SENATE BILL No. 348

April 27, 2011, Introduced by Senator KAHN and referred to the Committee on Appropriations.

A bill to impose a tax 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; and to impose certain remedies and penalties.

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:
5 (*i*) An insurer or health maintenance organization regulated
6 under the insurance code of 1956, 1956 PA 218, MCL 500.100 to
7 500.8302.
8 (*ii*) A health care corporation regulated under the nonprofit

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1 health care corporation reform act, 1980 PA 350, MCL 550.1101 to
2 550.1704.
3 (*iii*) A nonprofit dental care corporation subject to 1963 PA
4 125, MCL 550.351 to 550.373.
5 (*iv*) A specialty prepaid health plan as described in section
6 109f of the social welfare act, 1939 PA 280, MCL 400.109f.
7 (*v*) A group health plan sponsor including, but not limited to,
8 1 or more of the following:
9 (A) An employer if a group health plan is established or
10 maintained by a single employer.
11 (B) An employee organization if a plan is established or
12 maintained by an employee organization.
13 (C) If a plan is established or maintained by 2 or more
14 employers or jointly by 1 or more employers and 1 or more employee
15 organizations, the association, committee, joint board of trustees,
16 or other similar group of representatives of the parties that
17 establish or maintain the plan.
18 (b) "Claims-related expenses" means all of the following:
19 (*i*) Cost containment expenses including, but not limited to,
20 payments for utilization review, care management, disease
21 management, risk assessment, and similar administrative services
22 intended to reduce the claims paid for health and medical services
23 rendered to covered individuals by attempting to ensure that needed
24 services are delivered in the most efficacious manner possible or
25 by helping those covered individuals maintain or improve their
26 health.
27 (*ii*) Payments that are made to or by an organized group of

1 health and medical service providers in accordance with managed
2 care risk arrangements or network access agreements, which payments
3 are unrelated to the provision of services to specific covered
4 individuals.

5 (*iii*) General administrative expenses.

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

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

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

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

15 (g) "Group health plan" means an employee welfare benefit plan
16 as defined in section 3(1) of subtitle A of title I of the employee
17 retirement income security act of 1974, Public Law 93-406, 29 USC
18 1002, to the extent that the plan provides medical care, including
19 items and services paid for as medical care to employees or their
20 dependents as defined under the terms of the plan directly or
21 through insurance, reimbursement, or otherwise.

22 (h) "Group insurance coverage" means a form of voluntary
23 health and medical services insurance that covers members, with or
24 without their eligible dependents, and that is written under a
25 master policy.

26 (i) "Health and medical services" means 1 or more of the
27 following:

1 (*i*) Services included in furnishing medical care, dental care,
2 pharmaceutical benefits, or hospitalization, including, but not
3 limited to, services provided in a hospital or other medical
4 facility.
5 (*ii*) Ancillary services, including, but not limited to,
6 ambulatory services.
7 (*iii*) Services provided by a physician or other practitioner,
8 including, but not limited to, health professionals defined by
9 article 15 of the public health code, 1978 PA 368, MCL 333.16101 to
10 333.18838.
11 (*iv*) Behavioral health services, including, but not limited to,
12 mental health and substance abuse services.
13 (j) "Managed care risk arrangement" means an arrangement where
14 participating hospitals and physicians agree to a managed care risk
15 incentive which shares favorable and unfavorable claims experience.
16 Under a managed care risk arrangement, payment to a participating
17 physician is generally subject to a retention requirement and the
18 distribution of that retained payment is contingent on the result
19 of the risk incentive arrangement.
20 (k) "Network access agreement" means an agreement that allows
21 a network access to another provider network for certain services
22 that are not readily available in the accessing network.
23 (*l*) "Paid claims" means actual payments made to a health and
24 medical services provider or reimbursed to an individual by a third
25 party administrator, excess loss or stop loss carrier, a property
26 or casualty carrier, or a carrier. Paid claims include payments
27 made under a service contract for administrative services only,

1 cost-plus or noninsured benefit plan arrangements under section 211
2 of the nonprofit health care corporation reform act, 1980 PA 350,
3 MCL 550.1211, or section 5208 of the insurance code of 1956, 1956
4 PA 218, MCL 500.5208, for health and medical services provided
5 under group health plans, and individual, nongroup and group
6 insurance coverage delivered, issued for delivery, or renewed in
7 this state that affect the rights of an insured in this state and
8 bear a reasonable relation to this state, regardless of whether the
9 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 do not include any of the following:
17 (*i*) Claims-related expenses.
18 (*ii*) Payments made to a qualifying provider under an incentive
19 compensation arrangement if the payments are not reflected in the
20 processing of claims submitted for services rendered to specific
21 covered individuals.
22 (*iii*) Claims paid by carriers or third party administrators for
23 vision, specified accident, specified disease, accident-only
24 coverage, credit, disability income, long-term care, or medicare
25 supplement.
26 (*iv*) Claims paid for services rendered to a nonresident of this
27 state.

