2011 Public Act 152:
Publicly Funded Health Insurance Contribution Act
(MCL 15.561 – 15.569),
as amended by 2013 Public Acts
numbered 269 through 273

Frequently Asked Questions

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FAQ Notes:

[1] The term "the Act" is referencing the Publicly Funded Health Insurance Contribution Act, 2011 Public Act 152, as amended (MCL 15.561 – 15.569).

[2] The term "hard cap(s)" is referencing the cost limitations set forth in Section 3 of the Act (MCL 15.563).

Updated: February 10, 2021

2011 Public Act 152: FAQs

1. General

Q1-1. Does the Act permit the gross-up of compensation?

A1-1. The Act does not address compensation. The Act applies to a public employer's costs of medical benefit plans for all public employees and elected public officials.

Q1-2. What type of recourse do employees have if a public employer is going against (not following) the Act? The case is where retirees are being included in the total costs for the health care and the public employer will not remove them when calculating the Section 3 (MCL 15.563) "hard cap" amounts.

A1-2. The Act identifies what the State Treasurer or the Department of Education may/shall do if a public employer fails to comply with the Act. Section 9 of the Act (MCL 15.569) directs that the State Treasurer may make reductions in Economic Vitality Incentive Program (EVIP) payments the public employer received. The Department of Education shall assess a penalty on payments under the School Aid Fund during the period the public employer is not in compliance.

The Act does not address any recourse for employees, citizens, or other third parties if a public employer is believed not to be in compliance with the Act.

Q1-3. Is a public employer subject to a 10% reduction in economic vitality incentive program payments, as indicated in Section 9 of the Act (MCL 15.569), after September 30, 2012?

A1-3. Section 9 of 2011 Public Act 152 (MCL 15.569) states "[i]f a public employer fails to comply with this act, the public employer shall permit the state treasurer to reduce by 10% each economic vitality incentive program payment received under 2011 PA 63…during the period that the public employer fails to comply with this act…"

This section references 2011 Public Act 63, which was the FY 2012 appropriation bill. 2011 Public Act 63 is for the fiscal year ending September 30, 2012. Therefore, the penalty of a reduction in Economic Vitality Incentive Program payments would not apply beyond September 30, 2012. However, if the public employer is found not to be in compliance with 2011 Public Act 152, the public employer would face all sanctions generally available to enforce a law.

Additionally, a public employer's noncompliance with 2011 Public Act 152 may subject the public employer to the reduction or loss of funding other than from the

Economic Vitality Incentive Program. As an example, pursuant to 2012 PA 506 (MCL 247.668j), beginning September 30, 2014, the Michigan Department of Transportation *may* withhold all or part of the distributions to a local road agency from the Michigan Transportation Fund for the period the local road agency is not in compliance with 2011 Public Act 152.

2. Medical Benefit Plan Coverage Year

Q2-1. When does the benefit plan year begin?

A2-1. The Publicly Funded Health Insurance Contribution Act provides for certain limitations on the amount that public employers may contribute toward the annual cost of medical benefit plans that cover their employees. The Act applies to a "medical benefit plan coverage year" beginning on or after January 1, 2012. The Act does not use the term "plan year."

A "medical benefit plan coverage year" is defined under Section 2(g) of the Act (MCL 15.562(g)) as "…the 12-month period after the effective date of the contractual or self-insured medical coverage plan that a public employer provides to its employees or public officials."

Q2-2. Is "coverage year" the same thing as "plan year"?

A2-2. The Act does not use the term "plan year." See FAQ2-1 for the definition of the term "medical benefit plan coverage year." A "medical benefit plan coverage year" may or may not be the same as the period referred to as a "plan year."

Q2-3. Is the medical plan year referenced in the Act the plan year, the contract year, or the deductible year?

A2-3. The Act uses the term "medical benefit plan coverage year" rather than "plan year," "contract year," or "deductible year." See FAQ2-1 for the definition of the term "medical benefit plan coverage year."

Q2-4. The benefit year under our medical plan is July 1 – June 30, but deductibles begin accruing on January 1. On what date must we be in compliance with the Act for our medical plan?

A2-4. The Act does not use the term "benefit year," but instead uses the term "medical benefit plan coverage year." The "medical benefit plan coverage year" is the 12-month period that is applicable for determining compliance with the Act, even if the accrual of deductibles is tied to a different period. See FAQ2-1 for the definition of the term "medical benefit plan coverage year."

Q2-5. Can a public employer change the interval of the medical benefit plan coverage year for example from July 1-June 30 to a January 1-December 31 interval?

A2-5. Yes. When an insurance provider informs a public employer that it is altering the medical benefit plan coverage year from July 1-June 30 to a January 1-December 31 interval, a public employer may change the beginning and ending date of the 12-month interval of the “medical benefit plan coverage year.”

3. Medical Benefit Plan

Q3-1. Does 2011 Public Act 152, as amended, ("the Act") cover plans for dental and vision insurance?

A3-1. No. A "medical benefit plan" is defined under Section 2(3) of the Act as "…a plan…that provides for the payment of medical benefits, including, but not limited to, hospital and physician services, prescription drugs, and related benefits, for public employees or elected public officials…." Treasury has interpreted this definition of "medical benefit plan" to exclude separate plans for dental or vision insurance.

Q3-2. Is short or long term disability insurance considered a "related benefit" to be included in making the contribution calculations under 2011 Public Act 152, as amended ("the Act")?

A3-2. No. A "medical benefit plan" is defined under Section 2(3) of the Act as "…a plan…that provides for the payment of medical benefits, including, but not limited to, hospital and physician services, prescription drugs, and related benefits, for public employees or elected public officials…." Treasury has interpreted this definition of "medical benefit plan" to exclude plans for short or long term disability insurance.

Q3-3. A public employer provides a wellness program to employees. An example of a benefit provided through the program is a $100.00 reward to employees that quit smoking. Must a public employer include wellness program costs when calculating compliance under 2011 Public Act 152, as amended ("the Act")?

A3-3. No. A "medical benefit plan" is defined under Section 2(3) of the Act as "…a plan…that provides for the payment of medical benefits, including, but not limited to, hospital and physician services, prescription drugs, and related benefits, for public employees or elected public officials…." Treasury has interpreted this definition of "medical benefit plan" to exclude wellness programs.

4. Public Employer

Q4-1. Does a local unit of government housing commission have to comply with the Act?

A4-1. Yes. A local unit of government housing commission would not be exempt from the Act. The housing commission would fall under the definition of "public employer" in Section 2(h) of the Act (MCL 15.562(h)) that includes any "…local department, agency, or authority, or other local political subdivision..."

Q4-2. Does the Act apply to a Municipal Owned Electric Utility (i.e. "component unit")? Or would the Municipal Owned Electric Utility benefits be part of the city or other public employer calculations for the Act?

A4-2. Yes. The Act applies to the electric utility. Section 2(d) of the Act (MCL 15.562(d)) specifically defines "local unit of government" to include "a municipal electric utility system".

Q4-3. Is a public library required to follow the requirements of the Act?

A4-3. Yes. The Act applies to all public employers. A public library would fall within the definition of a public employer in Section 2(h) of the Act (MCL 15.562(h)). Subsection 2(h) prescribes in pertinent part that:

"'Public employer' means…a local unit of government or other political subdivision of this state; any intergovernmental, metropolitan, or local department, agency, or authority, or other local political subdivision…"

Q4-4. Is an authority which is organized as a non-profit corporation required to follow the requirements of the Act?

A4-4. Yes. An authority would fall within the definition of a public employer in Section 2(h) of the Act (MCL 15.562(h)). Its organization as a non-profit corporation is not relevant to its treatment under the Act. Subsection 2(h) of the Act prescribes in pertinent part that:

"'Public employer' means…a local unit of government or other political subdivision of this state; any intergovernmental, metropolitan, or local department, agency, or authority, or other local political subdivision…"

5. Covered Employees

Q5-1. Do district court employees fall under the Act?

A5-1. Yes. District court employees fall under the Act. District court employees (other than a federal district court) are employed by a county. The Act's definition of "local unit of government" in Section 2(d) (MCL 15.562(d)) includes a county. A local unit of government is identified as a "public employer" in Section 2(h) of the Act (MCL 15.562(h)).

All public employers must comply with the Act.

Q5-2. Does the Act cover elected public officials beginning January 1 or July 1?

A5-2. A public employer must be in compliance with the Act with respect to its medical benefit plans for each "medical benefit plan coverage year" beginning on or after January 1, 2012. The date that a particular person, such as an elected public official, would become subject to the requirements of the Act would depend upon the date that the official became covered under the public employer's medical benefit plan.

Q5-3. A public employer has retired employees that subscribe to the public employer health plan. Does the public employer need to consider the annual costs or illustrative rate and any payments paid by the public employer for reimbursement of health care costs paid for the benefit of the retiree when calculating their "hard cap" amounts under the provisions of Section 3 of the Act (MCL 15.563)?

A5-3. No. The Act directs in Section 2(e) (MCL 15.562(e)) that medical benefit plan means "…[a] medical benefit plan does not include benefits provided to individuals retired from a public employer."

6. Does 2011 Public Act 152 or 2011 Public Act 54 Apply?

Q6-1. A collective bargaining unit has a contract that expired on June 30, 2012. The contract was in existence prior to the passage of 2011 Public Act 152. A new contract was not ratified until July 18, 2012. The new contract has their medical benefit plan coverage year starting on August 1, 2012. Their old medical benefit plan coverage year ended on June 30, 2012. The public employer purchased carryover coverage for the month of July.

The union's understanding of 2011 Public Act 54 (MCL 423.215b) requires the employer to maintain the insurance benefit, and requires the employees to pay any increase in premiums. When the union went through the month of July under the 2011 Public Act 54, the employer kept up the reimbursement plan as designed in their previous insurance. Then the bargaining unit employees were notified by the public employer that the expenses that they had incurred during July were in excess of what was allowable monthly by 2011 Public Act 152 and the employees had to pay the money back.

A) When does the public employer need to comply with the 2011 Public Act 152 requirements for the successor collective bargaining agreement (CBA)?

B) For the month of July, do the 2011 Public Act 152 limits apply to this bargaining unit?

