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:

Sec. 1. This act shall be known and may be cited as the "health insurance claims assessment act".

Sec. 2. As used in this act:

(a) "Carrier" means any of the following:

(*i*) An insurer or health maintenance organization regulated under the insurance code of 1956, 1956 PA 218, MCL 500.100 to

500.8302.

(*ii*) A health care corporation regulated under the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1101 to 550.1704.

(*iii*) A nonprofit dental care corporation subject to 1963 PA 125, MCL 550.351 to 550.373.

(*iv*) A specialty prepaid health plan as described in section 109f of the social welfare act, 1939 PA 280, MCL 400.109f.

(*v*) A group health plan sponsor including, but not limited to, 1 or more of the following:

(A) An employer if a group health plan is established or maintained by a single employer.

(B) An employee organization if a plan is established or maintained by an employee organization.

(C) If a plan is established or maintained by 2 or more employers or jointly by 1 or more employers and 1 or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties that establish or maintain the plan.

(b) "Claims-related expenses" means all of the following:

(*i*) Cost containment expenses including, but not limited to, payments for utilization review, care or case management, disease management, medication review management, risk assessment, and similar administrative services intended to reduce the claims paid for health and medical services rendered to covered individuals by attempting to ensure that needed services are delivered in the most efficacious manner possible or by helping those covered individuals

maintain or improve their health.

(*ii*) Payments that are made to or by an organized group of health and medical service providers in accordance with managed care risk arrangements or network access agreements, which payments are unrelated to the provision of services to specific covered individuals.

(*iii*) General administrative expenses.

(c) "Commissioner" means the commissioner of the office of financial and insurance regulation or his or her designee.

(d) "Department" means the department of treasury.

(e) "Excess loss" or "stop loss" means coverage that provides insurance protection against the accumulation of total claims exceeding a stated level for a group as a whole or protection against a high-dollar claim on any 1 individual.

(f) "Federal employee health benefit program" means the program of health benefits plans, as defined in 5 USC 8901, available to federal employees under 5 USC 8901 to 8914.

(g) "Fund" means the health insurance claims assessment fund created in section 7.

(h) "Group health plan" means an employee welfare benefit plan as defined in section 3(1) of subtitle A of title I of the employee retirement income security act of 1974, Public Law 93-406, 29 USC 1002, to the extent that the plan provides medical care, including items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.

(i) "Group insurance coverage" means a form of voluntary

health and medical services insurance that covers members, with or without their eligible dependents, and that is written under a master policy.

(j) "Health and medical services" means 1 or more of the following:

(*i*) Services included in furnishing medical care, dental care, pharmaceutical benefits, or hospitalization, including, but not limited to, services provided in a hospital or other medical facility.

(*ii*) Ancillary services, including, but not limited to, ambulatory services and emergency and nonemergency transportation.

(*iii*) Services provided by a physician or other practitioner, including, but not limited to, health professionals, other than veterinarians, marriage and family therapists, athletic trainers, massage therapists, licensed professional counselors, and sanitarians, as defined by article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838.

(*iv*) Behavioral health services, including, but not limited to, mental health and substance abuse services.

(k) "Managed care risk arrangement" means an arrangement where participating hospitals and physicians agree to a managed care risk incentive which shares favorable and unfavorable claims experience. Under a managed care risk arrangement, payment to a participating physician is generally subject to a retention requirement and the distribution of that retained payment is contingent on the result of the risk incentive arrangement.

(*l*) "Medicare" means the federal medicare program established

under title XVIII of the social security act, 42 USC 1395 to 1395kkk-1.

(m) "Medicare advantage plan" means a plan of coverage for health benefits under part C of title XVIII of the social security act, 42 USC 1395w-21 to 1395w-29.

(n) "Medicare part D" means a plan of coverage for prescription drug benefits under part D of title XVIII of the social security act, 42 USC 1395w-101 to 1395w-152.

(o) "Network access agreement" means an agreement that allows a network access to another provider network for certain services that are not readily available in the accessing network.

(p) "Paid claims" means actual payments, net of recoveries, made to a health and medical services provider or reimbursed to an individual by a carrier, third party administrator, or excess loss or stop loss carrier. Paid claims include payments, net of recoveries, made under a service contract for administrative services only, cost-plus or noninsured benefit plan arrangements under section 211 of the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1211, or section 5208 of the insurance code of 1956, 1956 PA 218, MCL 500.5208, for health and medical services provided under group health plans, and individual, nongroup, and group insurance coverage to residents of this state in this state that affect the rights of an insured in this state and bear a reasonable relation to this state, regardless of whether the coverage is delivered, renewed, or issued for delivery in this state. If a carrier or a third party administrator is contractually entitled to withhold a certain amount from payments due to

providers of health and medical services in order to help ensure that the providers can fulfill any financial obligations they may have under a managed care risk arrangement, the full amounts due the providers before that amount is withheld shall be included in paid claims. Paid claims include claims or payments made under any federally approved waiver or initiative to integrate medicare and medicaid funding for dual eligibles under the patient protection and affordable care act, Public Law 111-148, and the health care and reconciliation act of 2010, Public Law 111-152. Paid claims do not include any of the following:

(*i*) Claims-related expenses.

