PUBLIC EMPLOYEES HEALTH BENEFIT ACT
Act 106 of 2007

AN ACT to prescribe the conditions upon which public employers may provide certain benefits; to require the compilation and release of certain information and data; to provide certain powers and duties to certain state officials, departments, agencies, and authorities; and to provide for appropriations.

History: 2007, Act 106, Imd. Eff. Oct. 1, 2007.

The People of the State of Michigan enact:

124.71 Short title.

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

History: 2007, Act 106, Imd. Eff. Oct. 1, 2007.

124.73 Definitions.

Sec. 3. As used in this act:

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

(b) "Commissioner" means the director of the department of insurance and financial services.

(c) "Covered individual" means an individual covered by a contract under section 15(3)(a)(*iv*).

(d) "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.

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

(f) "Public employer" means a city, village, township, county, or other political subdivision of this state; any intergovernmental, metropolitan, or local department, agency, or authority, or other local political subdivision; a school district, a public school academy, or an intermediate school district, as those terms are defined in the revised school code, 1976 PA 451, MCL 380.1 to 380.1852; or a community college or junior college described in section 7 of article VIII of the state constitution of 1963. Public employer includes a public university that elects to come under the provisions of this act.

(g) "Public employer pooled plan" or "pooled plan" means a public employer pooled plan established pursuant to section 5(1)(b).

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

(i) "Specialty prescription drug" means a prescription drug used to treat a rare, complex, or chronic medical condition that meets any of the following requirements:

(*i*) Requires special administration including, but not limited to, inhalation or infusion.

(*ii*) Requires special delivery or special storage.

(*iii*) Requires special oversight, intensive monitoring, or care coordination with a person licensed under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838.

History: 2007, Act 106, Imd. Eff. Oct. 1, 2007;—Am. 2018, Act 579, Eff. Mar. 29, 2019.

124.75 Medical, optical, or dental benefits provided to public employees; methods; solicitation of bids; number; frequency; participation of public employer in purchasing pool or coalition.

Sec. 5. (1) Subject to collective bargaining requirements, a public employer may provide medical, optical, or dental benefits to public employees and their dependents by any of the following methods:

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

(b) By joining with other public employers and establishing and maintaining a public employer pooled plan to provide medical, optical, or dental benefits to not fewer than 250 public employees on a self-insured

basis as provided in this act. A pooled plan shall accept any public employer that applies to become a member of the pooled plan, agrees to make the required payments, agrees to remain in the pool for a 3-year period, and satisfies the other reasonable provisions of the pooled plan. A public employer that leaves a pooled plan may not rejoin the pooled plan for 2 years after leaving the plan. A pooled plan under this subdivision does not constitute doing the business of insurance in this state and, except as provided in this act, is not subject to the insurance laws of this state. A pooled plan under this subdivision may enter into contracts and sue or be sued in its own name.

(c) By procuring coverage or benefits from 1 or more carriers, either on an individual basis or with 1 or more other public employers.

(2) A public employer or pooled plan procuring coverage or benefits from 1 or more carriers shall solicit from different carriers 4 or more bids when establishing a medical benefit plan, including at least 1 bid from a voluntary employees' beneficiary association described in section 501(c)(9) of the internal revenue code, 26 USC 501(c)(9). A public employer or pooled plan procuring coverage or benefits from 1 or more carriers shall solicit from different carriers 4 or more bids every 3 years when renewing or continuing a medical benefit plan, including at least 1 bid from a voluntary employees' beneficiary association described in section 501(c)(9) of the internal revenue code, 26 USC 501(c)(9). A public employer or pooled plan that provides for administration of a medical benefit plan using an authorized third party administrator, an insurer, a nonprofit health care corporation, or other entity authorized to provide services in connection with a noninsured medical benefit plan shall solicit from different carriers 4 or more bids for those administrative services when establishing a medical benefit plan. A public employer or pooled plan that provides for administration of a medical benefit plan using an authorized third party administrator, an insurer, a nonprofit health care corporation, or other entity authorized to provide services in connection with a noninsured medical benefit plan shall solicit from different carriers 4 or more bids for those administrative services every 3 years when renewing or continuing a medical benefit plan.

(3) This act does not prohibit a public employer from participating, for the payment of medical benefits and claims, in a purchasing pool or coalition to procure insurance, benefits, or coverage, or health care plan services or administrative services.

(4) A public university may establish a medical benefit plan to provide medical, dental, or optical benefits to its employees and their dependents by any of the methods set forth in this section.

(5) A medical benefit plan that provides medical benefits shall provide to covered individuals case management services that meet the case management accreditation standards established by the national committee on quality assurance, the joint commission on health care organizations, or the utilization review accreditation commission.