A6-1. A) We are assuming that the collective bargaining negotiations were for successor contracts to those that were in place prior to September 27, 2011. Pursuant to Section 5 of 2011 Public Act 152 ("the Act") (MCL 15.565(2)), a collective bargaining agreement (CBA) or other contract that is executed on or after September 27, 2011 shall not include terms that are inconsistent with the "hard cap" limitations in Section 3 of the Act (MCL 15.563) or the 80/20 percentage requirements of Section 4 of the Act (MCL 15.564).

Therefore, in this example, the public employer must comply with the Act for the medical benefit plan coverage year that began on August 1, 2012. This is based upon Section 3 (MCL 15.563) and 4 (MCL 15.564) of the Act directing that the "hard cap" limitations and the 80/20 percentage requirements apply for medical benefit plan coverage years beginning on or after January 1, 2012.

In the facts presented, the CBA expired on June 30, 2012. The new CBA was ratified on July 18, 2012 containing a provision that the medical benefit plan coverage year starts on August 1, 2012.

B) In the facts presented, 2011 Public Act 152 would apply starting August 1, 2012 and would not apply for July. However, 2011 Public Act 54 (MCL 423.215b) would apply for July.

2011 Public Act 54 (MCL 423.215b(1)) directs in relevant part that "…after the expiration date of a collective bargaining agreement [CBA] and until a successor [CBA] is in place, a public employer shall pay and provide wages and benefits at levels and amounts that are no greater than those in effect on the expiration date of the [CBA]. The prohibition in this subsection includes increases that would result from wage step increases. Employees who receive health, dental, vision, prescription, or other insurance benefits under a [CBA] shall bear any increased cost of maintaining those benefits that occurs after the expiration date. The public employer is authorized to make payroll deductions necessary to pay the increased costs of maintaining those benefits."

2011 Public Act 54 instructs at MCL 423.215b(4)(b) that "'[i]ncreased cost' in regard to insurance benefits means the difference in premiums or illustrated rates between the prior year and the current coverage year. The difference shall be calculated based on changes in cost by category of coverage and not on changes in individual employee marital or dependent status."

Pursuant to the above-cited statutory provisions, a public employer will need to comply with 2011 Public Act 54 until the new contract is in place. Once the new contract is negotiated, the contract and health insurance benefits will need to comply with the "hard cap" limitations of Section 3 of 2011 Public Act 152 (MCL 15.563) or the 80/20 percentage requirements of Section 4 of 2011 Public Act 152 (MCL 15.564).

Q6-2. A group of employees are covered by a collective bargaining agreement (CBA) that expired in 2005, prior to the passage of 2011 Public Act 54 and 2011 Public Act 152. The CBA has not been renegotiated. The expired contract states that the provisions of the expired CBA will be enforced until a new contract is ratified. Does the public employer need to comply with the requirements of 2011 Public Act 54 or 2011 Public Act 152 for this group of employees?

A6-2. Under the facts presented, the public employer did not have a CBA in effect for this group of employees on September 27, 2011 when 2011 Public Act 152 became effective. The public employer indicated that the CBA expired in 2005. The expired CBA's provision that the terms of the expired CBA will be enforced until a new contract is ratified does not constitute a CBA.

2011 Public Act 152 will apply to this group of employees for a medical benefit plan coverage year beginning on or after January 1, 2012, pursuant to Section 3 of 2011 Public Act 152 (MCL 15.563) and Section 4 of 2011 Public Act 152 (MCL 15.564).

Q6-3. A group of employees are covered by a collective bargaining agreement (CBA) that expired on June 30, 2014. The expired CBA complied under the "hard cap" limitations of Section 3 of 2011 Public Act 152 and was originally negotiated after the passage of 2011 Public Act 54 and 2011 Public Act 152. The public employer has voted to comply with the 80/20 percentage requirement under Section 4 of 2011 Public Act 152 (MCL 15.564) for the medical benefit plan coverage year starting on July 10, 2014. As of July 10, 2014, the CBA has not been renegotiated.

In accordance with 2011 Public Act 54, the public employer is paying the same amount as was paid for medical coverage prior to June 30, 2014 and any increase in the coverage amount is being charged to the employees at 100% (thus the employees are paying greater than 20%). For the employees under the expired CBA, does the amount the employees need to pay for medical benefits fall under 2011 Public Act 152 (in this case, the 80/20 percentage requirement of Section 4 of 2011 Public Act 152 (MCL 15.564)) or 2011 Public Act 54 (employees only responsible for 100% of any increased cost of maintaining their insurance benefits) until a new contract is negotiated?

A6-3. 2011 Public Act 54, the Public Employment Relations Act, prescribes in pertinent part at MCL 423.215b that after the expiration date of a CBA and until a successor CBA is in place, a public employer shall pay and provide wages and benefits at amounts that are no greater than those in effect on the expiration date of the CBA. 2011 Public Act 54 further directs that employees who receive health or other insurance benefits under a CBA shall bear any increased cost of maintaining those benefits that occurs after the expiration date. 2011 Public Act

54 defines “increased cost” as the difference in premiums or illustrated rates between the prior year and the current coverage year.

The subject CBA expired on June 30, 2014. No successor CBA is in place. For the medical benefit plan coverage year that began on July 10, 2014, the public employer has changed from offering the “hard cap” limitations found at Section 3 of 2011 Public Act 152 (MCL 15.563) to the 80/20 percentage requirement provided by Section 4 of 2011 Public Act 152 (MCL 15.564).

The Department of Treasury (Treasury) has no authority to administer or enforce 2011 Public Act 54. Treasury assists in administering 2011 Public Act 152. In the facts presented, Treasury’s focus would be that at the end of the current medical benefit plan coverage year, which ends July 9, 2015, the public employer has not paid more than 80% of the total annual costs of all of the medical benefit plans it offers or contributes to for its employees and elected public officials.

7. Compliance with Sections 3 (MCL 15.563) and 4 (MCL 15.564)

Q7-1. Do public employers need to do a majority vote each year if they are choosing the 80/20 percentage requirement option?

A7-1. Yes. Section 4(1) of the Act (MCL 15.564(1)) that provides the 80/20 percentage requirement option directs that "[b]y a majority vote of its governing body each year, prior to the beginning of the medical benefit plan coverage year, a public employer, excluding this state, may elect to comply with this section for a medical benefit plan coverage year instead of the requirements in Section 3..."

Q7-2. A public employer has not elected to comply with Section 4 of the Act (MCL 15.564) (providing for percentage-based limitations on contributions), and is therefore subject to the requirements of Section 3 of the Act (MCL 15.563) (providing for cap-based limitations on contributions). If the employer's contribution equals (but does not exceed) the full capped amount but the amount that employees pay is less than 20% of the total annual costs of their medical benefit plan, is the employer in compliance with the Act?

A7-2. Yes. Public employers must comply with Section 3 of the Act (MCL 15.563) (providing for capped contributions to medical benefit plans offered to employees) unless they elect instead to comply with Section 4 of the Act (MCL 15.564) (providing that they may not pay more than 80% of the total annual costs of all medical benefit plans offered to employees). Accordingly, for any medical benefit plan coverage year, an employer is subject to <u>either</u> the Section 3 (MCL 15.563) limitations, <u>or</u> the Section 4 (MCL 15.564) limitations. The two separate types of limitations do not apply at the same time.

Q7-3. Can a public employer use its fiscal year to determine the annual cap calculation under Section 3 (MCL 15.563)?

A7-3. No. The "hard cap" limitations under Section 3 of the Act (MCL 15.563) apply to each "medical benefit plan coverage year" beginning on or after January 1, 2012, and the "hard cap" limitations are based upon the number of employees with single-person, individual-and-spouse or individual-plus-1-nonspouse-dependent, and family insurance coverage. Therefore, the calculation of the "hard cap" limitations must be tied to the period of insurance coverage. Specifically, the "hard cap" calculation must be made for the same period as the "medical benefit plan coverage year." See FAQ2-1 for the definition of the term "medical benefit plan coverage year."

Q7-4. A.) If an employee opts out of health insurance coverage, can that employee be calculated into the "hard cap" amount, Section 3 of the Act (MCL 15.563)? Or does that employee have to be taken out of calculations for the "hard cap" amount, Section 3 of the Act (MCL 15.563)?

B.) If an employee opts out of health insurance coverage, can that employee be calculated into the 80/20 percentage requirement, Section 4 of the Act (MCL 15.564)? Or does that employee have to be taken out of calculations for the 80/20 percentage requirement, Section 4 of the Act (MCL 15.564)?

A7-4. A.) An employee or elected public official who declines the medical benefit plan offered or contributed to by the public employer is not included in the calculations for the "hard cap" amount, Section 3(3) of the Act (MCL 15.563(3))

B.) The public employer does not factor the number of employees or elected public officials, whether electing health insurance coverage or opting out of health insurance coverage when calculating their compliance under the 80/20 percentage requirement, Section 4 of the Act (MCL 15.564).

Q7-5 Has Been Rescinded and Replaced by Q7-22

Q7-5. A.) A public employer pays a monthly stipend to employees that choose to optout of taking health insurance, does the public employer need to include these dollars when calculating the total "hard cap" amount, Section 3 of the Act (MCL 15.563)?

B.) A public employer pays a monthly stipend to employees that choose to optout of taking health insurance, does the public employer need to include these dollars when calculating the 80/20 percentage requirement, Section 4 of the Act (MCL 15.564)?

A7-5. A.) Yes. The Act directs in Section 3 (MCL 15.563) that "…a public employer that offers or contributes to a medical benefit plan for its employees or elected public officials shall pay no more of the annual costs or illustrative rate and any payments for reimbursement…used for health care costs…[than the specified caps]…for a medical benefit plan coverage year beginning on or after January 1, 2012..."

A public employer must consider in the total annual medical benefit plan amount the monthly stipend it pays to employees who choose to opt out of taking health insurance. A public employer's payment to an employee in lieu of health care coverage is part of the public employer's overall medical benefit plan costs.

B.) Yes. The Act directs in Section 4 (MCL 15.564) that "…a public employer shall pay not more than 80% of the total annual costs of all the medical benefit plans it offers or contributes to for its employees and elected public officials. For purposes of this subsection, total annual costs includes the premium or illustrative rate of the medical benefit plan and all employer payments for reimbursement of…health care [costs] and payments into health savings accounts, flexible spending accounts, or similar accounts used for health care…"

A public employer's payment to an employee in lieu of health care coverage is part of the public employer's overall annual medical benefit plan costs.

