Legislative Analysis

HOUSE FISCAL AGENCY

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SCHOOL EMPLOYEE HEALTH BENEFITS

Senate Bill 895 as passed by the Senate
Senate Bill 896 as passed by the Senate
Sponsor: Sen. Shirley Johnson

Senate Bill 897 as passed by the Senate
Senate Bill 898 as passed by the Senate
Sponsor: Sen. Wayne Kuipers

House Committee: Education
Senate Committee: Education

Complete to 12-7-05

A SUMMARY OF SENATE BILLS 895 (S-1), 896 (S-1), 897 (S-1), AND 898 (S-1) AS REPORTED FROM HOUSE COMMITTEE ON 12-7-05

The bills would create the "School Employees Health Benefit Act" and amend various statutes to do the following:

- Require a school board or the board of trustees of a community college that provided health benefits to employees to provide those benefits in accordance with the proposed School Employees Health Benefit Act.

- Require that all school medical benefit plans and public universities in the state be offered the opportunity to participate in a catastrophic stop loss (CSL) benefit plan.

- Create a board of directors that, beginning July 1, 2006, would have to implement and administer one or more CSL benefit plans and a CSL fund.

- Require the CSL fund to reimburse a participating school medical benefit plan for a claim over a certain dollar threshold (of at least $50,000 per claim), as specified in the CSL benefit plan, and require the fund to assume liability for a covered claim exceeding the threshold.

- Allow a school employer to provide health benefits by self-insuring (individually or with other school employers), contributing to a trust fund, procuring coverage from a carrier, or entering into a multiple employer welfare arrangement (MEWA).

- Require all school medical benefit plans in the state to compile and make available to school employers claims utilization and cost information for the benefit plan in the aggregate and for the employer's claims and benefits under the benefit plan; and prohibit a school employer from entering into or renewing a benefit plan unless the employer were given that information.

- Provide for access for school employers, employees, and medical benefit plans to information concerning the cost and performance of certain health care providers, facilities, and services.

- Allow a municipal corporation to provide medical benefits under the proposed School Employees Health Benefit Act.

The bills are tie-barred to each other so that none would go into effect unless the others also were enacted. The following is a more detailed description of the bills.

<u>Senate Bill 895</u>

The bill would amend the Revised School Code to state that if the board of directors of a public school, an urban high school, or a strict discipline academy, or the school board of a school district or an intermediate school district provided medical, optical, or dental benefits to employees and their dependents, the board would have to provide those benefits in accordance with the proposed School Employees Health Benefit Act and would have to comply with that act.

<u>Senate Bill 896</u>

Board of Directors. The bill would create the new act and would establish a board of directors to administer a catastrophic stop loss (CSL) benefit plan and CSL fund. The board would consist of ten directors, eight of whom would be appointed by the governor with the advice and consent of the Senate. The appointed members would have to include the following:

** Two directors with some background in insurance issues representing school employers until July 1, 2007; and, effective on that date, two with some background in insurance issues representing school employers participating in a CSL benefit plan and CSL fund.

** Two directors with some background in insurance issues representing collective bargaining organizations that represented school employees, at least one of whom was recommended by the Michigan State AFL-CIO, until July 1, 2007; and, effective on that date, two with experience representing bargaining organizations that represented school employees of school employers as defined in the bill, including at least one recommended by the AFL-CIO.

** One director representing the general public.

** 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.

** One director representing the House of Representatives with some background in insurance issues, as recommended by the speaker of the House.
** One director representing the Senate with some background in insurance issues, as recommended by the Senate majority leader.

** One director who was an actuary in good standing with the American Academy of Actuaries or the Society of Actuaries, to serve ex officio and without vote.

** The commissioner of the Office of Financial and Insurance Services or a designee, who would serve ex officio and without vote.

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

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

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

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

The board would not be a state board or agency. The CSL fund administered by the board would not be a state fund.

CSL Fund & CSL Benefit Plans. Beginning July 1, 2006, the board would be required to implement and administer a CSL fund that provided one or more CSL benefit plans. The fund would have to reimburse a participating school medical benefit plan for a claim over a certain dollar threshold, as specified in the CSL benefit plan. (The bill would define "school medical benefit plan" as a plan established and maintained by one or more school employers that provides for the payment of medical benefits, including hospital and physician services, prescription drugs, and related benefits, to school employees. "School employer" would mean a school district, a public school academy, or an intermediate school district, and a community college or junior college.)

