Legislative Analysis

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SCHOOL MEDICAL BENEFIT PLANS

House Bill 4700 as enrolled
Public Act 95 of 2011
Sponsor: Rep. Deb Shaughnessy
House Committee: Education
Senate Committee: Committee of the Whole (rules suspended)

Revised First Analysis (9-1-11)

BRIEF SUMMARY: The bill would require that school districts and charter schools that have 100 or more employees in a medical plan either (1) own their health insurance policies or (2) have access by electronic means to certain claims utilization and cost information within ten business days of making a written request.

FISCAL IMPACT: House Bill 4700 as enrolled would have no fiscal impact on the state, but would have an indeterminate fiscal impact on local and intermediate school districts. To the extent that the bills would require that school districts have more complete access to health care claims and experience data, they could create potential savings for certain districts with a history of low health care costs by allowing them to more competitively bid out their health insurance. Districts with a history of higher health care costs would not likely achieve the same benefit from the bills and may see their health care costs increase if they participate in a pool whose membership decreases and is largely made up of similar districts with high health care cost experience.

THE APPARENT PROBLEM:

On April 27, 2011, Governor Snyder delivered an address in which he shared his performance-based Education Plan for Michigan's future. Among his goals, he said, was "a statewide school funding model based upon student proficiency and academic growth," beginning in 2013, and beyond. The governor also noted that in his February executive budget for Fiscal Year 2011-2013, he had proposed that "in fiscal year 2013 a portion of the state foundation allowance be allocated to school districts that pay no more than 80 percent of employee health care premiums or control costs in other ways." He continued: "Local school dashboards and school district accountability and transparency metrics also will be part of the funding discussion." These proposals have come to be known as "financial best practices."

On June 21, 2011, the legislature enacted a new funding incentive under Section 22f of the State School Aid Act, 2011 PA 62 (MCL 388.16622f), that appropriates $154 million to provide $100 per pupil allocations for the FY 2011-2012 school year to local school districts and public school academies (customarily called charter schools) meeting four out of five of the following financial best practices.

- Charge employees at least 10% of the health care premium

- Hold the policy on medical benefit plans (for employees directly employed by district)
- Develop and implement a Service Consolidation Plan
- Obtain competitive bids on non-instructional services
- Provide a dashboard or report card with specific indicators

On May 31 and June 1, 2011, respectively, identical bills were introduced in the House (House Bill 4700) and Senate (Senate Bill 400), to require that school districts implement the second of the five alternatives contained in the incentive plan. Specifically, the legislation requires that all school districts and charter schools that offer health insurance to 100 or more employees either become policy holders of their health insurance plans or have similar access to their employees' medical claims utilization data and cost information.

THE CONTENT OF THE BILL:

The bill requires that school districts and charter schools that offer medical benefit plans to 100 or more employees either (1) own their health insurance policies or (2) have access by electronic means certain claims utilization and cost information within ten business days of making a written request.

Specifically, House Bill 4700 amends the Revised School Code (MCL 380.1255a) to apply to the board of a school district, intermediate school district, or charter school that has 100 or more employees in a medical plan or a district or school that participates in an arrangement with one or more other public employers for a medical plan for 100 or more public employees as described in Section 15(2) of the Public Employee Health Benefits Act. It prohibits such a district or school from entering into a contract for a medical benefit plan unless the contract provides for <u>one</u> of the following:

- That the district or charter school is a policyholder for the medical benefit plan and, at all times during the period of the contract, will have access by electronic means to at least all of the claims utilization and cost information described in Section 15 of the Public Employee Health Benefits Act; <u>or</u>

- That, within ten business days after making a written request, the district or charter school would be given access by electronic means to at least all of the claims utilization and cost information described in Section 15 of the Public Employee Health Benefits Act.

[For the information found in Section 15 of that act, see ***Background Information***.]

The bill specifies that its provisions do not affect the ability of the district or charter school to be a policyholder for the medical benefit plan if the plan was provided for fewer than 100 employees.

Under the bill, "medical benefit plan" means that term as defined in Section 3 of the Public Employees Health Benefit Act, 2007 PA 106, MCL 124.73. There, the term is defined to as follows: " '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."

BACKGROUND INFORMATION:

Section 15 of the Public Employees Health Benefit Act, as amended by Public Act 93 of 2011 (Senate Bill 446) requires, as of October 1, 2011, that the following information be provided to the policyholders.

- A census of all covered employees, including all of the following: year of birth, gender, zip code, and the contract coverage type (single, dependent, or family, and number of covered individuals).

- Claims data for the employee group covered by the medical benefit plan, including all of the following:

  - For a *plan that provides health benefits*, information about hospital and medical claims presented in a manner that clearly shows all of the following for each of the three most recent experience years: number and total expenditures for hospital and medical claims, as well as the number of those claims exceeding $50,000, and the total expenditures for claims exceeding $50,000.