(*ii*) Payments made to a qualifying provider under an incentive compensation arrangement if the payments are not reflected in the processing of claims submitted for services rendered to specific covered individuals.

(*iii*) Claims paid by carriers or third party administrators for specified accident, accident-only coverage, credit, disability income, long-term care, health-related claims under automobile insurance, homeowners insurance, farm owners, commercial multi-peril, and worker's compensation, or coverage issued as a supplement to liability insurance.

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

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

(*vi*) Claims paid for services rendered outside of this state to

a person who is a resident of this state.

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

(*viii*) Reimbursements to individuals under a flexible spending arrangement as that term is defined in section 106(c)(2) of the internal revenue code, 26 USC 106, a health savings account as that term is defined in section 223 of the internal revenue code, 26 USC 223, an Archer medical savings account as defined in section 220 of the internal revenue code, 26 USC 220, a medicare advantage medical savings account as that term is defined in section 138 of the internal revenue code, 26 USC 138, and a health reimbursement account.

(*ix*) Health and medical services costs paid by an individual for cost-sharing requirements, including deductibles, coinsurance, or copays.

(q) "Qualifying provider" means a provider that is paid based on an incentive compensation arrangement.

(r) "Third party administrator" means an entity that processes claims under a service contract and that may also provide 1 or more other administrative services under a service contract.

Sec. 3. (1) For dates of service beginning on or after January 1, 2012, subject to subsections (2) and (3), there is levied upon and there shall be collected from every carrier and third party

administrator an assessment on that carrier's or third party administrator's paid claims at the following rate:

(a) In 2012, 1%.

(b) In 2013 and each year thereafter, except as otherwise provided in this subdivision, the rate levied in the immediately preceding year. However, if the department of treasury determines that the rate levied in the immediately preceding year collected revenue in an amount greater than 110% of $400,000,000.00, as annually adjusted for the medical inflation rate, the department of treasury shall reduce the rate to a rate that would have generated for the immediately preceding year revenue equal to 103% of $400,000,000.00, as annually adjusted for the medical inflation rate, which assessment rate shall not be greater than 1%. In 2013 only, the rate levied in the immediately preceding year shall be adjusted downward to reflect any amount collected in excess of $400,000,000.00.

(2) A carrier with a suspension or exemption under section 3717 of the insurance code of 1956, 1956 PA 218, MCL 500.3717, on the effective date of this act is subject to an assessment of 0.1%.

(3) All of the following apply to a group health plan that uses the services of a third party administrator or excess loss or stop loss insurer:

(a) A group health plan sponsor shall not be responsible for an assessment under this subsection for a paid claim where the assessment on that claim has been paid by a third party administrator or excess loss or stop loss insurer.

(b) Except as otherwise provided in subdivision (d), the third

party administrator shall be responsible for all assessments on paid claims paid by the third party administrator.

(c) Except as otherwise provided in subdivision (d), the excess loss or stop loss insurer shall be responsible for all assessments on paid claims paid by the excess loss or stop loss insurer.

(d) If there is both a third party administrator and an excess loss or stop loss insurer servicing the group health plan, the third party administrator shall be responsible for all assessments for paid claims that are not reimbursed by the excess loss or stop loss insurer and the excess loss or stop loss insurer shall be responsible for all assessments for paid claims that are reimbursable to the excess loss or stop loss insurer.

(4) To the extent an assessment paid under this section for paid claims for a group plan or individual subscriber is inaccurate due to subsequent claim adjustments or recoveries, subsequent filings shall be adjusted to accurately reflect the correct assessment based on actual claims paid.

(5) As used in this section, "medical inflation rate" means that rate determined by the annual national health expenditures accounts report issued by the federal center for medicare and medicaid, office of the actuary.

Sec. 3a. (1) A carrier that is required to file rates or file for approval rates with the commissioner is not required to file rates in order to collect the assessment levied under this act from an individual or group. The collected amount shall not be considered an element or factor of a rate.

(2) A carrier or third party administrator shall develop and implement a methodology by which it will collect the assessment levied under this act from an individual, employer, or group health plan, subject to all of the following:

(a) Any methodology shall be applied uniformly within a line of business.

(b) Except as provided in subdivision (d), health status or claims experience of an individual or group shall not be an element or factor of any methodology to collect the assessment from that individual or group.

(c) The amount collected from individuals and groups with insured coverage shall be determined as a percentage of premium.

(d) The amount collected from groups with uninsured or self-funded coverage shall be determined as a percentage of actual paid claims.

(e) The amount collected shall reflect only the assessment levied under this act, and shall not include any additional amounts such as related administrative expenses.

(f) A carrier shall notify the commissioner of the methodology used for the collection of the assessment levied under this act.

Sec. 4. (1) Every carrier and third party administrator with paid claims subject to the assessment under this act shall file with the department on April 15, July 15, October 15, and January 15 of each year a return for the preceding calendar quarter, in a form prescribed by the department, showing all information that the department considers necessary for the proper administration of this act. At the same time, each carrier and third party

administrator shall pay to the department the amount of the assessment imposed under this act with respect to the paid claims included in the return.

