HOUSE SUBSTITUTE FOR

SENATE BILL NO. 348

A bill to impose an assessment on certain health care claims; to impose certain duties and obligations on certain insurance or health coverage providers; to impose certain duties on certain state departments, agencies, and officials; to create certain funds; to authorize certain expenditures; to impose certain remedies and penalties; to provide for an appropriation; and to repeal acts and parts of acts.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

1 Sec. 1. This act shall be known and may be cited as the
2 "health insurance claims assessment act".
3 Sec. 2. As used in this act:
4 (a) "Carrier" means any of the following:

1 (*i*) An insurer or health maintenance organization regulated
2 under the insurance code of 1956, 1956 PA 218, MCL 500.100 to
3 500.8302.
4 (*ii*) A health care corporation regulated under the nonprofit
5 health care corporation reform act, 1980 PA 350, MCL 550.1101 to
6 550.1704.
7 (*iii*) A nonprofit dental care corporation subject to 1963 PA
8 125, MCL 550.351 to 550.373.
9 (*iv*) A specialty prepaid health plan.
10 (*v*) A group health plan sponsor including, but not limited to,
11 1 or more of the following:
12 (A) An employer if a group health plan is established or
13 maintained by a single employer.
14 (B) An employee organization if a plan is established or
15 maintained by an employee organization.
16 (C) If a plan is established or maintained by 2 or more
17 employers or jointly by 1 or more employers and 1 or more employee
18 organizations, the association, committee, joint board of trustees,
19 or other similar group of representatives of the parties that
20 establish or maintain the plan.
21 (b) "Claims-related expenses" means all of the following:
22 (*i*) Cost containment expenses including, but not limited to,
23 payments for utilization review, care or case management, disease
24 management, medication review management, risk assessment, and
25 similar administrative services intended to reduce the claims paid
26 for health and medical services rendered to covered individuals by
27 attempting to ensure that needed services are delivered in the most

1 efficacious manner possible or by helping those covered individuals
2 maintain or improve their health.
3 (*ii*) Payments that are made to or by an organized group of
4 health and medical service providers in accordance with managed
5 care risk arrangements or network access agreements, which payments
6 are unrelated to the provision of services to specific covered
7 individuals.
8 (*iii*) General administrative expenses.
9 (c) "Commissioner" means the commissioner of the office of
10 financial and insurance regulation or his or her designee.
11 (d) "Department" means the department of treasury.
12 (e) "Excess loss" or "stop loss" means coverage that provides
13 insurance protection against the accumulation of total claims
14 exceeding a stated level for a group as a whole or protection
15 against a high-dollar claim on any 1 individual.
16 (f) "Federal employee health benefit program" means the
17 program of health benefits plans, as defined in 5 USC 8901,
18 available to federal employees under 5 USC 8901 to 8914.
19 (g) "Fund" means the health insurance claims assessment fund
20 created in section 7.
21 (h) "Group health plan" means an employee welfare benefit plan
22 as defined in section 3(1) of subtitle A of title I of the employee
23 retirement income security act of 1974, Public Law 93-406, 29 USC
24 1002, to the extent that the plan provides medical care, including
25 items and services paid for as medical care to employees or their
26 dependents as defined under the terms of the plan directly or
27 through insurance, reimbursement, or otherwise.

1 (i) "Group insurance coverage" means a form of voluntary
2 health and medical services insurance that covers members, with or
3 without their eligible dependents, and that is written under a
4 master policy.
5 (j) "Health and medical services" means 1 or more of the
6 following:
7 (*i*) Services included in furnishing medical care, dental care,
8 pharmaceutical benefits, or hospitalization, including, but not
9 limited to, services provided in a hospital or other medical
10 facility.
11 (*ii*) Ancillary services, including, but not limited to,
12 ambulatory services and emergency and nonemergency transportation.
13 (*iii*) Services provided by a physician or other practitioner,
14 including, but not limited to, health professionals, other than
15 veterinarians, marriage and family therapists, athletic trainers,
16 massage therapists, licensed professional counselors, and
17 sanitarians, as defined by article 15 of the public health code,
18 1978 PA 368, MCL 333.16101 to 333.18838.
19 (*iv*) Behavioral health services, including, but not limited to,
20 mental health and substance abuse services.
21 (k) "Managed care risk arrangement" means an arrangement where
22 participating hospitals and physicians agree to a managed care risk
23 incentive which shares favorable and unfavorable claims experience.
24 Under a managed care risk arrangement, payment to a participating
25 physician is generally subject to a retention requirement and the
26 distribution of that retained payment is contingent on the result
27 of the risk incentive arrangement.