Q7-6 Has Been Rescinded – Individual-plus-1-nonspouse-dependent coverage "hard caps" are calculated using the same "hard cap" limitations as individual-and-spouse coverage, Section 3(1) of the Act (MCL 15.563(1))

Q7-6. Section 3 of the Act (MCL 15.563) specifies a "hard cap" of $11,000 for individual and spouse coverage and $15,000 for family. Our insurance allows us to insure a single parent plus a child as "individual plus one," but the law specifies individual and spouse. Are we required to use the family coverage figure for calculating the "hard cap" amount for the single parent and child?

A7-6. The "hard cap" limitations in Section 3 of the Act (MCL 15.563) are based upon the typical levels of coverage offered by most medical benefit plans. If a plan offers "individual plus one" coverage for a single parent plus a child that is comparable to the coverage offered for an "individual and spouse," or if a plan offers "individual plus one" coverage for a single parent plus a child in lieu of "individual and spouse" coverage, employees choosing "individual plus one" coverage to insure a single parent plus a child should be included in the "hard cap" calculation at the same rate specified for employees with "individual and spouse" coverage.

Q7-7. Under Section 3 of the Act (MCL 15.563), it is my understanding that the "hard cap" amounts are to be adjusted upwards with the health care component of CPI. Where are the revised "hard cap" numbers to be found?

A7-7. Section 3(1) of the Act (MCL 15.563(1)) stipulates that the new rates will be available "… By October 1 of each year after 2011, the state treasurer shall adjust the maximum payment permitted…for each coverage category for medical benefit plan coverage years beginning the succeeding calendar year, based on the change in the medical care component of the United States consumer price index [CPI] for the most recent 12-month period…"

The rates can be found on the Michigan Department of Treasury's website under Local Government Services.

Q7-8. Can local units of government elect to comply with Section 4 of the Act (MCL 15.564) (providing for contribution limits based on percentages) or exercise the opt-out provision of Section 8 of the Act (MCL 15.568) at any point during the year? How is the "year" determined for purposes of exercising these options? Must the local unit of government renew its election to opt out at the same time each year and if so, when?

A7-8. A public employer must be in compliance with the Act for each "medical benefit plan coverage year" beginning on or after January 1, 2012. See FAQ2-1 for the definition of the term "medical benefit plan coverage year." The first "medical benefit plan coverage year" falling under the Act would be the 12-month period beginning on the date on or after January 1, 2012 that new medical insurance coverage begins. A local unit of government may elect to comply with Section 4 of the Act (MCL 15.564(1)) or exercise the exemption ("opt-out") provision of Section 8 of the Act (MCL 15.568(1)) at any time prior to the beginning of the medical benefit plan coverage year. The elections must be made separately for each new "medical benefit plan coverage year."

Q7-9 Has Been Rescinded and Replaced by Q7-42

Q7-9. A public employer is currently on a partial self-funded plan, and all of the employee groups are under the "hard cap" effective 7/1/2012. In a self-funded plan, if a public employer exits the plan, they pay run-out costs for claims that are incurred but not reported ("IBNR") by the end of the plan. There is an accrual on the public employer's books to estimate this run-out cost, so they have recognized this expense on their general ledger, but it has not been paid.

A.) If the public employer switches from a self-funded plan to a full premium plan and had to pay the insurance carrier's rates immediately, while still paying the run-out costs of the self-funded plan, would both the premium and the run-out cost payments be used to determine compliance with the requirements of Section 3 of 2011 Public Act 152, as amended, ("the Act") (MCL 15.563) (providing for cap-based limitations on contributions) or Section 4 of the Act (MCL 15.564) (providing for percentage-based limitations on contributions)?

B.) If the actual run-out costs are lower than the calculation, how many years does a public employer have to wait before these funds are available for other use (if any)?

C.) Can the IBNR currently included in the public employer's rate calculations be used for run-out costs or are they separate calculations?

A7-9. A.) Yes. The Act directs in Section 3(1) (MCL 15.563(1)) that "…a public employer that offers or contributes to a medical benefit plan for its employees or elected public officials shall pay no more of the annual costs or illustrative rate…[than the specified caps]…for a medical benefit plan coverage year beginning on or after January 1, 2012..."

The Act directs in Section 4(2) (MCL 15.564(2)) that "…a public employer shall pay not more than 80% of the total annual costs of all of the medical benefit plans it offers or contributes to for its employees and elected public officials. For purposes of this subsection, total annual costs includes the premium or illustrative rate of the medical benefit plan and all employer payments for reimbursement of…health care [costs]..."

The run-out costs are still payments for a medical benefit plan (albeit now cancelled) for the public employer's employees and if overlap occurred in paying the insurance carrier's rates and the run-out claims that had accrued, both costs must be considered in determining compliance under Section 3 of the Act (MCL 15.563) and Section 4 of the Act (MCL 15.564).

B.) A public employer's compliance with the Act is determined by *how much of the total annual costs of the medical benefit plan the public employer paid*. The issue of the availability of funds when the actual run-out costs are lower than the calculation is not an issue within Treasury's purview to opine.

C.) The focus of the Act is upon medical benefit plan costs, i.e., hospital and physician services, prescription drugs, etc., the public employer pays, not just accrues, in the medical benefit plan coverage year. It is not clear what types of costs are represented by the designation "incurred but not reported". The key determination for compliance is when the public employer pays the medical benefit plan cost.

Q7-10 Has Been Rescinded and Replaced by Q7-27

Q7-10. Do employer contributions to a Retiree Health Savings program (RHS) or Health Care Savings Program (HCSP), both of which are for use upon retirement, need to be included when calculating either the "hard cap" amounts under Section 3 of 2011 Public Act 152, as amended, ("the Act") (MCL 15.563) or the 80/20 percentage requirement under Section 4 the Act (MCL 15.564)?

A7-10. Yes. The Act directs in Section 3 (MCL 15.563) that "…a public employer that offers or contributes to a medical benefit plan for its employees or elected public officials shall pay no more of the annual costs or illustrative rate…[than the specified caps]…for a medical benefit plan coverage year beginning on or after January 1, 2012...".

The Act directs in Section 4(2) (MCL 15.564(2)) that "…a public employer shall pay not more than 80% of the total annual costs of all of the medical benefit plans it offers or contributes to for its employees and elected public officials. For purposes of this subsection, total annual costs includes the premium or illustrative rate of the medical benefit plan and all employer payments for reimbursement of…health care [costs]..."

The definition of "medical benefit plan" in Section 2(e) of the Act (MCL 15.562(e)) is broad and would include a health care savings program used for the purpose of funding current public employees' health care costs in retirement. Subsection 2(e) directs that:

> "'**Medical benefit plan' means a plan established and maintained** by a carrier, a voluntary employees' beneficiary association described in section 501(c)(9) of the internal revenue code of 1986, 26 USC 501, or **by 1 or more public employers, that provides for the payment of medical benefits, including, but not limited to, hospital and**

physician services, prescription drugs, and related benefits, for public employees or elected public officials. Medical benefit plan does not include benefits provided to individuals **retired** from a public employer." (Emphasis added.)

Subsection 2(e)'s (MCL 15.562(e)) exclusion from the definition of medical benefit plan is expressly limited to benefits provided to individuals now retired.

The language in the Act limiting a public employer's contributions to the health care costs of its employees places the focus on what is being paid by the public agency now as opposed to when its employees benefit.

Also, the Act's limits on employer contributions are not restricted to just medical benefit plans, health savings accounts, and flexible spending accounts. Both "hard caps", Section 3 of the Act (MCL 15.563), and 80/20 percentage requirements, Section 4 of the Act (MCL 15.564), follow the listing of those three accounts with the phrase "or similar accounts used for health care costs."

Thus, under the Act, as currently written, a public employer's contributions to a health care savings program used for the purpose of funding current public employees' health care costs in retirement must be included in the calculation of the "hard cap" amounts, Section 3 of the Act (MCL 15.563), and the 80/20 percentage requirements, Section 4 of the Act (MCL 15.564).

Q7-11. A public employer has a policy where newly hired employees are required to pay 20 percent of their health insurance premiums. Since the inception of the policy, one employee has been hired and is paying 20 percent of the premiums. The public employer has a plan to have ALL employees paying 20 percent of their premiums by July 1, 2014. Does the public employer still need to comply with the Act for all employees by either complying with the "hard cap" amounts under Section 3 (MCL 15.563), the 80/20 percentage requirement under Section 4 (MCL 15.564), or by exempting itself ("opting out") under Section 8 (MCL 15.568)?

A7-11. Yes. The Act applies to all public employees.

However, Section 5(1) of the Act (MCL 15.565(1)) has specific provisions that "[i]f a collective bargaining agreement or other contract that is inconsistent with sections 3 and 4 is in effect for 1 or more employees of a public employer on September 27, 2011, the requirements of section 3 and 4 do not apply to an employee covered by that contract until the contract expires…"

Q7-12. If a public employer is trying to maintain compliance under Section 4 of the Act (MCL 15.564) by allocating an 80/20 cost share ratio, how does the public employer calculate employer/employee costs under a Health Reimbursement Arrangement (HRA) where the actual costs are not known until year end? Does the public employer only calculate based on the base cost of the plan (i.e. an 80/20 split on that) and not worry about the reimbursements?

A7-12. The public employer risks not being in compliance with the Act, if they pay more than 80% of the total annual costs.

The Act directs in Section 4(2) (MCL 15.564(2)) that "…a public employer shall pay not more than 80% of the total annual costs of all of the medical benefit plans it offers or contributes to for its employees and elected public officials. For purposes of this subsection, total annual costs includes the premium or illustrative rate of the medical benefit plan and all employer payments for reimbursement of…health care [costs]..."

Rescinded for Medical Benefit Plan Coverage Years beginning on or after January 1, 2014, see Q7-28

Q7-13. A) If an insurance company charges an annual "claims assessment" (usually 1% of all the claims paid during the previous year) at the end of each year, does the public employer need to include the "claims assessment" cost into the "hard cap" limitation or 80/20 percentage requirement calculation?

