AUTISM COVERAGE REIMBURSEMENT ACT
Act 101 of 2012

AN ACT to create an autism coverage reimbursement program to encourage insurance and health coverage providers to provide autism coverage; to impose certain duties on certain state departments, agencies, and officials; to create certain funds; to authorize certain expenditures; and to provide for an appropriation.

History: 2012, Act 101, Imd. Eff. Apr. 18, 2012.

Compiler's note: For transfer of autism coverage reimbursement program from department of licensing and regulatory affairs to department of insurance and financial services, see E.R.O. No. 2013-1, compiled at MCL 550.991.

The People of the State of Michigan enact:

550.1831 Short title.

Sec. 1. This act shall be known and may be cited as the "autism coverage reimbursement act".

History: 2012, Act 101, Imd. Eff. Apr. 18, 2012.

Compiler's note: For transfer of autism coverage reimbursement program from department of licensing and regulatory affairs to department of insurance and financial services, see E.R.O. No. 2013-1, compiled at MCL 550.991.

550.1833 Definitions.

Sec. 3. As used in this act:

(a) "Autism coverage reimbursement program" or "program" means the autism coverage reimbursement program created under section 5.

(b) "Autism diagnostic observation schedule", "autism spectrum disorders", "diagnosis of autism spectrum disorders", and "treatment of autism spectrum disorders" mean those terms as defined under section 416e of the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1416e, and section 3406s of the insurance code of 1956, 1956 PA 218, MCL 500.3406s.

(c) "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 specialty prepaid health plan.

(*iv*) 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.

(d) "Department" means the department of licensing and regulatory affairs.

(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 act" means the federal patient protection and affordable care act, Public Law 111-148, as amended by the federal health care and education reconciliation act of 2010, Public Law 111-152, and any regulations promulgated under those acts.

(g) "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) "Fund" means the autism coverage fund created in section 7.

(i) "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) "Medicaid" means the program of medical assistance established under title XIX of the social security act, 42 USC 1396 to 1396w-5.

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

(*l*) "Medicare advantage plan" means a plan of coverage for health benefits under part C of title XVIII of

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the social security act, 42 USC 1395w-21 to 1395w-28.

(m) "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-154.

(n) "Paid claims" means actual payments, net of recoveries, made for the diagnosis of autism spectrum disorders and treatment of autism spectrum disorders whether made to a provider or reimbursed to an individual by a carrier, third party administrator, or excess loss or stop loss carrier. Paid claims do not include any of the following:

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

(*ii*) Claims paid for services rendered to a person covered under a health benefit plan for federal employees.

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

(*iv*) Claims paid under a federal employee health benefit program, medicare, medicare advantage plan, medicare part D, tricare, by the United States veterans administration, and for high-risk pools established pursuant to the federal act.

(*v*) Costs paid by an individual for cost-sharing requirements, including deductibles, coinsurance, or copays.

(*vi*) Claims paid by, or on behalf of, this state.

(*vii*) Claims paid that are covered by medicaid.

(*viii*) Claims paid for which the carrier or third party administrator has already been reimbursed or compensated, in whole or in part, through any increase in premiums or rates or from any other source.

(*ix*) Beginning January 1, 2014, claims paid for services that are included in the essential health benefits as required pursuant to the federal act.

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

(p) "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: 2012, Act 101, Imd. Eff. Apr. 18, 2012.

Compiler's note: For transfer of autism coverage reimbursement program from department of licensing and regulatory affairs to department of insurance and financial services, see E.R.O. No. 2013-1, compiled at MCL 550.991.

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550.1835 Autism coverage reimbursement program; creation; operation; development of application, approval, and compliance process; forms; approval or denial of application; limitation on amount of coverage; receipt of funding by third party administrator; increase in rates by carrier.

Sec. 5. (1) No later than 120 days after the effective date of this act, the department shall create and operate an autism coverage reimbursement program to encourage carriers to provide coverage for the diagnosis of autism spectrum disorders and treatment of autism spectrum disorders and, to the extent coverage for the diagnosis of autism spectrum disorders and treatment of autism spectrum disorders is required under section 416e of the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1416e, or section 3406s of the insurance code of 1956, 1956 PA 218, MCL 500.3406s, to offset any additional costs that may be incurred as a result of the mandate.

(2) The department shall develop the application, approval, and compliance process necessary to operate and manage this program. The department shall develop and implement the use of an application form to be used by carriers and third party administrators who seek reimbursement for the coverage of autism spectrum disorders. The program standards, guidelines, templates, and any other forms used by the department to implement this program shall be published and available on the department's website.

(3) Subject to the limitations provided under this section, the program shall, as approved by the department, reimburse carriers and third party administrators in an amount equal to the amount of paid claims that are paid 180 days after the effective date of this act by the carrier or third party administrator. A carrier or third party administrator shall apply, on the form prescribed by the department, for approval of funding associated with paid claims. As part of the application, the applicant shall include the results from a completed autism diagnostic observation schedule or the results from any other annual development evaluation and documentation verifying those paid claims for which they are seeking reimbursement under this program. In determining whether to approve an application for the reimbursement of paid claims under this section, the department may review whether the treatment for which the paid claims were paid is consistent with current protocols and cost-containment practices as described in section 416e of the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1416e, or section 3406s of the insurance code of 1956, 1956 PA 218, MCL 500.3406s. The department shall review and consider applications in the order in

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which they are received and shall approve or deny an application within 30 days after receipt of the application.

(4) To the extent there is a cap on the amount of coverage mandated under section 416e of the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1416e, or section 3406s of the insurance code of 1956, 1956 PA 218, MCL 500.3406s, the department shall not approve more than the mandated amount to any carrier or third party administrator that seeks reimbursement under this act for paid claims.