1 (*v*) The proportionate share of claims paid for services
2 rendered to a person covered under a health benefit plan for
3 federal employees.
4 (*vi*) Claims paid for services rendered outside of this state to
5 a person who is a resident of this state.
6 (*vii*) Claims paid under medicare, medicare advantage, tricare,
7 and by the United States veterans administration.
8 (*viii*) Reimbursements to individuals under a flexible spending
9 arrangement as that term is defined in section 106(c)(2) of the
10 internal revenue code, 26 USC 106, a health savings account as that
11 term is defined in section 223 of the internal revenue code, 26 USC
12 223, an Archer medical savings account as defined in section 220 of
13 the internal revenue code, 26 USC 220, and a medicare advantage
14 medical savings account as that term is defined in section 138 of
15 the internal revenue code, 26 USC 138.
16 (*ix*) Health and medical services costs paid by an individual
17 for cost-sharing requirements, including deductibles or copays.
18 (m) "Qualifying provider" means a provider that is paid based
19 on an incentive compensation arrangement.
20 (n) "Third party administrator" means an entity that processes
21 claims under a service contract and that may also provide 1 or more
22 other administrative services under a service contract.
23 Sec. 3. Beginning October 1, 2011, there is levied upon and
24 there shall be collected from every carrier and third party
25 administrator in this state an assessment equal to 1% of that
26 carrier's or third party administrator's paid claims.
27 Sec. 4. (1) Every carrier and third party administrator with

1 paid claims subject to the assessment under this act shall file
2 with the department on or before the fifteenth day of each calendar
3 month a return for the preceding calendar month, in a form
4 prescribed by the department, showing all information that the
5 department considers necessary for the proper administration of
6 this act. At the same time, each carrier and third party
7 administrator shall pay to the department the amount of the
8 assessment imposed under this act with respect to the paid claims
9 included in the return.
10 (2) The assessment imposed under this act shall accrue to this
11 state on the last day of each calendar month.
12 (3) If a due date falls on a Saturday, Sunday, state holiday,
13 or legal banking holiday, the returns and assessments are due on
14 the next succeeding business day.
15 (4) The department, if necessary to ensure payment of the
16 assessment or to provide a more efficient administration, may
17 require the filing of returns and payment of the assessment for
18 other than monthly periods.
19 (5) The department may require that payment of the assessment
20 be made by an electronic funds transfer method approved by the
21 department.
22 Sec. 5. (1) A carrier or third party administrator liable for
23 an assessment under this act shall keep accurate and complete
24 records and pertinent documents as required by the department.
25 Records required by the department shall be retained for a period
26 of 4 years after the assessment imposed under this act to which the
27 records apply is due or as otherwise provided by law.

1 (2) If the department considers it necessary, the department
2 may require a person, by notice serviced upon that person, to make
3 a return, render under oath certain statements, or keep certain
4 records the department considers sufficient to show whether that
5 person is liable for the assessment under this act.
6 (3) If a carrier or third party administrator fails to file a
7 return or keep proper records as required under this section, or if
8 the department has reason to believe that any records kept or
9 returns filed are inaccurate or incomplete and that additional
10 assessments are due, the department may assess the amount of the
11 assessment due from the carrier or third party administrator based
12 on information that is available or that may become available to
13 the department. An assessment under this subsection is considered
14 prima facie correct under this act, and a carrier or third party
15 administrator has the burden of proof for refuting the assessment.
16 Sec. 6. (1) The department shall administer the assessment
17 imposed under this act under 1941 PA 122, MCL 205.1 to 205.31, and
18 this act. If 1941 PA 122, MCL 205.1 to 205.31, and this act
19 conflict, the provisions of this act apply. The assessment imposed
20 under this act shall be considered a tax for the purpose of 1941 PA
21 122, MCL 205.1 to 205.31.
22 (2) The department is authorized to promulgate rules to
23 implement this act under the administrative procedures act of 1969,
24 1969 PA 306, MCL 24.201 to 24.328.
25 (3) The assessment imposed under this act shall not be
26 considered an assessment or burden for purposes of the tax, or as a
27 credit toward or payment in lieu of the tax under section 476a of

1 the insurance code of 1956, 1956 PA 218, MCL 500.476a.
2 Sec. 7. (1) All money received and collected under this act
3 shall be deposited by the department in the health insurance claims
4 assessment fund established in this section.
5 (2) The health insurance claims assessment fund is created
6 within the department.
7 (3) The state treasurer may receive money or other assets from
8 any of the following sources for deposit into the fund:
9 (a) Money received by the department under this act.
10 (b) Interest and earnings from fund investments. The state
11 treasurer shall direct the investment of the fund. The state
12 treasurer shall credit to the fund interest and earnings from fund
13 investments.
14 (c) Donations of money made to the fund from any source.
15 (4) Money in the fund at the close of the fiscal year shall
16 remain in the fund and shall not lapse to the general fund.
17 (5) The department of treasury shall be the administrator of
18 the fund for auditing purposes.
19 (6) Except as otherwise provided in this act, the department
20 of treasury shall expend money from the fund, upon appropriation,
21 only for 1 or more of the following purposes:
22 (a) To finance medicaid program expenditures.
23 (b) To finance a shortfall in the medicaid program resulting
24 from disallowance of medicaid payments from the federal government.
25 (c) To offset any decline in revenue or increase in
26 expenditures caused by federal medicaid policy change.
27 (d) To finance department of community health or office of

1 financial and insurance regulation expenditures incurred to
2 implement, enforce, or otherwise carry out the responsibilities of
3 this act.
4 Sec. 8. An amount equal to 1% of the annual remittances of
5 assessments shall be retained by the department to implement and
6 administer this act.
7 Sec. 9. The department shall provide the commissioner with
8 written notice of any final determination that a carrier or a third
9 party administrator has failed to pay an assessment, interest, or
10 penalty when due. The commissioner may suspend or revoke, after
11 notice and hearing, the certificate of authority to transact
12 insurance in this state, or the license to operate in this state,
13 of any carrier or third party administrator that fails to pay an
14 assessment, interest, or penalty due under this act. A certificate
15 of authority to transact insurance in this state or a license to
16 operate in this state that is suspended or revoked under this
17 section shall not be reinstated unless any delinquent assessment,
18 interest, or penalty has been paid.
19 Enacting section 1. This act does not take effect unless
20 Senate Bill No. 347
21 of the 96th Legislature is enacted into law.