B) If so, which calculation year would they include the costs, in the year the costs are paid by the public employer or the year the "claims assessment" costs pertain to?

A7-13. A) The Health Insurance Claims Assessment Act (HICAA) (Michigan Claims Tax) is silent on whether the cost of HICAA should be considered a "cost" of a medical benefit plan for purposes of 2011 Public Act 152. As such, public employers may want to take a conservative approach and assume that the costs of compliance with HICAA are to be included as a cost to be added when figuring compliance with the "hard cap" limitation, Section 3 (MCL 15.563), or 80/20 percentage requirement calculation, Section 4 (MCL 15.564) of 2011 Public Act 152.

B) As HICAA is silent as to whether the assessment should be considered a "cost" of the public employer under 2011 Public Act 152, a public employer, in making its decision, may want to consider the language in Section 3 (MCL 15.563) of 2011 Public Act 152 that limits a public employer to paying "…no more of the annual costs…than a total amount equal to…[the specified caps]…for a medical benefit plan coverage year…"

Likewise, Section 4 (MCL 15.564) of 2011 Public Act 152 directs that for a medical benefit plan coverage year, "a public employer shall pay not more than 80% of the total annual costs…"

Q7-14. A public employer has a Health Reimbursement Account in which the public employer reimburses employees for a portion of their health care deductibles incurred in the course of the medical benefit plan coverage year. Some of the reimbursements will not be made, however, until after the end of the medical benefit plan coverage year, as employees may incur their medical expenses shortly before the end of the medical benefit plan coverage year, not leaving time for reimbursement before the end of that medical benefit plan coverage year.

What medical benefit plan coverage year should the public employer include the reimbursement cost for calculation of the "hard cap" limitations in Section 3 of the Act (MCL 15.563)?

A7-14. Section 3(1) of the Act (MCL 15.563(1)) directs that a public employer that contributes to a medical benefit plan for its employees "…shall pay no more of the annual costs…[including]…payments for reimbursement of…deductibles… than a total amount equal to…[the specified caps]…for a medical benefit plan coverage year…"

Based upon this statutory directive, the public employer should include the reimbursement cost in the medical benefit plan coverage year in which the public employer pays the reimbursement expense, not the medical benefit plan coverage year in which the employee incurs the medical expense.

Q7-15. What are the reporting requirements, if a public employer is out of compliance with the Act (i.e. their annual calculation is above either the Section 3 (MCL 15.563) "hard cap" amounts or the Section 4 (MCL 15.564) 80/20 percentage requirement)?

A7-15. The Act does not stipulate requirements public employers must follow if they are out of compliance. However, public employers may want to report it in their annual financial reports.

Q7-16. Does the public employer perform an analysis on the "hard cap" compliance under Section 3 of the Act (MCL 15.563) monthly or one time at the medical benefit plan renewal date?

A7-16. A public employer can perform the calculation as many times as they would like to ensure compliance with the requirements of Section 3 of the Act (MCL 15.563). However, the final calculation would be computed at the end of the public employer's medical benefit plan coverage year to show that they were in compliance with the Act.

Q7-17. Can a public employer pro-rate the "hard cap" amount under Section 3 of the Act (MCL 15.563) for an employee who changes their insurance status during the year? Example #1: An employee starts the medical benefit plan coverage year with individual coverage. During the medical benefit plan coverage year, the employee marries and changes insurance coverage to individual-and-spouse coverage. Example #2: During the medical benefit plan coverage year, an employee leaves employment with the public employer. The employee was not covered by insurance for the entire medical benefit plan coverage year.

A7-17. Yes. A public employer can pro-rate the "hard cap" limits established by Section 3 of the Act (MCL 15.563), if an employee changes status during the year. The calculation would be pro-rated for the time the employee was at each coverage level and/or the portion of the year they were employed.

Rescinded for Medical Benefit Plan Coverage Years beginning on or after January 1, 2014, see Q7-29

Q7-18. Can a public employer charge the "claims assessment" back to their employees and does the charge then get included in the "hard cap" calculation under Section 3 of 2011 Public Act 152 (MCL 15.563)) or the 80/20 percentage requirements calculation under Section 4 (MCL 15.564)?

A7-18. Nothing in the Health Insurance Claims Assessment Act (HICAA) addresses the relationship between an employer and its employees. Other laws, such as contract law and labor law, may govern that relationship, but the HICAA itself is silent on this issue. Accordingly, the HICAA neither permits nor prohibits an employer from passing the cost of the HICAA assessment on to its employees.

However, the employer, subject to the HICAA, that chooses to charge the assessment back to its employees still remains the entity ultimately responsible for paying the HICAA assessment.

The HICAA is silent on whether the cost of HICAA should be considered a "cost" of a medical benefit plan for purposes of 2011 Public Act 152. As such, public employers may want to take a conservative approach and assume that the costs of compliance with HICAA are to be included as a cost to be added when figuring compliance with the "hard cap" limitation, Section 3 (MCL 15.563), or 80/20 percentage requirement calculation, Section 4 (MCL 15.564) of 2011 Public Act 152.

Q7-19. How does a public employer allocate the Health Reimbursement Arrangement (HRA) funding and remain in compliance with the IRS guidelines in regarding to health reimbursement arrangements?

A7-19. The Michigan Department of Treasury (Treasury) is not in a position to opine as to compliance with IRS guidelines. The IRS or other professional should be consulted in that regard.

Treasury's guidance regarding the Act involves interpreting its statutory provisions. If, through a HRA a public employer reimburses employees for qualified medical expenses, the costs of reimbursement would fall under the "hard cap", Section 3 of the Act (MCL 15.563), or the 80/20 percentage calculation, Section 4 of the Act (MCL 15.564).

Section 3(1) of the Act (MCL 15.563(1)) directs that the "hard caps" apply to a public employer's payments for "…reimbursement of co-pays, deductibles, or payments into health savings accounts, flexible spending accounts, or similar accounts used for health care costs…"

Section 4(2) of the Act (MCL 15.564(2)) applies the 80/20 percentage limitation to "…all employer payments for reimbursement of co-pays, deductibles, and payments into health savings accounts, flexible spending accounts, or similar accounts used for health care…"

Q7-20. A collective bargaining agreement (CBA) with one of a public employer's unions has contained what is termed an "insurance fund balance" or an insurance reserve fund. While referenced within the CBA, this fund is maintained and managed by the public employer, and is not held in escrow or pursuant to the terms of any established trust. The "insurance fund balance" has been utilized to absorb annual premium increases (both for health and other insurance benefits) at the time of plan renewal.

The "insurance fund balance" is derived from two primary sources. First, when the public employer and this union negotiated cost savings adjustments for insurance programs in the past, the resulting savings were credited to the "insurance fund balance". Second, the CBA contains a formula which had the annual potential to either add or subtract amounts from the "insurance fund balance". The CBA specifically indicated that employee insurance premium contributions were to be paid from the "insurance fund balance" and, in the event that the fund balance became depleted, any excess premium contributions would be payroll deducted from the wages of the enrolled employees.

The public employer entered into a new CBA with this union effective July 1, 2012.

A.) May the amounts previously accrued in the "insurance fund balance" now be used by the public employer to offset or defray employee premium contributions where the amounts contributed by the public employer (i.e., by using resources from the "insurance fund balance") would thereby exceed the spending limitations established in Section 3 of the Act (MCL 15.563) and Section 4 of the Act (MCL 15.564)?

B.) Could the public employer, consistent with the Act, relinquish control of the currently accumulated "insurance fund balance" to an independent third party entity that would then distribute those funds to the employees in order to defray or offset employee premium contributions for health insurance otherwise required in connection with the implementation of the Act?

A7-20. A.) The answer is not without subjecting the public employer to the statutory penalties. The public employer's use of the "insurance fund balance" to pay any employee costs under the medical benefit plan must be included in determining if the public employer is in compliance with the "hard cap" limitations in Section 3 (MCL 15.563) or the 80/20 percentage limitations in Section 4 (MCL 15.564) for that medical benefit plan coverage year. The public employer's use of the "insurance fund balance" to offset employee premium contributions under the medical benefit plan would be part of the annual costs that are "capped" or limited to the 80/20

percentages for a medical benefit plan coverage year beginning on or after January 1, 2012.

B.) Any public employer funds (even if administered by an independent third party) would be the public employer's funds for purposes of the Act and would be considered in determining the public employer's compliance with the spending limitations in Section 3 "hard cap" (MCL 15.563), or Section 4 80/20 percentage limitations (MCL 15.564).

Q7-21. Does the Act allow a public employer to have multiple medical benefit plan coverage years? If so, how would a public employer comply under Section 3 of the Act (MCL 15.563) and Section 4 of the Act (MCL 15.564)?

A7-21. The Act does not specifically restrict a public employer from having different medical benefit plans for different employee groups; if the public employer has multiple medical benefit plans, it may have multiple medical benefit plan coverage years.

The Act directs in Section 3(1) (MCL 15.563(1)) that "…a public employer that offers or contributes to a medical benefit plan for its employees or elected public officials shall pay no more of the annual costs or illustrative rate…[than the specified caps]…for a medical benefit plan coverage year beginning on or after January 1, 2012…". According to this Section, the "hard cap" limitation would apply to each separate medical benefit plan coverage year. Therefore if a public employer had multiple medical benefit plan coverage years, there would be multiple calculations of the "hard cap" limitations: a separate "hard cap" limitation would tie to each medical benefit plan coverage year.

The Act directs in Section 4(2) (MCL 15.564(2)) that "…a public employer shall pay not more than 80% of the total annual costs of all the medical benefit plans it offers or contributes to for its employees and elected public officials. For purposes of this subsection, total annual costs includes the premium or illustrative rate of the medical benefit plan and all employer payments for reimbursement of…health care [costs]…". According to this Section, if the public employer elected to adopt the 80/20 percentage limitation, the 80/20 percentage limitation would apply to ***all*** the medical benefit plans it offers.

Q7-22 Replaces Q7-5

Q7-22. A public employer pays a monthly stipend to employees that choose to opt out of taking health insurance; does the public employer need to include these dollars when calculating the total "hard cap" amount, Section 3 of the Act (MCL 15.563), or when calculating the 80/20 percentage requirement, Section 4 of the Act (MCL 15.564)?