1 (*l*) "Medicaid contracted health plan" means that term as
2 defined in section 106 of the social welfare act, 1939 PA 280, MCL
3 400.106.
4 (m) "Medicaid managed care organization" means a medicaid
5 contracted health plan or a specialty prepaid health plan.
6 (n) "Medical inflation rate" means that rate determined by the
7 annual national health expenditures accounts report issued by the
8 federal centers for medicare and medicaid services, office of the
9 actuary.
10 (o) "Medicare" means the federal medicare program established
11 under title XVIII of the social security act, 42 USC 1395 to
12 1395kkk-1.
13 (p) "Medicare advantage plan" means a plan of coverage for
14 health benefits under part C of title XVIII of the social security
15 act, 42 USC 1395w-21 to 1395w-29.
16 (q) "Medicare part D" means a plan of coverage for
17 prescription drug benefits under part D of title XVIII of the
18 social security act, 42 USC 1395w-101 to 1395w-152.
19 (r) "Network access agreement" means an agreement that allows
20 a network access to another provider network for certain services
21 that are not readily available in the accessing network.
22 (s) "Paid claims" means actual payments, net of recoveries,
23 made to a health and medical services provider or reimbursed to an
24 individual by a carrier, third party administrator, or excess loss
25 or stop loss carrier. Paid claims include payments, net of
26 recoveries, made under a service contract for administrative
27 services only, cost-plus or noninsured benefit plan arrangements

1 under section 211 of the nonprofit health care corporation reform
2 act, 1980 PA 350, MCL 550.1211, or section 5208 of the insurance
3 code of 1956, 1956 PA 218, MCL 500.5208, for health and medical
4 services provided under group health plans, any claims for service
5 in this state by a pharmacy benefits manager, and individual,
6 nongroup, and group insurance coverage to residents of this state
7 in this state that affect the rights of an insured in this state
8 and bear a reasonable relation to this state, regardless of whether
9 the coverage is delivered, renewed, or issued for delivery in this
10 state. If a carrier or a third party administrator is contractually
11 entitled to withhold a certain amount from payments due to
12 providers of health and medical services in order to help ensure
13 that the providers can fulfill any financial obligations they may
14 have under a managed care risk arrangement, the full amounts due
15 the providers before that amount is withheld shall be included in
16 paid claims. Paid claims include claims or payments made under any
17 federally approved waiver or initiative to integrate medicare and
18 medicaid funding for dual eligibles under the patient protection
19 and affordable care act, Public Law 111-148, and the health care
20 and education reconciliation act of 2010, Public Law 111-152. Paid
21 claims do not include any of the following:
22 (*i*) Claims-related expenses.
23 (*ii*) Payments made to a qualifying provider under an incentive
24 compensation arrangement if the payments are not reflected in the
25 processing of claims submitted for services rendered to specific
26 covered individuals.
27 (*iii*) Claims paid by carriers or third party administrators for

1 specified accident, accident-only coverage, credit, disability
2 income, long-term care, health-related claims under automobile
3 insurance, homeowners insurance, farm owners, commercial multi-
4 peril, and worker's compensation, or coverage issued as a
5 supplement to liability insurance.

6 (*iv*) Claims paid for services rendered to a nonresident of this
7 state.

8 (*v*) The proportionate share of claims paid for services
9 rendered to a person covered under a health benefit plan for
10 federal employees.

