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BILL ANALYSIS

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Senate Bill 895 (Substitute S-1 as passed by the Senate)
Senate Bill 896 (Substitute S-1 as passed by the Senate)
Senate Bill 897 (Substitute S-1 as passed by the Senate)
Senate Bill 898 (Substitute S-1 as passed by the Senate)
Sponsor: Senator Shirley Johnson (S.B. 895 & 896)
Senator Wayne Kuipers (S.B. 897 & 898)
Committee: Education

Date Completed: 4-27-06

RATIONALE

Rising health care costs are a continuing problem for school systems across the State. According to the Michigan Association of School Boards, schools spend nearly $2,000 per student on employee health care, with health care costs rising at a faster rate than school budgets. In March 2005, the Michigan Legislative Council commissioned the Hay Group, an international consulting firm, to analyze whether integrating Michigan public school employees under a statewide health benefit plan would produce cost savings for the State and local school districts. According to the Hay Group's report, presented on July 13, 2005, school districts will pay an average of $11,362 for health insurance per employee in fiscal year 2005-06, for a total expenditure of $2,165 million (excluding dental and vision benefits). The Hay Group report outlined three options for statewide group benefit plans that the report projected could save from $146 million to $281 million in 2005 dollars. Others, however, have suggested approaches to school employee health coverage that would not involve a State-controlled benefit plan, except optional coverage for catastrophic claims. In particular, many believe that regional health insurance pools could allow school districts to reap cost savings. Others recommend that schools should have greater access to information about health care providers' prices and performance, as well as a district's claims history. It has been suggested that these and other measures would enhance competition in the health care market and enable school districts to control employee benefit costs.

CONTENT

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.

-- 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 on 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.

Senate Bill 895 (S-1) would amend the Revised School Code. Senate Bill 896 (S-1) would create the School Employees Health Benefit Act. Senate Bill 897 (S-1) would amend Public Act 35 of 1951 (which authorizes intergovernmental contracts between municipal corporations). Senate Bill 898 (S-1) would amend the Community College Act.

The four bills are tie-barred together.

Senate Bill 895 (S-1)

The bill states 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.

Senate Bill 896 (S-1)

Board of Directors

The bill would create a board of directors to administer a CSL benefit plan and CSL fund. The board would consist of 10 directors. The following members would be appointed by the Governor with the advice and consent of the Senate:

-- 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 that had selected a CSL plan and participated in the CSL fund, 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, including promoting nutrition and physical exercise and compliance with disease management programs and preventive service guidelines 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 10th member of the board would be the Commissioner of the Office of Financial and Insurance Services or his or her designee, who would serve ex officio and without vote.

The directors first appointed to the board would have to be appointed within 60 days of the bill's effective date. The board would be required to adopt rules providing for the composition and term of successor boards,

consistent with the membership described above. 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. 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 that exceeded the dollar threshold of the CSL benefit plan chosen by the school medical 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 consistent with the bill.

In establishing the fund and the CSL benefit plan or plans, the board would have to provide for 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 for 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 did not require any changes in the participating school medical benefit plan for payment from the fund, and would provide for continuity of health care treatment and

providers for individuals covered under the school medical benefit plan.
-- Maintain relevant and accurate loss and expense data relative to all liabilities of each CSL plan.
-- Require each school medical benefit plan to furnish claims data as required by the CSL fund.
-- Receive and distribute all sums required for the operation of the CSL fund.
-- Adopt a policy for investing and reinvesting the assets of the CSL fund that complied with investment limitations govering the assets of public employee retirement systems.
-- 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 CSL plan and participate in the CSL 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 applicable 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:

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

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

School Medical Benefit Plans

Subject to collective bargaining requirements under Public Act 336 of 1947, a school employer could provide medical, optical, and 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, either on an individual basis or with one or more other school employers.
-- Forming a multiple employer welfare arrangement under Chapter 70 of the Insurance Code.

A plan under either of the first three provisions would not constitute doing the business of insurance in the State, and would not be subject to the insurance laws of the State. 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.

School employers procuring coverage from one or more carriers could pool risks with other school employers to the extent

permitted under a written agreement. ("Carrier" would mean a health or vision insurance company; a health maintenance organization (HMO); a system of health delivery and financing as defined in Section 3573 of the Insurance Code (which provides for health care delivery systems similar to HMOs but not meeting requirements of the Code); a dental care corporation; and a nonprofit health care corporation.)

