SB-0994, As Passed House, May 29, 2018
SB-0994, As Passed Senate, May 17, 2018

SENATE BILL No. 994

May 10, 2018, Introduced by Senators SHIRKEY, HORN, STAMAS, MACGREGOR, PROOS and SCHMIDT and referred to the Committee on Michigan Competitiveness.

A bill to impose an assessment on certain insurance providers; to impose certain duties and obligations on certain insurance providers, 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:

Sec. 1. This act shall be known and may be cited as the "insurance provider assessment act".

Sec. 3. As used in this act:

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

(b) "Excess loss" or "stop loss" means coverage that provides insurance protection against the accumulation of total claims

SENATE BILL No. 994

exceeding a stated level for a group as a whole or protection against a high-dollar claim on any 1 individual.

(c) "Federal employee health benefit" means the program of health benefits plans, as defined in 5 USC 8901, available to federal employees under 5 USC 8901 to 8914.

(d) "Fund" means the insurance provider fund created in section 13.

(e) "Health insurer" means an insurer authorized under the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302, to deliver, issue for delivery, or renew in this state a health insurance policy. Health insurer includes a health maintenance organization. Health insurer does not include a state department or agency administering a plan of medical assistance under the social welfare act, 1939 PA 280, MCL 400.1 to 400.119b, or a person administering a self-funded plan.

(f) "Insurance provider" means a Medicaid managed care organization or a health insurer.

(g) "Medicaid contracted health plan" means a contracted health plan as that term is defined in section 106 of the social welfare act, 1939 PA 280, MCL 400.106.

(h) "Medicaid managed care organization" means a Medicaid contracted health plan or a specialty prepaid health plan.

(i) "Medicare" means the federal Medicare program established under title XVIII of the social security act, 42 USC 1395 to 1395*lll*.

(j) "Member months" means the total number of individuals for whom the insurance provider has recognized revenue for 1 month. If

revenue is recognized for only part of a month for an individual, a prorated partial member month may be counted. Member months are determined by the department of insurance and financial services and do not include individuals enrolled in short-term medical, 1-time limited duration, noncomprehensive medical, specified disease, limited benefit, accident only, accidental death and dismemberment, disability income, long-term care, Medicare supplement, stand-alone dental, dental, Medicare, Medicare advantage, Medicare part D, vision, prescription, other individual write-in coverage, federal employee health benefit, Tricare, other group write-in coverage, credit, stop loss, excess loss, administrative services only, or administrative services contracts.

(k) "Specialty prepaid health plan" means an entity designated by the department of health and human services as a regional entity pursuant to section 204b of the mental health code, 1974 PA 258, MCL 330.1204b, or a specialty prepaid health plan pursuant to section 232b of the mental health code, 1974 PA 258, MCL 330.1232b, to provide mental health services, services to individuals with developmental disabilities, and substance use disorder services.

Sec. 5. (1) If the department of health and human services has not already submitted an application to the federal Centers for Medicare and Medicaid Services to request a waiver, for a period of not less than 5 years, of the broad-based and uniformity provisions of section 1903(w)(3)(B) and (C) of title XIX of the social security act, 42 USC 1396b, relating to the assessment imposed under this act, the department of health and human services shall submit the request before October 1, 2018 and as necessary

thereafter to implement this act.

(2) Within 30 days after the effective date of this act, the department of health and human services shall notify the department of the number of member months and the rate to be imposed on these member months under section 7(1)(a)(*i*) for the 2018-2019 state fiscal year and identify the specialty prepaid health plans subject to the assessment under this act.

(3) Within 30 days after the effective date of this act, the department of insurance and financial services shall provide the department with a list of insurance providers by tier that are subject to the assessment under this act.

Sec. 7. (1) Beginning on the first day of the calendar quarter in which the director of the department of health and human services notifies the secretary of state and the department in writing that the federal Centers for Medicare and Medicaid Services has approved its request for a waiver of the broad-based and uniformity provisions of section 1903(w)(3)(B) and (C) of title XIX of the social security act, 42 USC 1396b, for implementation of this act or October 1, 2018, whichever is later, there is levied and imposed an annual assessment on the number of member months for each insurance provider reported on its annual financial statement filed with the department of insurance and financial services or the department of health and human services, whichever is applicable, for the previous calendar year at the following rates in the following circumstances:

(a) For tier 1, a Medicaid contracted health plan's member months supported with federal funds authorized under subchapter XIX

of the social security act, 42 USC 1396 to 1396w-5, as follows:

(*i*) For the number of member months and the dollar amount necessary per member month, as determined each year by the department of health and human services, to achieve a result of between 1.00 and 1.02 on the statistical test imposed by the federal Centers for Medicare and Medicaid Services according to 42 CFR 433.68(e).