A7-22. No. The Act defines "medical benefit plan costs" in Section 2(f) (MCL 15.562(f)) to exclude "…a payment by the public employer to an employee or elected public official in lieu of medical benefit plan coverage…"

Rescinded for Medical Benefit Plan Coverage Years beginning on or after January 1, 2014, see Q7-30

Q7-23. Should insurance agent commissions be included when calculating the total "hard cap" amount, Section 3 of the Act (MCL 15.563), or when calculating the 80/20 percentage requirement, Section 4 of the Act (MCL 15.564)?

A7-23. The Act does not expressly address whether agent commissions charged by providers to public employers are to be included in the limitations on the public employer's contributions to the costs of the medical benefit plan, the public employer may want to take a conservative approach and assume that the agent commissions are to be included as a cost to be added when figuring compliance with the "hard cap" limitation in Section 3 of the Act (MCL 15.563) or the 80/20 percentage requirement in Section 4 of the Act (MCL 15.564).

Q7-24. A self-funded public employer receives one set of illustrative rates from its insurance carrier which is applicable to all of it active employees and its retired employees up to age 65 and their dependents. Is a public employer entitled to rely upon the illustrative rates provided by its insurance carrier in calculating whether it is over or under the "hard caps" in Section 3 of the Act (MCL 15.563) for its active employees, despite the fact that some of the illustrative rate is attributable to the claims experience of retirees and their dependents?

A7-24. Yes, the public employer can rely on the illustrative rate provided by its insurance carrier. The Act does not address how the illustrative rate is determined. The Act places limits on how much of that illustrative rate a public employer may pay in a medical benefit plan coverage year beginning on or after January 1, 2012, for its employees and elected public officials.

Rescinded for Medical Benefit Plan Coverage Years beginning on or after January 1, 2014, see Q7-31

Q7-25. Does a public employer need to include the costs (taxes and fees) of the Patient Protection and Affordable Care Act (ACA) when calculating the total "hard cap" amount, Section 3 of 2011 Public Act 152 (MCL 15.563), or when calculating the 80/20 percentage requirement, Section 4 of 2011 Public Act 152 (MCL 15.564)?

A7-25. The federal Patient Protection and Affordable Care Act (ACA), Pub. L. 111-148, March 23, 2010, 124 Stat. 119, contains certain charges on health insurers and group health plans to offset the financing of the ACA. An amount that a public employer is required to pay pursuant to the ACA is not considered a part of the total annual costs of all the medical benefit plans the public employer offers or contributes to for its employees and elected public officials per 2011 Public Act 152.

Costs imposed on the public employer under the ACA are to offset ACA spending and to cover operational costs of the federal law and are not related to the costs of the public employer of providing benefits covered by the medical benefit plan.

Q7-26. A self-funded public employer receives one set of illustrative rates (for single, 2-person, and family coverage) from its insurance carrier which is applicable to all of its active employees and its retired employees up to age 65 and their dependents. The illustrative rates are based upon the claims experience of all active employees and retired employees up to age 65 and their dependents. The claims experience for the previous medical benefit plan coverage year indicates an approximate 45%/55% split between the actual costs of active employees and retirees. The illustrative rate reflects the actual amounts which are paid by the public employer for active employees and their dependents in the plan. The same amounts are also paid for retirees up to age 65 and their dependents, but the amounts paid for retirees and their dependents are not included by the public employer in its "hard cap" amount, Section 3 of the Act (MCL 15.563). Is the public employer entitled to rely upon the illustrative rates provided by its insurance carrier in calculating compliance with the "hard cap" limitation in Section 3 of the Act (MCL 15.563), despite the fact that some of the illustrative rate is attributable to the claims experience of retirees and their dependents?

A7-26. Yes, the public employer can rely on the illustrative rate provided by its insurance carrier. The Act does not address how the illustrative rate is determined. The Act places limits on how much of that illustrative rate a public employer may pay in a medical benefit plan coverage year beginning on or after January 1, 2012, for its employees and elected public officials.

Q7-27 Replaces Q7-10

Q7-27. Do employer contributions to a Retiree Health Savings program (RHS) or Health Care Savings Program (HCSP), both of which are for use upon retirement, need to be included when calculating either the "hard cap" amounts under Section 3 of the Act (MCL 15.563) or the 80/20 percentage requirement under Section 4 of the Act (MCL 15.564)?

A7-27. No. The Act defines a "medical benefit plan" in Section 2(e) (MCL 15.562(e)) such that "…[a m]edical benefit plan does not include benefits provided to individuals retired from a public employer or a public employer's contributions to a fund used for the sole purpose of funding health care benefits that are available to a public employee or an elected public official only upon retirement or separation from service."

Q7-28 Replaces Q7-13 – For medical benefit plan coverage years beginning on or after January 1, 2014

Q7-28. A.) If an insurance company charges an annual "claims assessment" (usually 1% of all the claims paid during the previous year) at the end of each year, does the public employer need to include the "claims assessment" cost into the "hard cap" limitation or 80/20 percentage requirement calculation?

B.) If so, which calculation year would they include the costs, in the year the costs are paid by the public employer or the year the "claims assessment" costs pertain to?

A7-28. A.) Yes. The Act defines "medical benefit plan costs" in Section 2(f)(*i*) (MCL 15.562(f)(*i*)) to include "[a]ny amount that the public employer pays directly or indirectly for the assessment levied pursuant to the health insurance claims assessment act, 2011 PA 142, MCL 550.1731 to 550.1741" for medical benefit plan coverage years beginning on or after January 1, 2014.

B.) Section 3(1) of the Act (MCL 15.563(1)) directs that a public employer that contributes to a medical benefit plan for its employees "…shall pay no more of the annual costs…than a total amount equal to…[the specified caps]…for a medical benefit plan coverage year…"

Based upon this statutory directive, the public employer should include the assessment in the medical benefit plan coverage year in which the public employer pays the assessment, not the medical benefit plan coverage year in which the employee's claim arises.

Q7-29 Replaces Q7-18 – For medical benefit plan coverage years beginning on or after January 1, 2014

Q7-29. Can a public employer charge the "claims assessment" back to their employees and does the charge then get included in the "hard cap" calculation under Section 3 of 2011 Public Act 152 (MCL 15.563)) or the 80/20 percentage requirements calculation under Section 4 (MCL 15.564)?

A7-29. Nothing in the Health Insurance Claims Assessment Act (HICAA) addresses the relationship between an employer and its employees. Other laws, such as contract law and labor law, may govern that relationship, but the HICAA itself is silent on this issue. Accordingly, the HICAA neither permits nor prohibits an employer from passing the cost of the HICAA assessment on to its employees.

However, the employer, subject to the HICAA, that chooses to charge the assessment back to its employees still remains the entity ultimately responsible for paying the HICAA assessment.

2011 Public Act 152 defines "medical benefit plan costs" in Section 2(f)(i) (MCL 15.562(f)(i)) to include "[a]ny amount that the public employer pays directly or indirectly for the assessment levied pursuant to the health insurance claims assessment act, 2011 PA 142, MCL 550.1731 to 550.1741" for medical benefit plan coverage years beginning on or after January 1, 2014.

Q7-30 Replaces Q7-23 – For medical benefit plan coverage years beginning on or after January 1, 2014

Q7-30. Should insurance agent commissions be included when calculating the total "hard cap" amount, Section 3 of the Act (MCL 15.563), or when calculating the 80/20 percentage requirement, Section 4 of the Act (MCL 15.564)?

A7-30. Yes. The Act defines "medical benefit plan costs" in Section 2(f)(*ii*) (MCL 15.562 (f)(*ii*)) to include "insurance agent or company commissions" for medical benefit plan coverage years beginning on or after January 1, 2014.

Revised
Q7-31 Replaces Q7-25 – For medical benefit plan coverage years beginning on or after January 1, 2014

Q7-31. Does a public employer need to include the costs (taxes and fees) of the Patient Protection and Affordable Care Act (“ACA”) when calculating the total “hard cap” amount, Section 3 of 2011 Public Act 152, as amended, (“the Act”) (MCL 15.563), or when calculating the 80/20 percentage requirement, Section 4 of the Act (MCL 15.564)?

A7-31. Yes. The Act defines “medical benefit plan costs” in Section 2(f)(*iii*) (MCL 15.562(f)(*iii*)) to include “any additional amount the public employer is required to pay as a fee or tax under the patient protection and affordable care act, Public Law 111-148, as amended by the federal health care and education reconciliation act of 2010, Public Law 111-152” for medical benefit plan coverage years beginning on or after January 1, 2014.

Treasury does not have the authority to interpret the ACA. Each public employer must determine if “any additional amount the public employer is required to pay [is] a fee or tax under the [ACA].”

Q7-32. Section 3(2) of 2013 Public Act 270 amends the “hard cap” limitation for individual-and-spouse coverage or individual-plus-1-nonspouse-dependent coverage. When does the new multiplier become effective? What multiplier should be used to calculate the maximum public employer payment?

A7-32. The enacting section specifically states which amendments are applied retroactively. In this case, Section 3(2) of 2013 Public Act 270 is not applied retroactively. Therefore, for medical benefit plan coverage years beginning on or after January 1, 2014, the multiplier used to calculate the maximum public employer payment for individual-and-spouse coverage or individual-plus-1-nonspouse-dependent coverage shall be $12,250.00.

Q7-33. Should insurance consulting fees be included when calculating the total “hard cap” amount, Section 3 of 2011 Public Act 152, as amended, (“the Act”) (MCL 15.563), or when calculating the 80/20 percentage requirement, Section 4 of the Act (MCL 15.564)?

A7-33. No. The public employer would not include consultant fees when calculating the total “hard cap” amount, Section 3 of the Act (MCL 15.563), or when calculating the 80/20 percentage requirement, Section 4 of the Act (MCL 15.564).

Q7-34. Under the Patient Protection and Affordable Care Act (ACA), small employers (under 50 employees) no longer get quoted on standard single, double, and family rates. Instead, every employee, spouse, and dependent is rated based on age. Two families can have different premiums based on ages of the employee, spouse, and dependent(s) and the number of children in the family. The same goes for singles and doubles. How should a public employer apply the total "hard cap" amount, Section 3 of the Act (MCL 15.563)? Are any fixes to the legislation being considered?