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 have 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 of the bill, the Commissioner would have to order the school medical benefit plan immediately to collect from any school employer that was a present or former member of the plan appropriately proportionate contributions sufficient to restore reserves to the required level. The Commissioner could take action that he or she considered necessary, including ordering the suspension or dissolution of a self-insured school medical benefit plan, if any of the following applied: the plan was consistently failing to maintain adequate reserves; it was using methods and practices that made further transaction of business hazardous or injurious to its members, employees, or beneficiaries, or to the public; the plan 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; the plan had failed or refused to furnish any report or statement required under the bill; or the Commissioner, upon investigation, determined that the plan was conducting business fraudulently or was not meeting its contractual obligations in good faith. Any proceedings under these provisions would have to be governed by the requirements and procedures of Sections 7074 to 7078 of the Insurance Code (which concern violations by multiple employer welfare arrangements).

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 people 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, precertification, or 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 plan.
-- Other information as 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 of documents containing the information, at cost, within a reasonable time upon request.

The claims utilization and cost information could include only de-identified health information as permitted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and could not include any protected health information as defined in HIPAA or regulations promulgated under that 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 timelines and accuracy, and make available easily accessible comparative ratings and descriptions of those plan administrators on a regular basis.

Also, working with other State departments and agencies, the Commissioner would have to ensure access on a regular basis for 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.

At least annually, the Commissioner would have to 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 (S-1)

Public Act 35 of 1951 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 (S-1)

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

MCL 380.632 et al. (S.B. 895)
124.5 (S.B. 897)
389.123 & 389.124 (S.B. 898)

ARGUMENTS

(Please note: The arguments contained in this analysis originate from sources outside the Senate Fiscal Agency. The Senate Fiscal Agency neither supports nor opposes legislation.)

Supporting Argument

The bills would reduce health care costs for public schools in several ways. First, they would allow schools to create regional insurance pools, distributing costs and risk across a greater number of people. Insurance pools have been shown to reduce costs in other states, and recently the Ottawa Area Intermediate School District and other school districts created the West Michigan Insurance Pool, which already has produced significant savings for its participants. According to testimony before the Senate Education Committee, the pool reduced their health care costs by 6% this year, compared with a projected increase of 16% that they would have faced outside the pool. The West Michigan Insurance Pool has been able to produce these cost savings without reducing benefits to its members, and has drawn such attention that many surrounding districts reportedly have expressed interest in joining the pool. The West Michigan Insurance Pool, however, faced significant regulatory obstacles in an approval process that took almost three years to complete. The bills would ease the

regulations, making it easier to establish such pools.

Other benefits of insurance pools include decreased administrative expenses. Rather than each district having to manage its own plan, an insurance pool can be administered centrally, reducing costs and operating more efficiently. In addition, a large pool can negotiate for better insurance rates based on the number of participants. Insurance companies typically offer discounts for large groups. Combining several small school districts into one pool allows the participants to qualify for lower rates.

The bills also would offer catastrophic stop loss coverage to every school district that offered health benefits to its employers. This coverage would protect school districts from having to pay very expensive claims, reducing costs for the districts and adding a level of protection against the relatively rare but very large claims that could bankrupt a plan or significantly raise the cost of health insurance for all employees in a district. The State could implement more than one CSL plan to meet the needs of different districts, and participation in the plans would be optional. The CSL fund would be financed initially through claims lag, or the time between when a claim was filed and the fund was billed for the claim, and school employers would have to pay premiums sufficient to cover expected losses and expenses. This proposal resembles successful State and Federal programs that address catastrophic insurance claims resulting from automobile accidents, natural disasters, bank failures, and acts of terrorism.

In addition, the CSL proposal would encourage a greater focus on wellness and preventive care, which could produce long-term cost savings as participants lived healthier lives. Most health care plans today focus only on treating illnesses once they have reached a critical stage. At that point, the treatment can be much more costly than preventive care would have been. The bills would require that incentives be provided to encourage benefit plans to offer health promotion and chronic care management programs. By encouraging preventive medicine focused on keeping people healthy, the plans could reduce their overall costs as fewer people got seriously ill or needed expensive treatment.