History: 2007, Act 106, Imd. Eff. Oct. 1, 2007;—Am. 2011, Act 93, Eff. Oct. 1, 2011.

124.77 Public employer pooled plan; certificate of registration; application; form; notice of additional information needed; investigation; issuance or denial of certificate of registration; notice of denial; request for hearing; books open to commissioner.

Sec. 7. (1) A person shall not establish or maintain a public employer pooled plan in this state unless the pooled plan obtains and maintains a certificate of registration pursuant to this act.

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

(a) Copies of all articles, bylaws, agreements, or other documents or instruments describing the rights and obligations of employers, employees, and beneficiaries with respect to the pooled plan and the expected number of public employees to be covered for medical, optical, or dental benefits under the pooled plan.

(b) Current financial statements of the pooled plan or, for a newly established pooled plan, 3 years of financial projections.

(c) A statement showing in full detail the plan upon which the pooled plan proposes to transact business and a copy of all contracts or other instruments that it proposes to make with or sell to its members, together with a copy of its plan description.

(3) The commissioner shall examine the application and documents submitted by the applicant for completeness and shall notify the applicant not later than 30 days after receipt of the application of any additional information needed. The commissioner may conduct any investigation that the commissioner considers necessary and examine under oath any person interested in or connected with the pooled plan.

(4) The commissioner shall issue or deny a certificate of registration within 90 days of receipt of the applicant's substantially completed application. The commissioner shall not issue a certificate of registration to the pooled plan unless the commissioner is satisfied that the pooled plan is in a stable and unimpaired

financial condition, that the pooled plan is qualified to maintain a medical benefit plan in compliance with this act, and that the pooled plan meets the requirements in section 9(1)(a), (e), (f), (g), and (h). The commissioner shall deny a certificate of registration to an applicant who fails to meet the requirements of this act. Notice of denial shall be in writing and shall set forth the basis for the denial. If the applicant submits a written request within 60 days after mailing of the notice of denial, the commissioner shall promptly conduct a hearing pursuant to the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, in which the applicant shall be given an opportunity to show compliance with the requirements of this act.

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

(6) A pooled plan shall open its books to the commissioner, and a final certificate of registration shall not be issued by the commissioner to a pooled plan until the pooled plan has collected cash reserves as provided in section 9.

History: 2007, Act 106, Imd. Eff. Oct. 1, 2007.

124.79 Public employer pooled plan; requirements; effect of insufficient reserves; authority of commissioner to take certain actions.

Sec. 9. (1) In addition to other requirements as provided in this act, a public employer pooled plan established on or after October 1, 2007 shall do all of the following:

(a) Establish and maintain minimum cash reserves of not less than 25% of the aggregate contributions in the current fiscal year or in the case of new applicants, 25% of the aggregate contributions projected to be collected during its first 12 months of operation, as applicable; or not less than 35% of the claims paid in the preceding fiscal year, whichever is greater. As an alternative, a pooled plan that has operated for 5 years or more may elect to maintain minimum cash reserves in an amount equal to 2.5% of the immediately preceding year's claims plus its most recent designated reserve for incurred but not reported claims, as indicated in its financial statement filed with the commissioner under subdivision (b). Reserves established pursuant to this section must be maintained in a separate, identifiable account and must not be commingled with other funds of the pooled plan. The pooled plan shall invest the required reserve in the types of investments allowed under section 910, 912, or 914 of the insurance code of 1956, 1956 PA 218, MCL 500.910, 500.912, and 500.914. Except as otherwise provided in this subdivision, the pooled plan may satisfy up to 100% of the reserve requirement in the first year of operation, up to 75% of the reserve requirement in the second year of operation, and up to 50% of the reserve requirement in the third and subsequent years of operation, through an irrevocable and unconditional letter of credit. A pooled plan that elects the alternative minimum cash reserve may not satisfy any portion of the reserve requirement with a letter of credit. As used in this subdivision, "letter of credit" means a letter of credit that meets all of the following requirements:

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

(*ii*) Is issued upon such terms and in a form as approved by the commissioner.

(*iii*) Is subject to draw by the commissioner, upon giving 5 business days' written notice to the pooled plan, or by the pooled plan for the member's benefit if the pooled plan is unable to pay claims as they come due.

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

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

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

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

(f) Possess a written commitment, binder, or policy for excess loss insurance issued by an insurer authorized to do business in this state in an amount approved by the commissioner. The binder or policy must provide not less than 30 days' notice of cancellation to the commissioner.

