the state treasury and is held in trust to support the contractual obligation for health benefits for beneficiaries.

(2) The state treasurer may receive money or other assets from any source for deposit into the fund. The state treasurer shall direct the investment of the fund. The state treasurer shall credit to the fund interest and earnings from fund investments.

(3) Money collected under this act shall be deposited in the fund.

(4) Money in the fund is continuously appropriated and may be expended upon authorization of the office of the state employer only for purposes of the MI health benefits program.

(5) Money in the fund at the close of the fiscal year shall remain in the fund and shall not lapse to the general fund.

(6) The office of the state employer shall be the administrator of the fund for auditing purposes.

Sec. 717. After the program has been implemented for public employers, the board may authorize the office of the state employer to make health benefit plans in the program available to private

employers on a voluntary basis on the same terms as health benefit plans are offered to public employers.