

SENATE BILL No. 96

February 2, 2017, Introduced by Senators SCHMIDT, NOFS and JONES and referred to the Committee on Insurance.

A bill to amend 2011 PA 142, entitled
"Health insurance claims assessment act,"
by amending section 2 (MCL 550.1732) and by adding section 2a.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

1 Sec. 2. As used in this act:

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

3 (i) An insurer or health maintenance organization regulated
4 under the insurance code of 1956, 1956 PA 218, MCL 500.100 to
5 500.8302.

6 (ii) A health care corporation regulated under the nonprofit
7 health care corporation reform act, 1980 PA 350, MCL 550.1101 to
8 550.1704.

9 (iii) A nonprofit dental care corporation subject to 1963 PA
10 125, MCL 550.351 to 550.373.

11 (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.~~**DIRECTOR.**

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

**(E) "DIRECTOR" MEANS THE DIRECTOR OF THE DEPARTMENT OF
INSURANCE AND FINANCIAL SERVICES OR HIS OR HER DESIGNEE.**

(F) ~~(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.

(G) ~~(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.

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

(I) ~~(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.

(J) ~~(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.

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

(i) Services included in furnishing medical care, dental care,

1 pharmaceutical benefits, or hospitalization, including, but not
2 limited to, services provided in a hospital or other medical
3 facility.

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

6 (iii) Services provided by a physician or other practitioner,
7 including, but not limited to, health professionals, other than
8 veterinarians, marriage and family therapists, athletic trainers,
9 massage therapists, licensed professional counselors, and
10 sanitarians, as defined by article 15 of the public health code,
11 1978 PA 368, MCL 333.16101 to 333.18838.

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

14 (I) ~~(k)~~—"Managed care risk arrangement" means an arrangement
15 ~~where~~ **BY WHICH** participating hospitals and physicians agree to a
16 managed care risk incentive ~~which~~ **THAT** shares favorable and
17 unfavorable claims experience. Under a managed care risk
18 arrangement, payment to a participating physician is generally
19 subject to a retention requirement and the distribution of that
20 retained payment is contingent on the result of the risk incentive
21 arrangement.

22 (M) ~~(l)~~—"Medicaid contracted health plan" means **A CONTRACTED**
23 **HEALTH PLAN AS** that term ~~as~~ **IS** defined in section 106 of the social
24 welfare act, 1939 PA 280, MCL 400.106.

25 (N) ~~(m)~~—"Medicaid managed care organization" means a ~~medicaid~~
26 **MEDICAID** contracted health plan or a specialty prepaid health plan.

27 (O) ~~(n)~~—"Medical inflation rate" means that rate determined by

1 the annual national health expenditures accounts report issued by
 2 the federal ~~centers~~**CENTERS** for ~~medicare~~**MEDICARE** and ~~medicaid~~
 3 ~~services, office~~**MEDICAID SERVICES, OFFICE** of the ~~actuary~~**.ACTUARY.**

4 (P) ~~(e)~~"Medicare" means the federal ~~medicare~~**MEDICARE** program
 5 established under title XVIII of the social security act, 42 USC
 6 1395 to ~~1395kkk-1~~**1395///.**

7 (Q) ~~(p)~~"Medicare advantage plan" means a plan of coverage for
 8 health benefits under part C of title XVIII of the social security
 9 act, 42 USC 1395w-21 to ~~1395w-29~~**1395W-28.**

10 (R) ~~(q)~~"Medicare part D" means a plan of coverage for
 11 prescription drug benefits under part D of title XVIII of the
 12 social security act, 42 USC 1395w-101 to ~~1395w-152~~**1395W-154.**

13 (S) **"MICHIGAN INDIAN TRIBE" MEANS A FEDERALLY RECOGNIZED**
 14 **INDIAN TRIBE THAT HAS TRUST LANDS LOCATED WITHIN THIS STATE.**

15 (T) ~~(r)~~"Network access agreement" means an agreement that
 16 allows a network access to another provider network for certain
 17 services that are not readily available in the accessing network.

18 (U) ~~(s)~~"Paid claims" means actual payments, net of
 19 recoveries, made to a health and medical services provider or
 20 reimbursed to an individual by a carrier, third party
 21 administrator, or excess loss or stop loss carrier. Paid claims
 22 include payments, net of recoveries, made under a service contract
 23 for administrative services only, cost-plus or noninsured benefit
 24 plan arrangements under section 211 of the nonprofit health care
 25 corporation reform act, 1980 PA 350, MCL 550.1211, or section 5208
 26 of the insurance code of 1956, 1956 PA 218, MCL 500.5208, for
 27 health and medical services provided under group health plans, any

1 claims for service in this state by a pharmacy benefits manager,
2 and individual, nongroup, and group insurance coverage to residents
3 of this state in this state that affect the rights of an insured in
4 this state and bear a reasonable relation to this state, regardless
5 of whether the coverage is delivered, renewed, or issued for
6 delivery in this state. If a carrier or a third party administrator
7 is contractually entitled to withhold a certain amount from
8 payments due to providers of health and medical services ~~in order~~
9 to help ensure that the providers can fulfill any financial
10 obligations they may have under a managed care risk arrangement,
11 the full amounts due the providers before that amount is withheld
12 ~~shall~~ **MUST** be included in paid claims. Paid claims include claims
13 or payments made under any federally approved waiver or initiative
14 to integrate ~~medicare~~ **MEDICARE** and ~~medicaid~~ **MEDICAID** funding for
15 dual eligibles under the patient protection and affordable care
16 act, Public Law 111-148, and the health care and education
17 reconciliation act of 2010, Public Law 111-152. Paid claims do not
18 include any of the following:

19 (i) Claims-related expenses.

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

24 (iii) Claims paid by carriers or third party administrators
25 for specified accident, accident-only coverage, credit, disability
26 income, long-term care, health-related claims under automobile
27 insurance, homeowners insurance, farm owners, commercial multi-

1 peril, and worker's compensation, or coverage issued as a
2 supplement to liability insurance.

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

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

8 (vi) Claims paid for services rendered outside of this state
9 to a person who is a resident of this state.

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

17 (viii) Reimbursements to individuals under a flexible spending
18 arrangement as that term is defined in section 106(c)(2) of the
19 internal revenue code **OF 1986**, 26 USC 106, a health savings account
20 as that term is defined in section 223 of the internal revenue code
21 **OF 1986**, 26 USC 223, an Archer ~~medical savings account~~ **MSA** as **THAT**
22 **TERM IS** defined in section 220 of the internal revenue code **OF**
23 **1986**, 26 USC 220, a ~~medicare~~ **MEDICARE** advantage ~~medical savings~~
24 ~~account~~ **MSA** as that term is defined in section 138 of the internal
25 revenue code **OF 1986**, 26 USC 138, or other health reimbursement
26 arrangement authorized under federal law.

27 (ix) Health and medical services costs paid by an individual

1 for cost-sharing requirements, including deductibles, coinsurance,
2 or copays.

3 (V) ~~(t)~~—"Qualifying provider" means a provider that is paid
4 based on an incentive compensation arrangement.

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

8 (X) ~~(v)~~—"Third party administrator" means an entity that
9 processes claims under a service contract and that may also provide
10 1 or more other administrative services under a service contract.

11 **SEC. 2A. THIS ACT DOES NOT APPLY TO CLAIMS PAID UNDER AN**
12 **EMPLOYEE HEALTH BENEFIT PROGRAM THAT IS MAINTAINED BY A MICHIGAN**
13 **INDIAN TRIBE.**

14 Enacting section 1. This amendatory act takes effect 90 days
15 after the date it is enacted into law.