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

(h) Provide for administration of the plan using personnel of the pooled plan, provided that the pooled plan has within its own organization adequate facilities and competent personnel to service the medical benefit plan, or by awarding a competitively bid contract, to an authorized third party administrator, an insurer, a nonprofit health care corporation, or other entity authorized to provide services in connection with a

noninsured medical benefit plan.

(2) If the commissioner finds that a pooled plan's reserves are not sufficient to meet the requirements of subsection (1)(a), the commissioner shall order the pooled plan to immediately collect from any public employer that is or has been a member of the pooled plan appropriately proportionate contributions sufficient to restore reserves to the required level. The commissioner may take such action as he or she considers necessary, including, but not limited to, ordering the suspension or dissolution of a pooled plan, if the pooled plan is consistently failing to maintain reserves as required in this section; is using methods and practices that render further transaction of business hazardous or injurious to its members, employees, beneficiaries, or to the public; has failed, after written request by the commissioner, to remove or discharge an officer, director, trustee, or employee who has been convicted of any crime involving fraud, dishonesty, or moral turpitude; has failed or refused to furnish any report or statement required under this act; or if the commissioner, upon investigation, determines that it is conducting business fraudulently or is not meeting its contractual obligations in good faith. Any proceedings by the commissioner under this subsection are governed by the requirements and procedures of sections 7074 to 7078 of the insurance code of 1956, 1956 PA 218, MCL 500.7074 to 500.7078.

History: 2007, Act 106, Imd. Eff. Oct. 1, 2007;—Am. 2017, Act 55, Eff. Sept. 13, 2017.

124.81 Access to books, records, and documents; payment of annual assessment.

Sec. 11. The commissioner, or any person appointed by the commissioner, may examine the affairs of any pooled plan, and for such purposes shall have free access to all the books, records, and documents that relate to the business of the plan, and may examine under oath its trustees, officers, agents, and employees in relation to the affairs, transactions, and condition of the pooled plan. Each authorized pooled plan shall pay an assessment annually to the commissioner to be deposited into the insurance bureau fund created in section 225 of the insurance code of 1956, 1956 PA 218, MCL 500.225, in an amount equal to 1/4 of 1% of the annual self-funded contributions made to the pooled plan for that year. The assessments paid under this section shall be appropriated to the office of financial and insurance services to cover the additional costs incurred by the office of financial and insurance services in the examination and regulation of pooled plans under this act.

History: 2007, Act 106, Imd. Eff. Oct. 1, 2007.

124.83 Articles, bylaws, and trust agreement; filing; notice of meetings; powers of board of trustees.

Sec. 13. (1) The articles, bylaws, and trust agreement of the pooled plan and all amendments thereto shall be filed with and presumed approved by the commissioner before becoming operative. The trust agreement shall be filed on a form prescribed by the commissioner.

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

(3) The powers of a pooled plan, except as otherwise provided, shall be exercised by the board of trustees chosen to carry out the purposes of the trust agreement. Not less than 50% of the trustees shall be persons who are covered under the pooled plan or the collective bargaining representatives of those persons. No trustee shall be an owner, officer, or employee of a third party administrator providing services to the pooled plan.

History: 2007, Act 106, Imd. Eff. Oct. 1, 2007.

124.85 Public employer with 50 or more employees; claims utilization and cost information; compilation; "relevant period" defined; disclosure; availability; protected health information not included.

Sec. 15. (1) Notwithstanding subsection (2), a public employer that has 50 or more employees in medical benefit plans shall be provided with claims utilization and cost information as provided in subsection (3).

(2) Two or more public employers that are in an arrangement and together have 50 or more employees in medical benefit plans or have signed a letter of intent to enter together 50 or more public employees into medical benefit plans, shall each be provided with claims utilization and cost information as provided in subsection (3) that is aggregated for all the public employees together of those public employers, and, except as otherwise permitted under subsection (1), shall not be separated out for any of those public employers.

(3) All medical benefit plans in this state shall compile, and shall make available in an electronic, spreadsheet-compatible format complete and accurate claims utilization and cost information for the medical benefit plan in the aggregate and for each public employer entitled to that information under subsection (1) or (2) and each subgroup of public employees of such a public employer if the subgroup has 50 or more public employees covered by the medical benefit plan, as follows:

(a) A census of all covered employees, including all of the following:

(*i*) Year of birth.

(*ii*) Gender.

(*iii*) Zip code.

(*iv*) The contract coverage type for the employee, such as single, 2-person, or family, and number of individuals covered by contract.

(b) Incurred and paid claims data for the employee group covered by the medical benefit plan, including at least all of the following:

(*i*) For a plan that provides medical benefits, information concerning enrollment and hospital and medical claims under the plan, presented in a manner that clearly shows all of the following:

(A) For each month, the total number of covered employees and the number of covered employees in each contract coverage type included in the census under subdivision (a)(*iv*).

