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BENEFIT NEWS BRIEFS

New Michigan Law Will Establish Two-Year 1% Tax On Certain Paid Health Care Claims Beginning January 1, 2012

Tax Will Sunset January 1, 2014

On August 24, 2011, the Michigan Legislature passed Senate Bill 348 (SB 348) (2011) which establishes a two-year 1% assessment on certain paid health care claims beginning January 1, 2012 and ending January 1, 2014. A companion bill, (SB 347) amends in tandem the Michigan Use Tax.

The Bill affects "Paid Claims" of Michigan residents for health care services received in Michigan.

The purpose of the two Bills is to generate State revenue to be used as a match for federal Medicaid funds in a way that satisfies current federal law. The 1% paid claims assessment is a broad-based assessment which should satisfy the federal government as a replacement for the current Michigan Use Tax model.

The assessment is to be paid by a number of entities including the Plan Sponsor of self-insured multiemployer Group Health Plans (GHP) or by the GHP's Third Party Administrator (TPA) or insurer. It appears that insurers and TPAs will be able to recoup the assessment from the GHP. Details on how the law will work will no doubt be announced by the Michigan Department of Treasury.

The main Michigan legislature page on the Bill is located at: *http://www.legislature.mi.gov/(S(2buanl45devp0h45pdoe0k3c))/mileg.aspx?page=getObject&objectName=2011-SB-0348.*

A copy of the most currently available version of the Bill as enacted is available at: *http://www.legislature.mi.gov/documents/2011-2012/billconcurred/Senate/pdf/2011-SCB-0348.pdf* or by "*clicking here*."

A specially prepared version of the Bill with a Table of Contents for ease of use is available by "*clicking here*."

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A Legislative Analysis of the Bill by the Michigan House Fiscal Agency is available at *http://www.legislature.mi.gov/documents/2011-2012/billanalysis/House/pdf/2011-HLA-0347-3.pdf* or by "*clicking here*."

Detailed Look at the New Law

We have taken the liberty of capitalizing the defined terms used in the Bill and omitting certain technical references, which are still available for review in the above copies of the Bill. Affected parties should read the full Bill (10 pages as formatted).

The Bill is titled the "*Health Insurance Claims Assessment Act*" (HICAA) (Section 1).

Section 3 establishes the 1% "*Paid Claims*" assessment. For dates of service beginning on or after January 1, 2012, there is an assessment of 1% levied upon every Carrier and TPA's Paid Claims and collected from every Carrier or TPA.

The assessment shall not exceed $10,000.00 per insured individual or covered life annually. Special rules apply to Group Health Plans (GHPs) that use TPAs. Before discussing these, let's take a look at certain defined terms.

This publication focuses on the application of the law to multiemployer GHPs and TPAs.

Definitions

Section 2 of the Bill contains "definitions". As noted above, the law applies to Paid Claims of Carriers and TPAs. Readers are encouraged to read the full definitions of the below terms and other defined terms.

Carrier

"Carrier" is defined to include:

- the association, committee, joint board of trustees, or other similar group of representatives of the parties that establish or maintain the plan, or

- plans that are established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, in which case. This includes multiemployer GHPs.

Third Party Administrator

"Third Party Administrator" is defined as an entity that processes claims under a service contract and that may also provide one or more other administrative services under a service contract.

Paid Claims
The definition of "Paid Claims" is of great interest as it defines what types of claims ARE subject to the 1% assessment and what claims ARE NOT subject to the assessment.

With that in mind, in general, **Paid Claims** means ***actual payments***, *net of recoveries*, made to a health and medical services provider or reimbursed to an individual by a Carrier, TPA, or excess loss or stop loss carrier. As a reminder, the Bill affects Paid Claims of Michigan residents for health care services received in Michigan and a Carrier includes a multiemployer GHP.

Paid Claims **ALSO INCLUDE** any payments, net of recoveries:

- made under a service contract for administrative services only,
- for cost-plus or noninsured benefit plan arrangement, for health and medical services provided under group health plans,
- for any claims for service in this state by a pharmacy benefits manager, and
- for 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 Michigan.

Paid claims **DO NOT INCLUDE** any of the following:

- "Claims-related expenses" (Note: *defined term, see Section 2(b)*).

- 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.

- Claims paid by Carriers or TPAs 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.

- Claims paid for services rendered to a nonresident of Michigan.

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

- Claims paid for services rendered outside of Michigan to a person who is a resident of Michigan.

- 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 Affordable Care Act.