These proposals are based on findings in the study done by the Hay Group and on best practices that have been shown to reduce health care costs in other states. The proposed changes have popular support; according to the Michigan Association of School Boards, a statewide poll showed that 62% of voters in Michigan are in favor of allowing school districts to form insurance pools. These bills represent a positive step in the right direction to bring health care costs under control without compromising the collective bargaining process. The money saved under the bills would allow school budgets to direct more money to the classroom, to pay for textbooks, to hire more and better teachers, and to make other improvements that would directly affect children.

Supporting Argument

The bills would provide greater transparency in Michigan health services, requiring health care providers to supply school districts with information on prices for services and performance quality so that districts could make more informed choices regarding health care. Currently, health care purchasers have access to limited information. Insurance companies do not always provide purchasers with the specific data on the quality of service or the costs of particular services from each provider that the purchaser needs to make the best decision. The bills would require that information to be available to plan purchasers, and also to individual members of the plan to help them in selecting care.

Insurers are also reluctant to release the claims history for a district. The bills would require insurers to release aggregated claims histories for each district, with all identifying information removed, to allow plan administrators to determine which types of benefits were frequently used and should be retained, and which were seldom used and could be eliminated to cut costs. The increased available information would allow purchasers to tailor their plans to the needs of their members and to seek competitive bids from providers based on cost and performance, increasing competition and lowering prices.

Opposing Argument

Two of the key provisions in the bills are already available to public school districts. The proposed insurance pools are currently

permitted under the laws regulating multiple employer welfare arrangements (MEWAs). The West Michigan Insurance Pool was recently developed and approved by the State under existing law. If school districts are interested in creating insurance pools, they can develop MEWAs modeled after the West Michigan pool. The two or three years it took to establish the pool is not unreasonable in view of its significance and newness. Also, the Michigan Education Special Services Association (MESSA), which covers about 55% of the State's public school and community college employees, currently offers the benefits and cost savings of insurance pooling. The bills, however, would remove the consumer protections offered under these plans, allowing the creation of insurance pools that would not be regulated as MEWAs or otherwise subject to the insurance code, making school employees the only unprotected employees in multiple-employer insurance pools in Michigan. Pools operated without proper oversight and regulation could be underfunded and financially unstable.

The legislation also would require the creation of one or more catastrophic stop loss benefit plans, which would be available to all public schools in Michigan. Such plans are already offered by the private sector, however, and it is unclear why the State should be involved in setting up a plan or plans that would be competing with private companies. Any cost savings that these plans could offer are already available to school districts on the open market. Offering similar CSL benefit plans through the State would not provide any new protection, benefits, or cost savings. Since participation in a CSL plan would be voluntary, it could end up being an insurer of last resort, consisting only of groups unable to purchase CSL benefits elsewhere. If the CSL plan or plans were subject to this adverse selection, then the fund could face difficulties remaining financially solvent. Furthermore, the bills would not require adequate up-front funding of the fund, which could be bankrupted if it had to pay several large claims in its first few months. Although the CSL fund would have to maintain reserves as required by the Commissioner, he or she would have no authority to examine the benefit plans in order to determine the necessary reserve level. According to OFIS, experience has shown that without adequate regulatory oversight, catastrophic funds fail financially within a few years. If the CSL fund were unable to pay, the bills do not specify who would be responsible for the payment of claims.

In sum, rather than lowering health care costs, the bills would create an unstable market and possibly insolvent insurance plans.

Opposing Argument

These bills are significantly different than the proposals set forth in the Hay Group report, and would destabilize the health insurance market in Michigan. The Hay Group recommended the adoption of a statewide group insurance plan, which, according to the report, would have to include all schools in order to yield the projected cost savings. The bills present a very different proposal, allowing voluntary regional pools or self-insurance or other options. Because the pools created under the bills would be voluntary, school districts would be able to jump in and out of the system, based on whether they could get a better rate within the pool or on their own.

The bills would compound this problem by requiring the release of claims experience data for each school district. The release of claims data could allow a pool to select only districts with low health costs to join the pool, leaving other districts with higher costs to face higher health premiums. The result would be a reduction in costs for healthy districts while districts with older or sicker employees would face higher costs, which would create a disincentive for districts to keep experienced, highly qualified teachers. Such selective "cherry picking" violates a basic principal of insurance: that the risks are spread equally across as many people as possible. If pools were able to pick and choose the districts with lower claims histories, the health insurance market in Michigan could be destabilized, reducing costs for some while driving up insurance premiums for others.