11 (*vi*) Claims paid for services rendered outside of this state to
12 a person who is a resident of this state.

13 (*vii*) Claims paid under a federal employee health benefit
14 program, medicare, medicare advantage, medicare part D, tricare, by
15 the United States veterans administration, and for high-risk pools
16 established pursuant to the patient protection and affordable care
17 act, Public Law 111-148, and the health care and education
18 reconciliation act of 2010, Public Law 111-152.

19 (*viii*) Reimbursements to individuals under a flexible spending
20 arrangement as that term is defined in section 106(c)(2) of the
21 internal revenue code, 26 USC 106, a health savings account as that
22 term is defined in section 223 of the internal revenue code, 26 USC
23 223, an Archer medical savings account as defined in section 220 of
24 the internal revenue code, 26 USC 220, a medicare advantage medical
25 savings account as that term is defined in section 138 of the
26 internal revenue code, 26 USC 138, or other health reimbursement
27 arrangement authorized under federal law.

1 (*ix*) Health and medical services costs paid by an individual
2 for cost-sharing requirements, including deductibles, coinsurance,
3 or copays.
4 (t) "Qualifying provider" means a provider that is paid based
5 on an incentive compensation arrangement.
6 (u) "Specialty prepaid health plan" means that term as
7 described in section 109f of the social welfare act, 1939 PA 280,
8 MCL 400.109f.
9 (v) "Third party administrator" means an entity that processes
10 claims under a service contract and that may also provide 1 or more
11 other administrative services under a service contract.
12 Sec. 3. (1) For dates of service beginning on or after January
13 1, 2012, subject to subsections (2), (3), and (4), there is levied
14 upon and there shall be collected from every carrier and third
15 party administrator an assessment of 1% on that carrier's or third
16 party administrator's paid claims.
17 (2) A carrier with a suspension or exemption under section
18 3717 of the insurance code of 1956, 1956 PA 218, MCL 500.3717, on
19 the effective date of this act is subject to an assessment of 0.1%.
20 (3) All of the following apply to a group health plan that
21 uses the services of a third party administrator or excess loss or
22 stop loss insurer:
23 (a) A group health plan sponsor shall not be responsible for
24 an assessment under this subsection for a paid claim where the
25 assessment on that claim has been paid by a third party
26 administrator or excess loss or stop loss insurer, except as
27 otherwise provided in section 3a(2).

1 (b) Except as otherwise provided in subdivision (d), the third
2 party administrator shall be responsible for all assessments on
3 paid claims paid by the third party administrator.
4 (c) Except as otherwise provided in subdivision (d), the
5 excess loss or stop loss insurer shall be responsible for all
6 assessments on paid claims paid by the excess loss or stop loss
7 insurer.
8 (d) If there is both a third party administrator and an excess
9 loss or stop loss insurer servicing the group health plan, the
10 third party administrator shall be responsible for all assessments
11 for paid claims that are not reimbursed by the excess loss or stop
12 loss insurer and the excess loss or stop loss insurer shall be
13 responsible for all assessments for paid claims that are
14 reimbursable to the excess loss or stop loss insurer.
15 (4) The assessment under this section shall not exceed
16 $10,000.00 per insured individual or covered life annually.
17 (5) To the extent an assessment paid under this section for
18 paid claims for a group plan or individual subscriber is inaccurate
19 due to subsequent claim adjustments or recoveries, subsequent
20 filings shall be adjusted to accurately reflect the correct
21 assessment based on actual claims paid.
22 (6) If the assessment under this section collects revenue in
23 an amount greater than $400,000,000.00, adjusted annually by the
24 medical inflation rate, each carrier and third party administrator
25 that paid the assessment shall receive a proportional credit
26 against the carrier's or third party administrator's assessment in
27 the immediately succeeding year. The department shall send a notice