(B) For each month, the total number of covered individuals and the number of covered individuals in each contract coverage type included in the census under subdivision (a)(*iv*).

(C) Number and total expenditures for inpatient claims for each month.

(D) Number and total expenditures for outpatient claims for each month.

(E) Number and total expenditures for all other medical claims for equipment, devices, and services, including services rendered in the private office of a physician or other health professional, for each month.

(*ii*) For a plan that provides prescription drug benefits, information concerning enrollment and prescription drugs claims under the plan, presented in a manner that clearly shows all of the following:

(A) For each month, the total number of covered employees and the number of covered employees in each contract coverage type included in the census under subdivision (a)(*iv*).

(B) For each month, the total number of covered individuals and the number of covered individuals in each contract coverage type included in the census under subdivision (a)(*iv*).

(C) Amount charged and amount paid for prescription drugs claims for each month.

(D) Total amount charged and amount paid for brand prescription drugs claims for each month.

(E) Total amount charged and amount paid for generic prescription drugs claims for each month.

(F) Total amount charged and amount paid for specialty prescription drug claims for each month.

(G) The 50 prescription drugs for which claims were most frequently paid.

(H) The 50 prescription drugs for which expenditures were the largest.

(*iii*) For a plan that provides medical or prescription drug benefits, in addition to the information required under subparagraphs (*i*) and (*ii*), as applicable, information concerning covered individuals with total medical or prescription drug claims, or both, exceeding $25,000.00 for any 12-month period for which claims utilization and cost information are provided, presented in a manner that clearly shows all of the following separately for each covered individual:

(A) Total medical expenditures for the individual.

(B) Total prescription drug expenditures for the individual.

(C) Whether the covered individual is currently covered by the medical benefit plan.

(D) The covered individual's diagnoses.

(*iv*) For a plan that provides dental benefits, information concerning dental claims and total expenditures for these claims under the plan, presented in a manner that clearly shows at least all of the following:

(A) Number of claims submitted and total charged.

(B) Number of and total expenditures for claims paid.

(C) Total expenditures for claims submitted to network providers.

(*v*) For a plan that provides optical benefits, information concerning optical claims and total expenditures for these claims under the plan, presented in a manner that clearly shows at least all of the following:

(A) Number of claims submitted and total charged.

(B) Number of and total expenditures for claims paid.

(C) Total expenditures for claims submitted to network providers.

(c) Fees and administrative expenses for the most recent experience year, reported separately for medical, prescription drug, dental, and optical plans, and presented in a manner that clearly shows at least all of the following:

(*i*) The dollar amounts paid for specific and aggregate stop-loss insurance.

(*ii*) The dollar amount of administrative expenses incurred or paid, reported separately for medical, pharmacy, dental, and vision.

(*iii*) The total dollar amount of retentions and other expenses.

(*iv*) The dollar amount for all service fees paid.

(*v*) The dollar amount of any fees or commissions 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, prescription drug, stop-loss, dental, and vision.

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

(d) For medical, prescription drug, dental, and optical plans, a benefit summary for the current year's plan and, if benefits have changed during any of the 2 most recent 12-month periods for which claims utilization and cost information are provided, a brief benefit summary for each of those periods for which the benefits were different.

(4) Except as otherwise provided in subsection (3) and subject to subsection (5), claims utilization and cost information required to be compiled under this section must be compiled as follows:

(a) On an annual basis.

(b) At the request of a public employer. A public employer may not request claims utilization and cost information more than 4 times per calendar year. Claims utilization and cost information compiled upon the request of a public employer must be compiled within 30 days after the request.

(5) Claims utilization and cost information compiled under this section must cover a relevant period. For purposes of this subsection, the term "relevant period" means the 24-month period ending no more than 60 days before the compilation of the information for the medical benefit plan under consideration. However, if the medical benefit plan has been in effect for a period of less than 24 months, the relevant period shall be that shorter period.

(6) A public employer or combination of public employers shall disclose the claims utilization and cost information required to be provided under subsections (1) and (2) to any carrier or administrator it solicits to provide benefits or administrative services for its medical benefit plan, and to the employee representative of employees covered under the medical benefit plan, and upon request to any carrier or administrator who requests the opportunity to submit a proposal to provide benefits or administrative services for the medical benefit plan at the time of the request for bids. The public employer shall make the claims utilization and cost information required under this section available within a reasonable period of time.

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

History: 2007, Act 106, Imd. Eff. Oct. 1, 2007;—Am. 2011, Act 93, Eff. Oct. 1, 2011;—Am. 2018, Act 579, Eff. Mar. 29, 2019.