The release of employees' claims histories also could violate the individuals' privacy. Health information is very sensitive and personal, and even if all identifying markers were removed from the data, employers might be able to tell which employee had a particular condition, particularly in smaller

districts or in cases involving unusual illnesses or conditions.

Legislative Analyst: Curtis Walker

FISCAL IMPACT

Senate Bills 895 and 898

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

Local: The bills would require school districts, public school academies, intermediate school districts, and community colleges that offer medical, optical, or dental benefits to employees and their dependents to provide those benefits in accordance with the proposed School Employees Health Benefit Act. The only local mandate under that Act would require a school employer to be furnished with complete and accurate claims utilization and cost information with respect to the employer's claims and benefits when entering into or renewing a medical benefit plan. Therefore, the fiscal impact on school employers under the bills would be zero (unless a benefits provider under contract with a school employer chose to increase the premiums charged to cover any costs associated with providing claims data), though the availability of claims data could lead to different benefit choices.

Senate Bill 896

State: The State would see new administrative costs associated with the creation of a catastrophic stop loss fund and the creation of a board of directors for oversight and management of the fund. Specific State costs could include the hiring of skilled actuaries trained in determining the stop loss premiums charged to participating school employers, and information technology costs pertaining to the collection and manipulation of necessary data. However, costs the State would incur in creating and overseeing the fund should be included in the premiums charged to participating school employers, thereby resulting in zero net State costs, once the premium fees were collected and used to pay for start-up and maintenance. Other responsibilities imposed by the bill would increase the administrative costs of the Office of Financial and Insurance Services within the Department of Labor and Economic Growth and could not be recovered via the premiums charged to participating school employers. This office would be required to collect and ensure access to data on the cost efficiency and performance of administrative service providers and health care facilities and providers.

Local: According to A Model for Saving Public School Health Care Dollars Through Large Claim Pooling, Increased Competition and Improving Health Care Quality, an August 10, 2005, report sponsored by the Michigan Federation of Teachers and School Related Personnel and the International Union of Operating Engineers Local 547, the estimated savings for the proposed model partially contained within the bill are $156 million in the first year, representing savings of 7.20% of the total cost of school employee health care. The savings in this report assume that 75% of groups that are currently fully insured would move to self-funding through purchasing coalitions or pools, and the report uses HayGroup assumptions found in the July 13, 2005, paper, Report on the Feasibility and Cost-Effectiveness of a Consolidated State-wide Health Benefits System for Michigan Public School Employees.

Through the creation in the bill of a statewide catastrophic stop loss fund available to participating school employers (defined as school districts, public school academies, intermediate districts, and community colleges), and through the availability of health care claims data (mandated under the bill in any contract signed by a school employer when offering medical benefits), the proposal estimates that 75% of currently fully-insured groups would become self insured, thereby saving 2.77% due to the self-funding (or "pay-as-you-go") of medical claims, rather than the purchase of policies.

Other estimated savings reported in A Model for Saving Public School Health Dollars include frequent updates of employer eligibility, more aggressive checks of students' eligibility for benefits, negotiated administrative fees, provider access fees, and pharmacy carve-out (savings estimated to equal 4.88% of total school employer health care costs). However, the bill itself would not force these savings; instead, if a school employer did regionally pool and self-insure, it would be in the best interests of

that employer to undertake these activities and generate the possible savings. Again, however, this bill would not force or guarantee those stated savings, but likely would make it easier for a self-funded, pooled benefit arrangement to occur due to the availability of a statewide catastrophic stop loss fund and health care claims data.

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

Senate Bill 897

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

Local: The bill would allow municipal corporations to group self-insure if the benefits were provided as permitted under the School Employees Health Benefit Act. Therefore, the fiscal impact under the bill is indeterminate and would depend upon how many municipal corporations used the bill's provisions and any resulting changes the provisions would make in the cost of providing insurance. The bill would expand the circumstance under which municipal corporations are allowed to pool group self-insurance, but would not mandate such activities. The availability of this type of arrangement could lead to changes in the provision of benefits, and corresponding differences in costs, but the bill itself would not require those benefit changes.

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