A7-34. The Act does not address how rates are determined. Section 3(1) of the Act (MCL 15.563(1)) places a limit on how much of the annual costs or illustrative rate a public employer may pay in a medical benefit plan coverage year. Section 3(1) requires the State Treasurer to adjust the maximum payment for each coverage category annually based on the change in the medical care component of the United States consumer price index.

The Michigan Department of Treasury is not presently aware of any pending legislation addressing this concern.

Q7-35. When must a public employer apply 2013 Public Act 270's amendments to calculate its contribution limit for those employees that have elected coverage similar to "individual-plus-1-nonspouse-dependent coverage", for which calculations have previously been made pursuant to the employer's practice of using the "family coverage" hard-cap contribution limit, instead of the "individual-and-spouse coverage" limit?

A7-35. 2013 Public Act 270, which became effective on December 30, 2013, amended Section 3 of the Publicly Funded Health Insurance Contribution Act, 2011 Public Act 152 (MCL 15.563). The amendment created the designation "subsection 3(1)" and added the emphasized language to the hard cap limitations that a public employer shall pay no more than a total amount equal to "$11,000.00 times the number of employees and elected public officials with individual-and-spouse coverage ***or individual-plus-1-nonspouse dependent coverage***."

2013 Public Act 270 also added Subsection 3(2) to 2011 Public Act 152 (MCL 15.563(2)), which directs that for a medical benefit plan coverage year beginning January 1, 2014 through December 31, 2014, the multiplier for individual-and-spouse coverage or individual-plus-1-nonspouse-dependent coverage shall be $12,250.00.

Finally, 2013 Public Act 270 added Subsection 3(3) to 2011 Public Act 152 (MCL 15.563(3)), which prescribes that employees and elected public officials who

decline the medical benefit plan offered or contributed to by the public employer are not included in the public employer's calculation of its maximum total annual medical benefit plan costs.

Enacting section 1 of 2013 Public Act 270 directs that:

> "Section 3(1) and (3) of the publicly funded health insurance contribution act, 2011 PA 152, MCL 15.563, as amended or added by this amendatory act, clarifies the original intent of the legislature that a public employee or elected official who declines the public employer's medical benefit plan coverage is not an employee or elected public official for purposes of calculating the public employer's maximum total annual medical benefit plan costs. These amendments are curative and apply retroactively."

The fact that the amendment to subsection 3(1) (MCL 15.563(1)) is retroactive to the date 2011 Public Act 152 first became effective, which is September 27, 2011, means that the date a collective bargaining agreement (CBA) became effective is significant. If a current CBA was in effect on September 27, 2011, "…the requirements of section 3 or 4 do not apply to an employee covered by that contract until the contract expires…", pursuant to Subsection 5(1) of 2011 Public Act 152 (MCL 15.565(1)). Thus, the public employer would apply the individual-plus-1-nonspouse-dependent coverage hard cap when the CBA expires.

However, if the current CBA was executed on or after September 27, 2011, the public employer was subject to the hard cap limitation for individual-plus-1-nonspouse-dependent coverage for a medical benefit plan coverage year beginning on or after January 1, 2012. This is pursuant to Subsection 5(2) of 2011 Public Act 152 (MCL 15.565(2)), which prescribes that "A collective bargaining agreement or other contract that is executed on or after September 27, 2011 shall not include terms that are inconsistent with the requirements of sections 3 and 4".

Q7-36. A public employer provides a Supplemental Voluntary Benefit plan to employees and the public employer pays a portion of the premium costs. The Supplemental Voluntary Benefit plan provides insurance coverage for items such as cancer/specified-disease, heart attack, accident, et cetera. The insurance company pays out any claims directly to the employee, not to doctors or medical facilities, unless otherwise assigned. The employee can use the money from the claims to cover costs including but not limited to transportation, childcare, copayments, deductibles, and living expenses.

Do public employers need to include the premium costs paid to purchase Supplemental Voluntary Benefits for employees, when calculating compliance under either Section 3 of the Act (MCL 15.563) or Section 4 of the Act (MCL 15.564)?

A7-36. The Act regulates a public employer’s payments toward the total annual costs of all *medical benefit plans* it offers or contributes to for its employees and elected public officials.

A “medical benefit plan” is defined in pertinent part in Section 2(e) of the Act (MCL 15.562(e)) as “…a plan established and maintained by a carrier…that provides for the payment of medical benefits, including, but not limited to, hospital and physician services, prescription drugs, and related benefits, for public employees or elected public officials…”

Section 3 of the Act (MCL 15.563), in placing the “hard cap” limitation on a public employer’s contributions to a medical benefit plan, directs that the hard caps apply to “…payments for reimbursement of co-pays, deductibles, or payments into health savings accounts, flexible spending accounts, or similar accounts used *for health care costs*…” The Act’s definition of “flexible spending account” as “…a *medical expense* flexible spending account…” emphasizes the account is restricted to payment of health care costs, see Section 2(b) of the Act (MCL 15.562(b)).

Section 4 of the Act (MCL 15.564), which contains the 80/20 percentage requirement on a public employer’s contributions to its medical benefit plans, repeats the direction from Section 3 that the limitations apply to “…payments for reimbursement of co-pays, deductibles, and payments into health savings accounts, flexible spending accounts, or similar accounts used *for health care costs…*”

In the facts presented, public employers do not need to include the premium costs they pay to purchase a Supplemental Voluntary Benefit plan for their employees when calculating compliance under either the “hard cap” limitation in

Section 3 of the Act (MCL 15.563) or the 80/20 percentage requirement in Section 4 of the Act (MCL 15.564).

Q7-37. A group of employees are covered by a collective bargaining agreement ("CBA"), which existed prior to the passage of 2011 Public Act 152, as amended, ("the Act"), with an expiration date of August 31, 2014. The new contract takes effect September 1, 2014. The medical benefit plan coverage year for the covered employees is September 1, 2014 through June 30, 2015. The public employer is complying with the Act under the "hard cap" limitations of Section 3 of the Act (MCL 15.563).

Is the public employer allowed to use the annual "hard cap" limitation amounts to calculate compliance with the Act or does the public employer need to pro-rate the annual "hard cap" limitations over 10 months (the length of the medical benefit plan coverage year)?

A7-37. The annual "hard cap" limitation amounts are based on a 12-month medical benefit plan coverage year. A public employer with a medical benefit plan coverage year less than 12 months must pro-rate the annual "hard cap" limitation amounts accordingly.

"Medical benefit plan coverage year" is defined in Section 2(g) of the Act (MCL 15.562(g)) as, "…the 12-month period after the effective date of the contractual or self-insured medical coverage plan that a public employer provides to its employees or public officials." Department guidance has been clear that "[a] 'medical benefit plan coverage year' may or may not be the same as the period referred to as a 'plan year'." See the answer to FAQ2-2.

Section 3 of the Act directs that "…for a medical benefit plan coverage year beginning on or after January 1, 2012..." a public employer that offers or contributes to a medical benefit plan for its employees or elected public officials, "…shall pay no more of the annual costs…" than a total amount equal to specified "hard caps" times the number of employees or public officials with that type of coverage.

In advising that a public employer cannot use its fiscal year to determine the annual "hard cap" calculation, the Department instructed that "[S]pecifically, the 'hard cap' calculation must be made for the same period as the 'medical benefit plan coverage year'." See the answer to FAQ7-3.

Therefore, just as a public employer can pro-rate the "hard cap" limits if an employee changes status during the medical benefit plan coverage year (see the answer to FAQ7-17), a public employer with a medical benefit plan coverage

year less than 12 months must pro-rate the annual “hard cap” limitation amounts accordingly.

Q7-38. A public employer provides a health plan and a high deductible plan for its employees. The public employer has elected to comply with the 80/20 percentage requirement, Section 4 of 2011 Public Act 152, as amended, (“the Act”) (MCL 15.564). The public employer pays 80% and the employees pay 20% of the health insurance plan premium costs. Additionally, the high deductible plan requires an employee to cover the first $1,250 of health costs under single coverage and the first $2,500 of health costs under 2 person and family coverage. Over the course of the year, an employee may never reach the deductible amount. The public employer pays 80% of the high deductible amount (i.e. $1,000 for single coverage and $2,000 for 2 person and family coverage).

Are the employees required to have 20% of the high deductible amount deducted from their paycheck? At the end of the year, how would the public employer calculate compliance with the 80/20 percentage requirement, Section 4 of the Act (MCL 15.564), when employees have not reached the full deductible amount?

A7-38. Section 4 of the Act (MCL 15.564) prohibits a public employer from paying “more than 80% of the total annual costs of all of the medical benefit plans it offers or contributes to for its employees and elected public officials” in a medical benefit plan coverage year. Section 4 of the Act (MCL 15.564) further directs in pertinent part that “total annual costs includes the premium or illustrative rate of the medical benefit plan and all employer payments for reimbursement of co-pays, deductibles . . .” In a high deductible plan, the focus of Section 4 of the Act (MCL 15.564) would be on the percentage the public employer *reimburses* the employee or elected public official for deductible costs actually used or incurred.

In the information presented, the public employer would be in compliance with the Act if in the medical benefit plan coverage year the public employer pays no more than 80% of the total costs of the health plan and the high deductible plan.

Q7-39. If the interval of the medical benefit plan coverage year changes from July 1-June 30 to a January 1-December 31 interval, can the public employer pay the increased medical benefit plan "hard cap" limitation effective January 1 in the transition year without violating the limitations of Section 4?

A7-39. The "hard cap" limitations under Section 3 of the Act (MCL 15.563) and the 80/20 percentage requirement under Section 4 of the Act (MCL 15.564) apply to each "medical benefit plan coverage year" beginning on or after January 1, 2012. The "hard cap" limitations are based upon the number of employees or elected public officials with single-person, individual-and-spouse or individual-plus-1-nonspouse-dependent, and family insurance coverage. The calculation of the "hard cap" limitation and the "80/20" limitation must be made for the same period as the "medical benefit plan coverage year". See FAQ2-1 for the definition of the term "medical benefit plan coverage year."