- Reimbursements to individuals under a flexible spending arrangement, a health savings account, an Archer medical savings account; a Medicare Advantage Medical Savings Account, or other Health Reimbursement Arrangement authorized under federal law.

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

NOTE: Regarding claims of non-residents and services provided out-of-state, some provider's billing address may be is different from the address where services were rendered. This may cause the Carrier or TPA to capture both addresses.

Special Rules for GHPs Using TPA, Excess Loss or Stop Loss Insurers

The following are special assessment payment rules that apply to GHPs that use a TPA, excess loss or stop loss insurer.

- A GHP plan sponsor (includes Board of Trustees of multiemployer GHPs) shall not be responsible for an assessment Paid Claim where the assessment on that claim has been paid by a TPA, excess loss or stop loss insurer.

- The TPA shall be responsible for all assessments on Paid Claims paid by the TPA.

- 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.

- If there is both a TPA and an excess loss or stop loss insurer servicing the GHP, the TPA 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.

Remember, where the GHP does not use a TPA but is self-administered - uninsured/self-insured/ self-funded – the GHP Plan Sponsor retains the duty to pay the assessment, determined as a percentage of actual Paid Claims and the GHPs excess loss or stop loss insurer shall be responsible for all assessments on Paid Claims paid by the excess loss or stop loss insurer.

Adjustments for Inaccurate Assessments and Overfunding Credits

The Bill allows for adjustment of inaccurate assessments (Section 3(5)) If the amount of monies collected by the assessment collects revenue in an amount greater than $400,000,000.00, adjusted annually by the medical inflation rate, then each Carrier and TPA that paid the assessment shall receive a proportional credit against the Carrier's or TPAs assessment in the immediately succeeding year. (Section 3(6))

Filing of Quarterly Reports

Section 4 of the Bill requires every Carrier and TPA with Paid Claims subject to the assessment to file a return with the Michigan Department of Treasury (Department) on April 30, July 30, October 30 and January 30 of each year a return for the preceding calendar quarter (the form is yet to be prescribed by the Michigan Department of Treasury). Thus, the first returns will be due April 30, 2012 for the 1st quarter of 2012.

At the same time, each Carrier and TPA shall pay to the Department the amount of the assessment owed with respect to the Paid Claims included in the return. The Department may also require each Carrier and TPA to file an annual reconciliation return with the Department.

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.

The Department may require that payment of the assessment be made by an approved electronic funds transfer method.

Recordkeeping (4-Year Requirement)

The Bill imposes record-keeping requirements on affected entities. A Carrier or TPA liable for an assessment must keep accurate and complete records and pertinent documents as required by the Department for a period of 4 years after the assessment to which the records apply is due or as otherwise provided by law.

Penalty For Failure To Timely Pay Assessment

The Bill has teeth. Under Section 10, ***failure to pay*** the assessment can result in the insurer or TPA's ***loss of the right to operate in the state of Michigan***.

What About *ERISA* Preemption and Self-Funded Plans?

Some commenters have suggested that the Bill should be preempted for self-funded health plans by *ERISA.* There may very well be such litigation in the future. Two important cases are the U.S. Supreme Court's decision in *New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.,* 514 U.S. 645, 115 S.Ct. 1671 (1995), and on remand, *Travelers v. Pataki,* 63 F. 3d 89 (2d Cir. 1995).

In *Travelers*, commercial insurers and their trade associations brought suits challenging New York statutes imposing surcharges on hospital rates for patients

whose commercial insurance coverage was purchased by health care plans governed by *ERISA*, among other things. The Supreme Court held that statute providing for surcharges did not "relate to" employee benefit plans under *ERISA* and, accordingly, was not preempted. On remand, the Second Circuit found no exemption for self-funded plans either. Admittedly the legal dynamics are different between *Travelers* and the present new Michigan law, so *ERISA* preemption litigation cannot be ruled out. The new Michigan law should be compared to the analysis of *Travelers Ins.*, *Pataki* and their progeny.

What About the Future?

Carriers (including multiemployer GHPs) and TPAs should begin working towards implementing the new law. This will include determining how to segregate what is "paid claim" from what is not, as well as determining whether medical services were given to Michigan resident by a Michigan provider. GHPs that use a TPA will want to ensure the TPA will be following the special rules applicable to TPAs and GHPs. It is expected that the Michigan Department of Treasury will have information on its website in the near future. Affected GHPs and TPAs may wish to monitor the website at: *http://www.michigan.gov/treasury/.*

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