(2) If a due date falls on a Saturday, Sunday, state holiday, or legal banking holiday, the returns and assessments are due on the next succeeding business day.

(3) The department may require that payment of the assessment be made by an electronic funds transfer method approved by the department.

Sec. 5. (1) A carrier or third party administrator liable for an assessment under this act shall keep accurate and complete records and pertinent documents as required by the department. Records required by the department shall be retained for a period of 4 years after the assessment imposed under this act to which the records apply is due or as otherwise provided by law.

(2) If the department considers it necessary, the department may require a person, by notice served upon that person, to make a return, render under oath certain statements, or keep certain records the department considers sufficient to show whether that person is liable for the assessment under this act.

(3) If a carrier or third party administrator fails to file a return or keep proper records as required under this section, or if the department has reason to believe that any records kept or returns filed are inaccurate or incomplete and that additional assessments are due, the department may assess the amount of the assessment due from the carrier or third party administrator based on information that is available or that may become available to

the department. An assessment under this subsection is considered prima facie correct under this act, and a carrier or third party administrator has the burden of proof for refuting the assessment.

Sec. 6. (1) The department shall administer the assessment imposed under this act under 1941 PA 122, MCL 205.1 to 205.31, and this act. If 1941 PA 122, MCL 205.1 to 205.31, and this act conflict, the provisions of this act apply. The assessment imposed under this act shall be considered a tax for the purpose of 1941 PA 122, MCL 205.1 to 205.31.

(2) The department is authorized to promulgate rules to implement this act under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328.

(3) The assessment imposed under this act shall not be considered an assessment or burden for purposes of the tax, or as a credit toward or payment in lieu of the tax under section 476a of the insurance code of 1956, 1956 PA 218, MCL 500.476a.

(4) The department shall submit an annual report to the state budget director and the senate and house of representatives standing committees on appropriations not later than 120 days after the January fifteenth quarterly filing that states the amount of revenue received under this act for the immediately preceding calendar year.

Sec. 7. (1) All money received and collected under this act shall be deposited by the department in the health insurance claims assessment fund established in this section.

(2) The health insurance claims assessment fund is created within the department.

(3) The state treasurer may receive money or other assets from any of the following sources for deposit into the fund:

(a) Money received by the department under this act.

(b) Interest and earnings from fund investments. The state treasurer shall direct the investment of the fund. The state treasurer shall credit to the fund interest and earnings from fund investments.

(c) Donations of money made to the fund from any source.

(4) Money in the fund at the close of the fiscal year shall remain in the fund and shall not lapse to the general fund.

(5) Except as otherwise provided in this act, the department of treasury shall transfer money from the fund, upon appropriation in the respective departments, only for 1 or more of the following purposes:

(a) To finance medicaid program expenditures, including actuarial soundness for carriers with contracts under sections 106(2)(a) and 109f(2) of the social welfare act, 1939 PA 280, MCL 400.106 and 400.109f, consistent with federal requirements under 42 CFR 438.6.

(b) To finance a shortfall in the medicaid program resulting from disallowance of medicaid payments from the federal government.

(c) To offset any decline in revenue or increase in expenditures caused by federal medicaid policy change.

(d) To finance graduate medical education programs.

(e) To reimburse for uncompensated health and medical care.

(f) To finance activities to identify and eliminate fraud, waste, and abuse in the medicaid system.

(g) To finance department of community health or office of financial and insurance regulation expenditures incurred to implement, enforce, or otherwise carry out the responsibilities of this act.

Sec. 8. There is appropriated to the department of treasury for the 2010-2011 state fiscal year $1,000,000.00 to begin implementing the requirements of this act. Any portion of the amount appropriated under this section that is not expended in the 2010-2011 state fiscal year shall not lapse to the general fund but shall be carried forward in a work project account that is in compliance with section 451a of the management and budget act, 1984 PA 431, MCL 18.1451a, for the following state fiscal year.

Sec. 9. For administration and compliance requirements created by this act, in the 2011-2012 state fiscal year and each fiscal year thereafter, the department of treasury shall receive from the health insurance claims assessment fund created in section 7 an amount not to exceed 1% of the annual remittances under this act in the 2011-2012 state fiscal year, subject to annual appropriation by the legislature.

Sec. 10. The department shall provide the commissioner with written notice of any final determination that a carrier or a third party administrator has failed to pay an assessment, interest, or penalty when due. The commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state, or the license to operate in this state, of any carrier or third party administrator that fails to pay an assessment, interest, or penalty due under this act. A certificate

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of authority to transact insurance in this state or a license to operate in this state that is suspended or revoked under this section shall not be reinstated unless any delinquent assessment, interest, or penalty has been paid.

<<Sec. 11. The department of treasury shall develop and implement a dashboard to provide information to the citizens of this state, which dashboard shall include, but is not limited to, the level of compliance, effectiveness, and efficiency of carriers subject to the assessment levied under this act.>>

Enacting section 1. This act does not take effect unless Senate Bill No. 347 of the 96th Legislature is enacted into law.

Enacting section 2. This act is repealed effective January 1, 2016.