When an insurance provider informs a public employer that it is altering the medical benefit plan coverage year from July 1-June 30 to a January 1-December 31 interval, a public employer may change the beginning and ending date of the 12-month interval of the "medical benefit plan coverage year." However, the annual "hard cap" limitation amounts are based on a 12-month "medical benefit plan coverage year." Therefore, just as a public employer can pro-rate the "hard cap" limits if an employee changes status during the medical benefit plan coverage year (see FAQ7-17), a public employer with a "medical benefit plan coverage year" less than 12 months must pro-rate the annual "hard cap" limitation amounts accordingly. Likewise, the 80/20 percentage requirement under Section 4 of the Act (MCL 15.564) would be based on the public employer's shortened medical benefit plan coverage year.

Q7-40. Can a public employer implement the 2017 "hard cap" limitations on July 1, 2017 and then after 6 months implement the 2018 "hard cap" limitations on January 1, 2018 if the insurance provider is changing from a fiscal year to a calendar year for the medical benefit plan coverage year?

A7-40. Due to the insurance provider changing the coverage year from a fiscal year to a calendar year, the first "medical benefit plan coverage year" is 6 months, running from July 1, 2017 through December 31, 2017. The annual "hard cap" limitation amounts under Section 3 of the Act (MCL 15.563) are based on a 12-month "medical benefit plan coverage year." So, a public employer's compliance with the "hard cap" limitations would be based upon the public employer pro-rating the annual "hard cap" limitations for a 6 month period.

The second "medical benefit plan coverage year" is 12 months, running from January 1, 2018 through December 31, 2018. Pursuant to Section 3(1) of the Act (MCL 15.563(1)) by October 1 of each year "…the state treasurer shall adjust the

maximum payment permitted...for each coverage category for medical benefit plan coverage years beginning the succeeding calendar year, based on the change in the medical care component of the United States consumer price index..." Thus, a public employer would be in compliance with the Act for the "medical benefit plan coverage year" running from January 1, 2018 through December 31, 2018 if its payments do not exceed the adjusted maximum payment for the 2018 calendar year.

Q7-41. An insurance provider is changing the medical benefit plan coverage year from July 1, 2017-June 30, 2018 to a July 1, 2017-December 31, 2018 interval. For the period of July 1, 2017 to December 31, 2018, would the public employer apply the 2017 "hard cap" limitation amounts for the 18-month "medical benefit plan coverage year"?

A7-41. Based upon the information below, the answer is "No." Section 2(g) of the Act (MCL 15.562(g)) defines "medical benefit plan coverage year" as "…the 12-month period after the effective date of the contractual or self-insured medical coverage plan that a public employer provides to its employees or public officials." The Department in the Frequently Asked Questions (FAQs) on the Act has advised that, "A 'medical benefit plan coverage year' may or may not be the same as the period referred to as a 'plan year.'" See the answer to FAQ2-2. Also, "The 'medical benefit plan coverage year' is the 12-month period that is applicable for determining compliance with the Act, even if the accrual of deductibles is tied to a different period." See the answer to FAQ2-4.

Section 3 of the Act (MCL 15.563) limits a public employer's contributions to its medical benefit plan to specified "hard cap" limitations based upon the number of employees or elected public officials within certain classifications of coverage. Section 3 of the Act is clear that the analysis of a public employer's compliance with the "hard cap" limitations will be based upon an "annual" or 12-month period:

> "…a public employer that offers or contributes to a medical benefit plan for its employees or elected public officials shall pay no more of the *annual costs* or illustrative rate and any payments for reimbursement of co-pays, deductibles…than a total amount equal to [specified "hard caps" times the number of employees and elected public officials with certain classifications of coverage]…" (MCL 15.563(1)). (Emphasis added.)

A helpful FAQ for the question is FAQ7-37. The situation involves a group of employees under a collective bargaining agreement (CBA) in existence on the date the Act became effective. The CBA eventually expired on August 31, 2014 with the new contract commencing on September 1, 2014. This resulted in these employees having a medical benefit plan coverage year of 10 months running from September 1, 2014 through June 30, 2015.

> The question in FAQ7-37 is, "Is the public employer allowed to use the annual 'hard cap' limitation amounts to calculate compliance with the Act or does the public employer need to pro-rate the annual 'hard cap' limitations over 10 months (the length of the medical benefit plan coverage year)?"
>
> The answer in FAQ7-37 is:
>
>> "The annual 'hard cap' limitation amounts are based on a 12-month medical benefit plan coverage year. A public employer with a medical benefit plan coverage year less than 12 months must pro-rate the annual 'hard cap' limitation amounts accordingly…
>>
>> …In advising that a public employer cannot use its fiscal year to determine the annual 'hard cap' limitation, the Department instructed that "[S]pecifically, the 'hard cap' calculation must be made for the same period as the [statutorily defined] 'medical benefit plan coverage year.' See the answer to FAQ7-3.
>>
>> Therefore, just as a public employer can pro-rate the 'hard cap' limits if an employee changes status during the medical benefit plan coverage year (see the answer to FAQ7-17), a public employer with a medical benefit plan coverage year less than 12 months must pro-rate the annual 'hard cap' limitation amounts accordingly."

The insurance provider's decision that the new premium rates taking effect on July 1, 2017 would not be changed until January 1, 2019 does not override the Act's mandate that compliance with the "hard cap" limitations will be based upon an "annual" or 12-month period. Thus, the adjusted "hard cap" maximum amounts announced by October 1, 2016 will apply to the medical benefit plan coverage year running from July 1, 2017 through June 30, 2018. The adjusted "hard cap" maximum amounts announced by October 1, 2017 will apply to the medical benefit plan coverage year running from July 1, 2018 through December 31, 2018. The public employer would pro-rate the annual "hard cap" amounts announced in the fall of 2017 over the 6-month medical benefit plan coverage year in 2018.

Q7-42 Replaces Q7-9

Q7-42. A public employer is currently on a partial self-funded plan, and all of the employee groups are under the "hard cap" effective 7/1/2012. In a self-funded plan, if a public employer exits the plan, they pay run-out costs for claims that are incurred but not reported ("IBNR") by the end of the plan. There is an accrual on the public employer's books to estimate this run-out cost, so they have recognized this expense on their general ledger, but it has not been paid.

A.) If the public employer switches from a self-funded plan to a full premium plan and had to pay the insurance carrier's rates immediately, while still paying the run-out costs of the self-funded plan, would both the premium and the run-out cost payments be used to determine compliance with the requirements of Section 3 of 2011 Public Act 152, as amended, ("the Act") (MCL 15.563) (providing for cap-based limitations on contributions) or Section 4 of the Act (MCL 15.564) (providing for percentage-based limitations on contributions)?

B.) If the actual run-out costs are lower than the calculation, how many years does a public employer have to wait before these funds are available for other use (if any)?

C.) If after all IBNR claims are processed and paid the actual costs exceed the funds allocated and booked by the public employer, would the excess amounts be used to determine compliance with the requirements of Section 3 or Section 4 of the Act?

A7-42 A.) No. The Act provides that the annual costs subject to the hard cap limitation or 80% limitation include the premium or illustrative rate, reimbursement of employees' or elected public officials' out-of-pocket expenses (co-pays, deductibles, etc.) and/or contributions to certain health-related accounts (flexible spending account, health savings account, etc.).

Illustrative rates include an allocation for IBNR claims. This allocation is paid by the public employer and employees when the illustrative rate is paid and accrued on the public employer's books during the medical benefit plan coverage year. Run-out (i.e., payment of the IBNR) claims are attributable to the medical benefit plan coverage year in which they accrued, and the illustrative rate was paid.

B.) A public employer's compliance with the Act is determined by how much of the total annual costs of the medical benefit plan the public employer paid. The issue of the availability of funds when the actual run-out costs are lower than the calculation is not an issue within Treasury's purview to opine.

C.) Yes. The excess amounts are payments made in the medical benefit plan coverage year in which they are paid and booked. They must, therefore, be included with the premiums being paid for the fully insured medical benefit plan.

8. Collective Bargaining Units

Q8-1. A) Can a public employer choose to have one collective bargaining unit fall under Section 3 of the Act (MCL 15.563) and another collective bargaining unit fall under Section 4 of the Act (MCL 15.564)?

B) Can subdivisions of collective bargaining units fall under different sections?

A8-1. A) No. Section 4(2) of the Act (MCL 15.564(2)) provides that when a public employer has elected to have Section 4 of the Act (MCL 15.564) apply (if a public employer elects the 80/20 percentage requirement, then it must pass a resolution each year), it shall pay not more than 80% of the total annual costs of "all of the medical benefit plans" it offers or contributes to. The implication of this language is that an election to comply with Section 4 of the Act (MCL 15.564) (rather than Section 3 of the Act (MCL 15.563)) affects all of the public employer's medical benefit plans (if it has more than one). Section 4(2) of the Act (MCL 15.564(2)) also provides that where the public employer elects to comply with Section 4 of the Act (MCL 15.564), any elected public official who participates in "a medical benefit plan" offered by the public employer must pay at least 20% of the total annual plan costs. Again, this language implicates that an election to comply with Section 4 of the Act (MCL 15.564) affects all of the public employer's medical benefit plans.

B) No. Subdivisions of collective bargaining units cannot fall under different sections.

Q8-2. Section 5(2) of the Act (MCL 15.565(2)) specifies that collective bargaining agreements (CBA) or other contracts executed on or after September 15, 2011 must comply with the requirements of the Act. However, the Act had not been signed into law as of that date. Is that date still effective?

A8-2. 2013 Public Act 272, amended Section 5 of 2011 Public Act 152 (MCL 15.565) to clarify the original intent of the legislature that September 27, 2011 is the date on and after which a new contract must comply with 2011 Public Act 152.

Q8-3. May a public employer impose the "hard cap" requirements of Section 3 of the Act (MCL 15.563) or the 80/20 percentage requirements of Section 4 of the Act (MCL 15.564) with respect to 1 or more employees who are covered by a collective bargaining agreement (CBA) or other contract prior to the expiration date of the agreement or other contract that was in effect prior to September 27, 2011?

A8-3. No, if the imposition of those requirements would be contrary to the terms of the CBA or other contract that was in effect prior to September 27, 2011. Section 5(1) of the Act (MCL 15.565(1)) exempts CBAs and other contracts that are in effect prior to September 27, 2011 from compliance with the Act's requirements. Therefore, if the imposition of the new requirements under either Section 3 of the Act (MCL 15.563) or Section 4 of the Act (MCL 15.564) would be contrary to the terms of the contract, an employer may not impose those requirements with respect to 1 or more employees who are covered by a CBA or other contract until the contract has expired, is renewed, or is extended.

