The Robbins Group & Regency Employee Benefits

Legislative Brief

MICHIGAN HEALTH INSURANCE CLAIMS ASSESSMENT ACT

Michigan instituted an assessment on paid health care claims under Michigan Senate Bill No. 348, effective August 24, 2011.

This bill created the "**Health Insurance Claims Assessment Act"** and initially initiated a 1% assessment on paid health claims, however, **effective 7/1/14 that assessment was reduced to .075%.**

Who Must Pay the Assessment? The Act directly assesses insurance companies and third party administrators, rather than group health plan sponsors, However, the Act will likely cause an increase in the amount health plan sponsors pay for coverage since the assessment will likely be passed on to the plan sponsor. Employers will primarily fund the fee; however, the fee amounts and payments are likely to be processed by the insurance carrier and/or Third Party Administrator. Employers will need to work with their health plan vendor to understand how the assessment will be managed and the potential impact on the employer's cost to provide health benefits.

Why Was this Assessment Implemented? The revenue collected for the assessment will be deposited into the Health Insurance Claims Assessment Fund, which will be created by the Department of Treasury. The money in this fund will be restricted and used primarily to support Michigan's Medicaid program. Multiplied by federal matching dollars, the $400 million raised by the claims tax would have a total impact of $1.2 billion to $1.3 billion on the Medicaid budget. As part of the Health Insurance Claims and Assessment Act, the Use Tax that was assessed against specific insurance carriers that provide Medicaid benefits will be eliminated. The result will be a net gain for the state collected across a wider range of payers than the former Use Tax.

What Claims Will Be Subject to the Assessment? The Act broadly defines the "paid claims" that are assessed the surcharge. Eligible "paid claims" include actual payments made to a health and medical services provider or reimbursed to an individual by a third party administrator, excess loss or stop loss carrier, a property or casualty carrier, or any other type of carrier, including an insurer, health care corporation, or group health plan sponsor.

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Under the Act, paid claims include payments:

- made under a service contract for administrative services;
- cost-plus or noninsured benefit plan arrangements;
- for health and medical services provided under group health plans; and
- for individuals, non-group, and group insurance coverage to residents of Michigan that affect the rights of an insured person in Michigan and bear a reasonable relation to Michigan, even if the coverage is not delivered, renewed, or issued for delivery in Michigan.

Several categories of payments are exempted from the definition of paid claims including:

- claims-related expenses;
- certain payments under an incentive compensation arrangement;
- claims for specified payments under forms of insurance other than health insurance (e.g. homeowners or automotive insurance);
- claims for services provided to a nonresident of Michigan or for services provided outside the state to a Michigan resident;
- claims paid for federal employees or payments made by Medicare, Medicaid, and the Veterans Administration;
- FSA reimbursements; and
- Co-pays, deductibles, and other healthcare costs paid by an individual.

The Act also sets up a reporting and payment schedule, along with record-keeping requirements. Each carrier and third party administrator with eligible paid claims must file a return and payment for the preceding quarter on April 30, July 30, October 30, and January 30.