1 of credit to each carrier or third party administrator entitled to
2 a credit under this subsection not later than July 1. A carrier or
3 third party administrator entitled to a credit under this
4 subsection shall apply that credit to the July 30 payment. Any
5 unused credit shall be carried forward and applied to subsequent
6 payments. If a carrier or third party administrator entitled to a
7 credit under this subsection has no liability under this act in the
8 immediately succeeding year or if this act is no longer in effect,
9 the department shall issue that carrier or third party
10 administrator a refund in the amount of any unused credit. If a
11 third party administrator receives a credit or refund under this
12 subsection, the third party administrator shall apply that credit
13 or refund to the benefit of the entity for which it processed the
14 claims under a service contract.
15 Sec. 3a. (1) A carrier that is required to file rates or file
16 for approval rates with the commissioner is not required to file
17 rates in order to collect the assessment levied under this act from
18 an individual or group. The collected amount shall not be
19 considered an element or factor of a rate.
20 (2) A carrier or third party administrator shall develop and
21 implement a methodology by which it will collect the assessment
22 levied under this act from an individual, employer, or group health
23 plan, subject to all of the following:
24 (a) Any methodology shall be applied uniformly within a line
25 of business.
26 (b) Except as provided in subdivision (d), health status or
27 claims experience of an individual or group shall not be an element

1 or factor of any methodology to collect the assessment from that
2 individual or group.
3 (c) The amount collected from individuals and groups with
4 insured coverage shall be determined as a percentage of premium.
5 (d) The amount collected from groups with uninsured or self-
6 funded coverage shall be determined as a percentage of actual paid
7 claims.
8 (e) The amount collected shall reflect only the assessment
9 levied under this act, and shall not include any additional amounts
10 such as related administrative expenses.
11 (f) A carrier shall notify the commissioner of the methodology
12 used for the collection of the assessment levied under this act.
13 Sec. 4. (1) Every carrier and third party administrator with
14 paid claims subject to the assessment under this act shall file
15 with the department on April 30, July 30, October 30, and January
16 30 of each year a return for the preceding calendar quarter, in a
17 form prescribed by the department, showing all information that the
18 department considers necessary for the proper administration of
19 this act. At the same time, each carrier and third party
20 administrator shall pay to the department the amount of the
21 assessment imposed under this act with respect to the paid claims
22 included in the return. The department may require each carrier and
23 third party administrator to file with the department an annual
24 reconciliation return.
25 (2) If a due date falls on a Saturday, Sunday, state holiday,
26 or legal banking holiday, the returns and assessments are due on
27 the next succeeding business day.

1 (3) The department may require that payment of the assessment
2 be made by an electronic funds transfer method approved by the
3 department.
4 Sec. 5. (1) A carrier or third party administrator liable for
5 an assessment under this act shall keep accurate and complete
6 records and pertinent documents as required by the department.
7 Records required by the department shall be retained for a period
8 of 4 years after the assessment imposed under this act to which the
9 records apply is due or as otherwise provided by law.
10 (2) If the department considers it necessary, the department
11 may require a person, by notice served upon that person, to make a
12 return, render under oath certain statements, or keep certain
13 records the department considers sufficient to show whether that
14 person is liable for the assessment under this act.
15 (3) If a carrier or third party administrator fails to file a
16 return or keep proper records as required under this section, or if
17 the department has reason to believe that any records kept or
18 returns filed are inaccurate or incomplete and that additional
19 assessments are due, the department may assess the amount of the
20 assessment due from the carrier or third party administrator based
21 on information that is available or that may become available to
22 the department. An assessment under this subsection is considered
23 prima facie correct under this act, and a carrier or third party
24 administrator has the burden of proof for refuting the assessment.
25 Sec. 6. (1) The department shall administer the assessment
26 imposed under this act under 1941 PA 122, MCL 205.1 to 205.31, and
27 this act. If 1941 PA 122, MCL 205.1 to 205.31, and this act