The board would have to develop a plan to provide for the nonprofit operation and management of the CSL fund and each benefit plan created under the bill.

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

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

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

Also, in establishing the fund and each CSL benefit plan, the board would have to do all of the following:

- Provide that each benefit plan would not require any changes in the participating school's medical benefit plan, and would provide for continuity of health care treatment and providers for individuals covered under the school's medical benefit plan.
- Maintain relevant and accurate loss and expense data for each plan.
- Require each school medical benefit plan to furnish claims data as required by the CSL benefit plan selected by that school medical benefit plan.
- Receive and distribute all sums required by the operation of the CSL benefit plan.
- Adopt a policy for investing and reinvesting the assets of the CSL fund.
- Provide a comprehensive program of case management services that would have to be offered to a participating school medical benefit plan for a covered individual whose claim was covered under, or was likely to become covered under, the CSL fund.

All school medical benefit plans and public universities in the state would have to be offered the opportunity to select a catastrophic stop loss benefit plan and participate in a CSL benefit fund.

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

• Assume all liability for any covered claim exceeding the dollar threshold under the CSL benefit plan.
• Maintain relevant and accurate loss and expense data for all liabilities of the CSL fund.
• Maintain reserves as required by the commissioner for the preservation, maintenance, and operation of the fund.

Authorized Activities of the Board. The board would have the authority to do any of the following:

• Sue and be sued in the name of the catastrophic stop loss fund. A judgment against the board would not create any director liability against the participating school medical benefit plans or school employers.
• Reinsure all or any portion of its potential liability with reinsurers licensed to transact insurance in this state or approved by the commissioner.
• Provide for appropriate housing, equipment, and personnel as necessary to ensure the efficient operation of the CSL plan and the fund.
• Adopt reasonable rules for the administration of the plan and the fund, enforce those rules, and delegate authority as the board considered necessary to assure proper administration and operation.
• Contract for goods and services, including independent claims management, actuarial, investment, and legal services to assure the efficient operation of the plan and the fund.
• Perform other acts that were necessary or proper to accomplish the purposes of the catastrophic stop loss fund.
• Hear and determine complaints concerning the operation of the catastrophic stop loss fund.

School Medical Benefit Plans. Subject to collective bargaining requirements under Public Act 336 of 1947, a school employer could provide medical, optical, or dental benefits to employees and their dependents by any of the following methods:

• Establishing and maintaining a plan on a self-insured basis as provided in the bill.
• Joining with other school employers and establishing and maintaining a plan on a self-insured basis as provided in the bill.
• Entering into an agreement under which contributions were made to a trust fund for the purpose of providing medical, dental, or optical benefits to school employees and their dependents under a plan agreed to by their employer.
• Procuring coverage from one or more carriers (a health insurance company, a health maintenance organization, and a nonprofit health care corporation), either on an individual basis or with one or more other school employers.

• Forming a multiple employer welfare arrangement (MEWA) under Chapter 70 of the Insurance Code.

A plan under either of the first two provisions would not constitute doing the business of insurance in the state, and would not be subject to the insurance laws of the state. If a school employer entered into an agreement under which contributions were made to a trust fund, the trust fund could receive contributions from one or more school employers and could provide benefits to employees of one or more school employers.

The bill states that the proposed act would not prohibit a school employer from participating, for the payment of medical benefits and claims, in a purchasing pool or coalition to procure insurance or coverage, health care plan services, or administrative services.

A school medical benefit plan participating in a CSL benefit plan that elected not to participate in a case management program would have to provide to covered individuals case management services that met accreditation standards established by the National Committee on Quality Assurance, the Joint Commission on Health Care Organizations, or the Utilization Review Accreditation Commission.

Self-Insured Medical Benefit Plans. A self-insured school medical benefit plan would have to maintain such reserves as necessary to cover the projected cost of medical benefits for covered individuals. A report of amounts reserved and disbursements made from them, together with a written report from a member of the American Academy of Actuaries or the Society of Actuaries certifying whether the amounts reserved conformed to these requirements, were computed in accordance with accepted loss reserving standards, and were fairly stated in accordance with sound loss reserving principles, would have to be filed with the commissioner within 90 days after last day of the school employer's fiscal year. The report would have to be made available for inspection by any person at all reasonable times during business hours, and copies of the report would have to be provided, at cost, within a reasonable period of time upon request.

