HEALTH INSURANCE CLAIMS ASSESSMENT ACT (EXCERPT)
Act 142 of 2011

***** *550.1732 THIS SECTION IS REPEALED BY ACT 173 OF 2018 EFFECTIVE: See MCL 550.1731a* *****

550.1732 Definitions.

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.

(*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*) "Medicaid contracted health plan" means that term as defined in section 106 of the social welfare act, 1939 PA 280, MCL 400.106.

(m) "Medicaid managed care organization" means a medicaid contracted health plan or a specialty prepaid health plan.

(n) "Medical inflation rate" means that rate determined by the annual national health expenditures accounts report issued by the federal centers for medicare and medicaid services, office of the actuary.

(o) "Medicare" means the federal medicare program established under title XVIII of the social security act, 42 USC 1395 to 1395kkk-1.

(p) "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.

(q) "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.

(r) "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.

(s) "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, any claims for service in this state by a pharmacy benefits manager, 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 education 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, or other health reimbursement arrangement authorized under federal law.

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

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

(u) "Specialty prepaid health plan" means that term as described in section 109f of the social welfare act, 1939 PA 280, MCL 400.109f.

(v) "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.

History: 2011, Act 142, Imd. Eff. Sept. 20, 2011.

Compiler's note: For references to office of financial and insurance regulation to be deemed as department of insurance and financial services, and abolishment of office of financial and insurance regulation, see E.R.O. No. 2013-1, compiled at MCL 550.991.

For references to commissioner of office of financial and insurance regulation to be deemed as references to director of department of insurance and financial services, and abolishment of office of commissioner of office of financial and insurance regulation, see E.R.O. No. 2013-1, compiled at MCL 550.991.

Enacting section 2 of Act 142 of 2011 provides:

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

Enacting section 2 of Act 58 of 2013 provides:

"Enacting section 2. This act is repealed effective January 1, 2018."

Enacting section 1 of Act 50 of 2016 provides:

"Enacting section 1. Enacting section 2 of 2011 PA 142, as amended by 2013 PA 58, is repealed."