(5) If a third party administrator receives any funding under this program, the third party administrator shall apply that funding to the benefit of the carrier covering the claim upon which the funding was received.

(6) If the department determines at the end of the fiscal year that a carrier was not fully reimbursed for paid claims paid due to a shortfall in the reimbursement fund for the fiscal year, and the carrier increases its rates in the following year to cover the total amount of such unreimbursed paid claims, the rate increase shall not be considered reimbursement or compensation for paid claims paid under section 3(n)(*viii*), if the commissioner determines that such rate increase is a reasonable recoupment of the amount of such unreimbursed paid claims.

History: 2012, Act 101, Imd. Eff. Apr. 18, 2012.

Compiler's note: For transfer of autism coverage reimbursement program from department of licensing and regulatory affairs to department of insurance and financial services, see E.R.O. No. 2013-1, compiled at MCL 550.991.

550.1837 Autism coverage fund; creation within state treasury; investment; credit of interest and earnings; administration of fund by department for auditing purposes; expenditures; reimbursement; insufficient money in fund; notice of insufficient funds; money in fund at close of fiscal year; payment of claim approved under MCL 550.1835; reimbursement to carrier or third party administrator; formula.

Sec. 7. (1) The autism coverage fund is created within the state treasury.

(2) The state treasurer may receive money or other assets from any source for deposit into the fund. The state treasurer shall direct the investment of the fund. The state treasurer shall credit to the fund interest and earnings from fund investments.

(3) The department is the administrator of the fund for auditing purposes. The department shall expend money from the fund, on appropriation, only for the purpose of creating, operating, and funding the program.

(4) Except as otherwise provided in subsection (7), the department shall reimburse carriers and third party administrators from the fund in the order in which the applications are approved under the program. If there is insufficient money in the fund to reimburse a carrier or third party administrator for paid claims approved under section 5, reimbursement must not be made. However, applications that are approved but not reimbursed may be paid if revenues of the fund become available.

(5) The department shall develop and implement a process to notify carriers, third party administrators, and the legislature that funds in this program may be insufficient to cover future claims when the department reasonably believes that within 60 days the funds in the program will be insufficient to pay claims. The process shall, at a minimum, do all of the following:

(a) Identify a specific date by which carriers and third party administrators will no longer receive reimbursement for claims submitted to the program.

(b) Outline a clear process indicating the order in which claims pending with the program will be paid.

(c) Outline a clear process indicating the order in which claims that were pending with the program when funds became insufficient will be paid if funds subsequently become available.

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

(7) Subject to subsection (8), from money appropriated to the fund in calendar year 2016, the department shall reimburse a carrier or third party administrator for a paid claim approved under section 5 pursuant to the formula under subsection (8) if the following conditions are met:

(a) The carrier or third party administrator submits its application under section 5 before May 1, 2016.

(b) The services for which the carrier or third party administrator is seeking reimbursement were provided before January 1, 2016.

(c) The department has not already fully reimbursed the carrier or third party administrator for the paid claim.

(d) The department approves the paid claim of the carrier or third party administrator before August 1, 2016.

(8) The department shall reimburse a carrier or third party administrator under subsection (7) pursuant to the following formula:

(a) First, divide the money appropriated to the fund in calendar year 2016 by the total paid claims approved

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under section 5 that meet the conditions under subsection (7).

(b) Second, multiply the calculation under subdivision (a) by the amount of the carrier's or third party administrator's paid claims approved under section 5 that meet the conditions of subsection (7).

History: 2012, Act 101, Imd. Eff. Apr. 18, 2012;—Am. 2016, Act 310, Imd. Eff. Oct. 6, 2016.

Compiler's note: For transfer of autism coverage reimbursement program from department of licensing and regulatory affairs to department of insurance and financial services, see E.R.O. No. 2013-1, compiled at MCL 550.991.

550.1838 University autism programs and autism family assistance services; appropriation; reimbursement.

Sec. 8. In addition to any other use for money in the fund under section 7, for the 2014-2015 fiscal year only, up to $8,500,000.00 may be expended from the fund, upon appropriation, for university autism programs and autism family assistance services as specified in section 1902 of article IV of 2014 PA 252. It is the intent of the legislature that for the 2015-2016 fiscal year, $5,500,000.00 or the amount expended from the fund under this section if less than $5,500,000.00 will be appropriated to reimburse the fund for the expenditures authorized for the 2014-2015 fiscal year under this section.

History: Add. 2014, Act 401, Imd. Eff. Dec. 29, 2014;—Am. 2015, Act 8, Imd. Eff. Apr. 1, 2015.

550.1839 Annual report.

Sec. 9. 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 April 1 of each year that includes, but is not limited to, all of the following:

(a) The total number of applications received under this program in the immediately preceding calendar year.

(b) The number of applications approved and the total amount of funding awarded under this program in the immediately preceding calendar year.

(c) The amount of administrative costs used to administer the program in the immediately preceding calendar year.

History: 2012, Act 101, Imd. Eff. Apr. 18, 2012.

Compiler's note: For transfer of autism coverage reimbursement program from department of licensing and regulatory affairs to department of insurance and financial services, see E.R.O. No. 2013-1, compiled at MCL 550.991.

550.1841 Implementation of program.

Sec. 11. (1) The department shall not implement the program under this act until the legislature has appropriated sufficient funds to cover the same.

(2) Not more than 1% of the annual appropriation made to the autism coverage fund may be used for the purpose of administering the program authorized under this act.

History: 2012, Act 101, Imd. Eff. Apr. 18, 2012.

Compiler's note: For transfer of autism coverage reimbursement program from department of licensing and regulatory affairs to department of insurance and financial services, see E.R.O. No. 2013-1, compiled at MCL 550.991.

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