Q8-4. What happens when a three year contract stipulates the 80/20 percentage requirements of Section 4 of the Act (MCL 15.564), but then in the second year of the contract the public employer changes to the "hard cap" requirements of Section 3 of the Act (MCL 15.563)? Do the employees under the contract have to switch to the "hard cap" requirements of Section 3 of the Act (MCL 15.563) or can they stay with the 80/20 percentage requirements of Section 4 of the Act (MCL 15.564)?

A8-4. A public employer needs to have a majority vote each year, if they are choosing the 80/20 percentage requirements of Section 4 of the Act (MCL 15.564) instead of the "hard cap" requirements of Section 3 of the Act (MCL 15.563). Section 4(1) (MCL 15.564(1)) of the Act, that provides the 80/20 percentage option, directs that "[b]y a majority vote of its governing body **each year**, prior to the beginning of the medical benefit plan coverage year, a public employer, excluding this state, may elect to comply with this section for a medical benefit plan coverage year instead of the requirements in Section 3…" (MCL 15.563). (Emphasis added.)

The emphasized language indicates that the majority vote to select the 80/20 percentage option under Section 4 of the Act (MCL 15.564) must be made each year for each succeeding medical benefit plan coverage year. If the public employer does not elect by a majority vote the 80/20 percentage option each year, the public employer must comply with the "hard cap" requirements of Section 3 of the Act (MCL 15.563).

Q8-5. A public employer issued individual employment contracts to administrators and other employees. The contracts were in effect prior to September 27, 2011. There is no single "group" employment contract covering these non-union employees. Are these individual employment contracts within the scope of the exemption created by Section 5 of the Act (MCL 15.565)?

A8-5. Section 5(1) of the Act (MCL 15.565(1)) directs that "…a collective bargaining agreement or other contract that is inconsistent with sections 3 and 4 is in effect for 1 or more employees of a public employer on September 27, 2011, the requirements of section 3 or 4 do not apply to an employee covered by that contract until the contract expires…"

Therefore, an individual employment contract in effect at the time the Act became effective, September 27, 2011, would fall under the exemption provided by Section 5 (MCL 15.565), if the arrangement between the public employer and individual is not "At Will" but a contract with a specified end date.

An individual employment contract in effect on or before September 27, 2011 with a definite expiration date would be exempt from the "hard cap" limitations of Section 3 of the Act (MCL 15.563) and the 80/20 percentages of Section 4 of the Act (MCL 15.564), until the contract expires, is extended, or renewed.

Q8-6. A collective bargaining agreement (CBA) expired in December 2012. In the CBA, there was a separate moratorium agreement on health care costs and premiums until December 31, 2013. Does the public employer need to comply with the requirements of the Act, as of January 1, 2013, for the group of employees covered by the moratorium under the expired CBA?

A8-6. Yes. The public employer would need to comply with the Act for a medical benefit plan coverage year beginning after the CBA expired in December 2012.

Section 5 of the Act (MCL 15.565) directs that if a CBA or other contract that is inconsistent with the Act is in effect for 1 or more employees of a public employer on September 27, 2011, the requirements of the Act do not apply to an employee covered by that contract until the contract expires. Thus, the public employer did not need to comply with the Act until after the CBA expired in December 2012.

The expired CBA's provision that there is a moratorium or postponement of action on health care costs and premiums until December 31, 2013, does not constitute a CBA.

Q8-7. A public employer and its union employees have a contract that expires on June 30, 2013. The employer's medical benefit plan coverage year begins on August 1st of each year. The employer's non-union employees have been under the Act since August 1, 2012.

When is the public employer required to comply with the Act with regard to its union employees in terms of applying the "hard cap" limitation of Section 3 of the Act (MCL 15.563) or the 80/20 percentage requirement of Section 4 of the Act (MCL 15.564)?

A8-7. We are assuming that the collective bargaining agreement (CBA) that expired on June 30, 2013 was in effect on September 27, 2011 when the Act became effective. Section 5 of the Act (MCL 15.565) directs that if a CBA or other contract that is inconsistent with the Act is in effect for 1 or more employees of a public employer on September 27, 2011, the requirements of the Act do not apply to an employee covered by that contract until the contract expires.

Thus, the public employer would have to be in compliance with the Act regarding the union employees on July 1, 2013. The public employer could implement the "hard cap" limitation of Section 3 of the Act (MCL 15.563) or the 80/20 percentage requirement of Section 4 of the Act (MCL 15.564) for the union employees on a pro-rata basis based upon the portion of the medical benefit plan coverage year the union employees were covered by that medical benefit plan.

9. Compliance with Section 8 (MCL 15.568)

Q9-1. Are all public employers eligible to exempt themselves from the Act?

A9-1. No. The Act directs in Section 8(1) (MCL 15.568(1)) that "[b]y a 2/3 vote of its governing body each year…a **local unit of government** may exempt itself from the requirements of this act for the next succeeding medical benefit plan coverage year." (Emphasis added.)

A local unit of government is defined in Section 2(d) of the Act (MCL 15.562(d)) as "…a city, village, township, or county, a municipal electric utility system as defined in section 4 of the Michigan energy employment act of 1976, 1976 PA 448, MCL 460.804, an authority created under chapter VIA of the aeronautics code of the state of Michigan, 1945 PA 327, MCL 259.108 to 259.125c, or an authority created under 1939 PA 147, MCL 119.51 to 119.62."

Q9-2. How long can a local unit of government exempt itself from the requirements of the Act? Is there a maximum number of times?

A9-2. The Act directs in Section 8(1) (MCL 15.568(1)) that "[b]y a 2/3 vote of its governing body each year, prior to the beginning of the medical benefit plan coverage year, a local unit of government may exempt itself from the requirements of this act for the next succeeding medical benefit plan coverage year." An annual 2/3 vote of the governing body is required to extend the exemption. There is no limitation on the number of times a local unit of government can exempt itself from the Act.

Q9-3. Can local units of government elect to comply with Section 4 of Act (MCL 15.564) (providing for contribution limits based on percentages) or exercise the opt-out provision of Section 8 of the Act (MCL 15.568) at any point during the year? How is the "year" determined for purposes of exercising these options? Must the local unit of government renew its election to opt out at the same time each year and if so, when?

A9-3. A public employer must be in compliance with the Act for each "medical benefit plan coverage year" beginning on or after January 1, 2012. See FAQ2-1 for the definition of the term "medical benefit plan coverage year." The first "medical benefit plan coverage year" falling under the Act would be the 12-month period beginning on the date on or after January 1, 2012 that new medical insurance coverage begins. A local unit of government may elect to comply with Section 4 of the Act (MCL 15.564) or exercise the exemption ("opt-out") provision of Section 8 of the Act (MCL 15.568) at any time "…prior to the beginning of the medical benefit plan coverage year…" The elections must be made separately for each new "medical benefit plan coverage year."

Q9-4. A local unit of government that created a housing commission has exempted ("opted out") itself from the requirements of the Act. The housing commission would like to follow the lead of the local unit of government and exempt itself from the Act. However, the Act does not include the housing commission as an entity that is eligible to exempt itself from the Act. If the housing commission follows the lead of the local unit of government and exempts itself, even though they are not allowed to by law, is the local unit of government penalized?

A9-4. It would appear, from the facts presented, that as the local unit of government created the housing commission, the local unit of government's decision to "opt out" of the Act would include the housing commission, whether that entity chose to follow the local unit of government's lead or not.

However, if the housing commission has such autonomy that it falls outside the umbrella of the local unit of government's decision, the housing commission, as a public employer, must comply with the Act's limitations on its contributions to its medical benefit plan for its employees by following the "hard cap" requirements, Section 3 (MCL 15.563) or the 80/20 percentage requirements, Section 4 (MCL 15.564).

Also, if the housing commission is not an "arm of the local unit of government", and thus autonomous, the housing commission does not meet the definition of a "local unit of government" in subsection 2(d) of the Act (MCL 15.562(d)) and would not be eligible to exempt itself or "opt out" of the requirements of the Act.

An autonomous housing commission is not one of the entities that qualify for Economic Vitality Incentive Program (EVIP) payments as it is not an eligible city, village, township, or county. So, the penalty of a reduction in EVIP payments would not apply.

However, if the housing commission, as a public employer, was found not to be in compliance with the Act, the housing commission would face all sanctions generally available to enforce a law.

Q9-5. There is a public library that is under its own board. The library employees are on the same insurance plan/policy as a local unit of government's employees, however, the library employees are not employees of the local unit of government.

A.) If the local unit of government exempts itself from the Act, can the public library also exempt itself even though it is not in the definition of a "local unit of government"? Is the public library also under the local unit of government's exemption since they are on the same policy?

B.) If the public library cannot exempt itself under the Act, what is the penalty for noncompliance?

A9-5. A.) Notwithstanding the public library having its own board and the description of the library employees as not being the local unit of government's employees, from the facts presented it does not appear the public library has the authority to operate autonomously from the local unit of government.

So, if the local unit of government exempts itself from compliance with the Act under Section 8 of the Act (MCL 15.568), the local unit of government's decision would include the public library, whether the public library chose to follow the local unit of government's lead or not.

However, if the public library has such autonomy that it falls outside the local unit of government's decision, the public library could not exempt itself from compliance with the Act. The express language of the Act in Section 8(1) (MCL 15.568(1)) limits the election to be exempt from the Act to a "local unit of government," which does not include a public library. A "local unit of government" is defined in relevant part in the Act as "a city, village, township, or county." See Section 2(d) of the Act (MCL 15.562(d)).

So, if the public library is autonomous and not an “arm of the local unit of government”, even though the library employees are on the same insurance plan/policy as the City, their public employer is not eligible to “opt out” of the requirements of the Act.

B.) An autonomous public library is not one of the entities that qualify for Economic Vitality Incentive Program (EVIP) payments as it is not an eligible city, village, township, or county. So, the penalty of a reduction in EVIP payments would not apply.

However, if the public library, as a public employer, was found not to be in compliance with the Act, the public library would face all sanctions generally available to enforce a law.