  - For a *plan that provides prescription drug benefits*, information concerning prescription drug claims under the plan, presented in a manner that clearly shows all of the following: the amount charged and the amount paid for prescription drugs claims, brand prescription drugs, and generic prescription drugs for each of the three most recent experience years; and the 50 most frequently prescribed brand and generic prescriptions for which claims were made for the most recent experience period.

  - For a *plan that provides dental benefits and for a plan that provides optical benefits*, information concerning claims and total expenditures for these claims, presented in a manner that clearly shows at least all of the following for each of the three most recent experience years: number of claims submitted and total charge; the number of and total expenditures for claims paid; and total expenditures for claims submitted to network providers.

- Fees and administrative expenses for the most recent experience year, reported separately for health, dental, and optical plans, and presented in a manner that clearly shows at least all of the following: (1) the dollar amounts paid for specific and aggregate stop-loss insurance; (2) the dollar amount of administrative expenses incurred or paid, reported separately for medical, pharmacy, dental, and vision; (3) the total dollar amount of retentions and other expenses; (4) the dollar amount for all service fees paid; (5) the dollar amount of any fees or commission paid to agents, consultants, third party administrators, or brokers by the medical benefit plan, or by any public employer or carrier participating in or providing services to the medical benefit plan, reported separately for medical, pharmacy, stop-loss, dental, and vision; and (6) other information as may be required by the commissioner.

- For health, dental, and optical plans, a benefit summary for the current year's plan and, if benefits have changed during any of the three most recent experience years, a brief benefit summary for each of those experience years for which the benefits were different.

ARGUMENTS:

For:

Proponents of the legislation offer several arguments in favor of the bill. They say that, along with the other financial best practices identified by the governor and the legislature, it will be cost effective. In particular, proponents argue this financial best practice will save school districts money during these tough economic times, enabling districts and charter schools to hold down their health care costs. Representatives of school boards say that most employers with over 100 employees can get detailed claims data from the insurance carrier because they are the policyholder. This is not always the case with school districts. Access to this data is essential in order to manage health insurance costs. For example, it allows a district to determine which benefits most affect costs. The bill makes a district the policyholder or gives them the same kind of rapid access to data, allowing them to better design insurance coverage to protect the health of employees and the financial health of a school district.

Of the financial best practice incentive in general, the chairman of the House Education Committee notes: "It's a unique opportunity to give schools in tough financial times the ability to receive more money per pupil if they meet four out of five requirements."

Advocates for the bill say it offers a much-needed reform. They note that currently, the Michigan Education Special Services Association (MESSA)--founded by the Michigan Education Association--serves as the collectively bargained health insurer for about 45 percent of all Michigan school districts. Further, MESSA reportedly retains ownership of its health insurance policies, working in partnership with Blue Cross Blue Shield of Michigan. As the chairman of the Senate Education Committee—who sponsored similar legislation in the Senate—has noted, "When someone else owns your policy you can't adjust the deductible. You can't make a decision on comprehensive damage. You can't make the decision on whether you want to do rental car coverage. Basically, we want the consumer to be able to determine their coverage and under the MESSA system they don't have that opportunity to adjust the benefit levels within the prescribed plan."

Against:

Opponents of the legislation raise three objections. First, some question the need to make this component of the "financial best practice incentive" a requirement. They say that the design of employee benefits is a matter of local control, and that flexibility should be maintained by local school districts, rather than having uniform standards imposed by the state.

Second, some opponents of the legislation say it is an attack--one of many during this legislative session--on the collective bargaining process. These opponents note that after a district is named as the policyholder of the benefit package, school officials could negotiate the overall specifications for the level of coverage at the collective bargaining table, and then unilaterally seek competitive bids for those health benefits, without the input of their employees. These opponents say that the legislation denies educators both a voice and a choice, thereby challenging their professionalism.

Third, some opponents say the legislation is directed squarely at the Michigan Education Special Services Association (MESSA), which was formed by the Michigan Education Association decades ago, when small school districts could not find insurance coverage for their employees. As MESSA has grown, opponents note that it has been subjected to several political efforts that would limit its market share, in order to diminish the capacity of educators when they collectively bargain.

The director of communications for MESSA, however, has said he doesn't think a district naming itself the policyholder on insurance plans is incompatible with buying a MESSA plan, but at the same time, he noted, it’s often done with the intent of dropping MESSA coverage. He pointed out that MESSA is a VEBA--a Voluntary Employee Beneficiary Association--which groups policies from underwriters into packages. Most parts of those packages are purchased from Blue Cross/Blue Shield of Michigan, he said, but MESSA bundles elements from BCS Life as well. He continued: although MESSA is the policyholder on its plans by virtue of being the entity that purchases them from the underwriters, a school board resolution declaring the district to be the policyholder wouldn’t necessarily be incompatible with bargaining a MESSA plan, as long as the district didn’t try to assert any rights that would conflict with MESSA’s policyholder rights.

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