1 conflict, the provisions of this act apply. The assessment imposed
2 under this act shall be considered a tax for the purpose of 1941 PA
3 122, MCL 205.1 to 205.31.
4 (2) The department is authorized to promulgate rules to
5 implement this act under the administrative procedures act of 1969,
6 1969 PA 306, MCL 24.201 to 24.328.
7 (3) The assessment imposed under this act shall not be
8 considered an assessment or burden for purposes of the tax, or as a
9 credit toward or payment in lieu of the tax under section 476a of
10 the insurance code of 1956, 1956 PA 218, MCL 500.476a.
11 (4) The department shall submit an annual report to the state
12 budget director and the senate and house of representatives
13 standing committees on appropriations not later than 120 days after
14 the January thirtieth quarterly filing that states the amount of
15 revenue received under this act for the immediately preceding
16 calendar year.
17 Sec. 7. (1) All money received and collected under this act
18 shall be deposited by the department in the health insurance claims
19 assessment fund established in this section.
20 (2) The health insurance claims assessment fund is created
21 within the department.
22 (3) The state treasurer may receive money or other assets from
23 any of the following sources for deposit into the fund:
24 (a) Money received by the department under this act.
25 (b) Interest and earnings from fund investments. The state
26 treasurer shall direct the investment of the fund. The state
27 treasurer shall credit to the fund interest and earnings from fund

1 investments.
2 (c) Donations of money made to the fund from any source.
3 (4) Money in the fund at the close of the fiscal year shall
4 remain in the fund and shall not lapse to the general fund and
5 shall remain available after this act is repealed January 1, 2014
6 to pay any remaining credits or refunds due under section 3(6)
7 until all pending appeals and claims are resolved.
8 (5) Except as otherwise provided in this act, the department
9 shall transfer money from the fund, upon appropriation in the
10 respective departments, only for the following:
11 (a) To finance the expenditures of medicaid managed care
12 organizations that include medicaid contracted health plans and
13 specialty prepaid health plans.
14 (b) To pay any credits or refunds due under section 3(6).
15 Sec. 8. There is appropriated to the department for the 2010-
16 2011 state fiscal year $1,000,000.00 to begin implementing the
17 requirements of this act. Any portion of the amount appropriated
18 under this section that is not expended in the 2010-2011 state
19 fiscal year shall not lapse to the general fund but shall be
20 carried forward in a work project account that is in compliance
21 with section 451a of the management and budget act, 1984 PA 431,
22 MCL 18.1451a, for the following state fiscal year.
23 Sec. 9. (1) For administration and compliance requirements
24 created by this act, in the 2011-2012 state fiscal year and each
25 fiscal year thereafter, the department shall receive from the
26 health insurance claims assessment fund created in section 7 an
27 amount not to exceed 1% of the annual remittances under this act in

1 the 2011-2012 state fiscal year, subject to annual appropriation by
2 the legislature.
3 (2) Not later than March 1 of each year, the department shall
4 report to the appropriations committees of the house of
5 representatives and the senate and to the house and senate fiscal
6 agencies the costs incurred for administration and compliance
7 requirements as of the end of the immediately preceding state
8 fiscal year.
9 Sec. 10. The department shall provide the commissioner with
10 written notice of any final determination that a carrier or a third
11 party administrator has failed to pay an assessment, interest, or
12 penalty when due. The commissioner may suspend or revoke, after
13 notice and hearing, the certificate of authority to transact
14 insurance in this state, or the license to operate in this state,
15 of any carrier or third party administrator that fails to pay an
16 assessment, interest, or penalty due under this act. A certificate
17 of authority to transact insurance in this state or a license to
18 operate in this state that is suspended or revoked under this
19 section shall not be reinstated unless any delinquent assessment,
20 interest, or penalty has been paid.
21 Sec. 11. The department shall develop and implement a
22 dashboard to provide information to the citizens of this state,
23 which dashboard shall include, but is not limited to, the amount of
24 revenue collected from carriers and third party administrators
25 subject to the assessment levied under this act.
26 Enacting section 1. This act does not take effect unless
27 Senate Bill No. 347 of the 96th Legislature is enacted into law.

1 Enacting section 2. This act is repealed effective January 1,
2 2014.