A self-insured school medical benefit plan also would have to provide for administration of the plan using personnel of the school employer or employers, personnel of an organization representing the employees, or by awarding a contract, which would not need to be competitively bid, to any person, political subdivision, or corporation. No such contract could be entered into without full, prior, public disclosure of all terms and conditions, including at least a statement listing all representations made in connection with any possible savings and losses resulting from the contract, and potential liability of the school employer or employee.

Further, a school medical benefit plan would have to enter into a contract with a member of the American Academy of Actuaries or the Society of Actuaries for the preparation of the written actuarial evaluation of a plan as required under the bill. The evaluation would have to be based on all of the following information: access fees to a facility and provider network; paid claims for the previous three years; estimated incurred claims for the

previous three years; plan administrative costs; chronic case management fees; disease case management fees; and preventive and wellness plan fees.

A school medical benefit plan also would have to enter into agreements with providers of services to the school medical benefit plan, subject to the requirements of the bill and as established by the commissioner.

If the commissioner found that a self-insured school medical benefit plan's reserves were not sufficient to meet the requirements, the commissioner would order the plan to immediately collect from any school employer that was or had been a member of the plan appropriately proportionate contributions sufficient to restore reserves to the required level. The commissioner could take such action as he or she considered necessary, including, but not limited to ordering the suspension or dissolution of a self-insured plan, if the plan was consistently failing to maintain adequate reserves; was using methods and practices that rendered further transaction of business hazardous or injurious to its members, employees, beneficiaries, or to the public; had failed, after written request by the commissioner, to remove or discharge an officer, director, trustee, or employee who had been convicted of any crime involving fraud, dishonesty, or moral turpitude; had failed or refused to furnish any report or statement required under this act; or if the commissioner, upon investigation, determined that it was conducting business fraudulently or was not meeting its contractual obligations in good faith. Any proceedings by the commissioner would be governed by the applicable requirements and procedures of the insurance code.

To the extent permitted under the written agreement, a school employer could assume the risks of any other school employers.

Disclosure of Benefit Plan Information. Beginning on the bill's effective date, all school medical benefit plans in the state would be required to compile and make available upon request to the school employer complete and accurate claims utilization and cost information for the benefit plan in the aggregate and for each school employer as follows:

- The number of persons covered under the school medical benefit plan.
- If applicable, the number of people covered under a policy, certificate, or contract issued by a carrier.
- The number of claims paid.
- The dollar amounts of claims paid and of claims incurred but not reported.
- The claims experience, by coverage component and by provider.
- The dollar amount of premiums or fees paid, if any.
- The dollar amount of administrative expenses incurred or paid.
- The dollar amount of retentions.
- The dollar amount of provider, network, case management, pre-certification, and other service fees paid.
- The dollar amount of any fees paid or commissions paid to agents or brokers by the school medical benefit plan or by any school employer or carrier participating in or providing services to the school medical benefit plan.
- Other information as may be required by the commissioner.

Beginning on the bill's effective date, a school employer would be prohibited from entering into or renewing a school medical benefit plan unless the employer would be furnished with complete and accurate claims utilization and cost information, described above, with respect to the employer's claims and benefits under the school medical benefit plan.

The claims utilization and cost information would have to be compiled on an annual basis, covering the 36-month period ending not more than 120 days before the effective date or renewal date of the school medical benefit plan under consideration. If the plan had been in effect for less than 36 months, the information would have to be compiled for that shorter period.

A school employer or combination of school employers would have to make public the claims utilization and cost information not later than 60 days before the effective date or renewal date of the school medical benefit plan or the administrative services agreement under consideration. The school employer would have to make the claims utilization and cost information available for inspection by any person at all reasonable times during regular business hours, and would have to provide copies, at cost, within a reasonable time upon request.

The claims utilization and cost information could not include any protected health information as defined in the Health Insurance Portability and Accountability Act of 1996, (HIPAA) or regulations promulgated under that act, and could not include any protected health information as defined in the act (which prohibits a person from knowingly obtaining, disclosing, or using individually identifiable health information relating to an individual).

Comparison of Services. To encourage and facilitate informed decisions concerning school medical benefit plan design, the administration of plans, the selection of medical service providers, and the planning of medical care, the commissioner would have to gather data evaluating and comparing the cost, efficiency, and performance of administrative services provided to school 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.

Also, working with other state departments and agencies, the commissioner would have to ensure access on a regular basis for school employers, school medical benefit plans, and covered school employees to information concerning cost and performance of Michigan hospitals, medical clinics, and other health care facilities, including licensure, accreditation, and performance measures for those facilities; and information concerning cost and performance of Michigan physicians and other health care providers, including medical training, years in practice, board certification, verified licensure information, patient experience, and the results of at least two clinical performance measures of physicians and other health care providers.

Buyer's Guide. The bill specifies that at least annually, the commissioner prepare and make available for distribution to school employers and other interested people a buyer's

guide for school employers that provided information necessary to make informed decisions concerning school medical benefit plan design, the administration of school medical benefit plans, the selection of medical service providers, and the planning of medical care similar to information provided to assist buyers in making informed decisions in the buyer's guide to auto insurance in Michigan, the buyer's guide to home and renter's insurance in Michigan, and the HMO consumer's guide.

Senate Bill 897

The bill would amend Public Act 35 of 1951 (which authorizes intergovernmental contracts between municipal corporations) to allow a municipal corporation to provide medical benefits as would be permitted under the proposed School Employees Health Benefit Act.

Public Act 35 specifies that a group self-insurance pool may not provide for hospital, medical, surgical, or dental benefits to the employees of the member municipalities in the pool except when those benefits arise from the obligations and responsibilities of the pool in providing automobile insurance coverage. The bill would add an exception from that prohibition if the municipal corporation were providing hospital, medical, surgical, or dental benefits as would be permitted under the proposed School Employees Health Benefit Act.

Senate Bill 898

The bill would amend the Community College Act to require a board of trustees of a community college that provided medical benefits to employees to provide those benefits in accordance with the proposed School Employees Health Benefit Act.

Specifically, the bill would authorize the board of trustees of a community college to select and employ administrative officers, teachers, and other employees it found necessary to operate the community college district and establish the terms and conditions of their service or employment. If the board provided medical, optical, or dental benefits to employees and their dependents, the board would have to provide those benefits in accordance with the proposed School Employees Health Benefit Act and would have to comply with that act.

Under the Community College Act, a board of trustees may delegate to the chief executive officer the authority to select and employ personnel of the community college. The bill would add that if the chief executive officer provided medical, optical, and dental benefits to employees and their dependents, he or she would have to provide those benefits in accordance with the proposed School Employees Health Benefit Act and would have to comply with that act.

FISCAL IMPACT:

Senate Bills 895 and 898 would require those school districts, intermediate school districts, public school academies, urban high school academies, strict discipline academies and community colleges which provide medical, optical, or dental benefits to provide them according to the proposed School Employees Health Benefit Act. The proposed act would provide them with health care claims utilization and cost data, which they could then use to make informed decisions about the health care benefits they offer and potentially reduce the cost of providing health care benefits.

Senate Bill 896 embodies key parts of the proposal *A Model for Saving Public School Health Care Dollars Through Large Claim Pooling, Increased Competition, and Improving Health Care Quality* sponsored by the Michigan Federation of Teachers & School Related Personnel and the International Union of Operating Engineers Local 547. By creating a state-sponsored catastrophic stop loss fund, allowing school employers to form self-insured pools for providing health care benefits, and requiring that claims utilization and cost data be provided to employers, the proposal estimates that the bill would encourage 75% of groups who are currently fully-insured to instead self-insure and potentially reduce costs by 2.77%. In addition, the proposal suggests that if the bill creates such an environment, school employers also would be able to take advantage of additional savings in the form of reduced administrative costs and fees and group pharmaceutical savings which could further reduce costs by another 4.88%. In total, the proposal estimates a first-year savings of $156.0 million or 7.20% of the total cost of school employee health care.

Senate Bill 896 also would create new administrative costs to the State in the creation of the catastrophic stop loss fund and a board of directors to manage the fund. However, those costs could be rolled into the premiums paid by participating school employers, reducing the net cost to the State to zero. The bill would also create additional administrative costs for the Office of Financial and Insurance Services within the Department of Labor and Economic Growth due to provisions which would require the office to collect and ensure access to data on the cost efficiency and performance of service providers. These costs, on the other hand, would not be included in premiums and would be borne by the State.

Senate Bill 897 would allow municipal corporations to provide health care benefits through self-insured pools if done so in accordance in with the School Employee Health Benefit Act. In doing so, the bill could lead to changes in health care benefits and potentially reduce the cost of providing health care benefits incurred by local governments.

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■ This analysis was prepared by nonpartisan House staff for use by House members in their deliberations, and does not constitute an official statement of legislative intent.