(*ii*) For each remaining member month not assessed under subparagraph (*i*), $1.20 per member month.

(b) For tier 2, a health insurer's member months not supported with federal funds authorized under subchapter XIX of the social security act, 42 USC 1396 to 1396w-5, $2.40 per member month.

(c) For tier 3, a specialty prepaid health plan's member months supported with federal funds authorized under subchapter XIX of the social security act, 42 USC 1396 to 1396w-5, $1.20 per member month.

(2) Beginning May 15 and by each May 15 thereafter, the department of insurance and financial services and the department of health and human services shall make available to the department the number of member months for each insurance provider and the necessary assessment information for the department to calculate the assessment due under this act, including the number of member months and the rate to be imposed in accordance with subsection (1)(a)(*i*) to satisfy the statistical test.

(3) For the initial year of implementation only, the department shall notify each insurance provider after June 15, 2018 but before October 15, 2018, of the number of member months and the

rate imposed on these member months in accordance with subsection (1)(a)(*i*) and of its assessment, prorated for 2 quarters, due based on the insurance provider's member months for the previous calendar year. The initial assessment is payable in 2 equal installments. Each insurance provider shall submit the payments to the department by January 30, 2019 and April 30, 2019.

(4) The department shall notify each insurance provider after June 1, but before June 15 each year after implementation, of the number of member months and the rate imposed on these member months under subsection (1)(a)(*i*) and of its annual assessment due under this act based on the insurance provider's member months for the previous calendar year. The assessment is payable on a quarterly basis and each insurance provider shall submit quarterly payments on July 30, October 30, January 30, and April 30 to the department for the amount of the assessment imposed under this act with respect to the number of member months reported on its financial statements for the previous calendar year.

(5) If a due date falls on a Saturday, Sunday, state holiday, or legal banking holiday, the payments are due on the next succeeding business day.

(6) The department may require that payment of the assessment be made by an electronic funds transfer method approved by the department.

Sec. 9. (1) An insurance provider liable for the assessment under this act shall keep accurate and complete records and pertinent documents as may be required by the department. Records required by the department shall be retained for a period of 4

years after the assessment imposed under this act to which the records apply is due or as otherwise provided by law.

(2) If the department considers it necessary, the department may require a person, by notice served upon that person, to make a return, render under oath certain statements, or keep certain records the department considers sufficient to show whether that person is liable for the assessment under this act.

(3) If an insurance provider fails to file a return or keep proper records as may be required under this section, or if the department has reason to believe that any records kept or returns filed are inaccurate or incomplete and that additional assessments are due, the department may compute the amount of the assessment due from the insurance provider based on information that is available or that may become available to the department. An assessment under this subsection is considered prima facie correct under this act, and an insurance provider has the burden of proof for refuting the assessment.

Sec. 11. (1) The department shall administer the assessment imposed under this act under 1941 PA 122, MCL 205.1 to 205.31, and this act. If 1941 PA 122, MCL 205.1 to 205.31, and this act conflict, the provisions of this act apply. The assessment imposed under this act is a tax for the purpose of 1941 PA 122, MCL 205.1 to 205.31.

(2) The department is authorized to promulgate rules to implement this act under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328.

(3) The assessment imposed under this act shall not be

considered an assessment or burden for purposes of the tax, or as a credit toward or payment in lieu of the tax under section 476a of the insurance code of 1956, 1956 PA 218, MCL 500.476a.

(4) The department shall submit an annual report to the state budget director, the senate and house of representatives standing committees on appropriations, and the senate and house fiscal agencies not later than 120 days after May 15 that states the amount of revenue collected from insurance providers under this act for the immediately preceding state fiscal year and the costs incurred for administration and compliance requirements under this act for the immediately preceding state fiscal year.

Sec. 13. (1) All money received and collected under this act shall be deposited by the department in the insurance provider fund established in this section.

(2) The insurance provider fund is created within the state treasury and shall be administered by the department for auditing purposes.

(3) 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.

(4) The department shall expend money from the fund, upon appropriation, only for 1 or more of the following purposes:

(a) Beginning in the 2018-2019 state fiscal year, the first $14,000,000.00 to be appropriated for the payment of actuarially sound capitation rates to Medicaid managed care organizations, and each state fiscal year thereafter, the amount necessary to continue

to support the payment of actuarially sound capitation rates to Medicaid managed care organizations.

(b) For the 2018-2019 state fiscal year, to appropriate an amount not to exceed $315,000,000.00 to offset the net revenue lost under the health insurance claims assessment act, 2011 PA 142, MCL 550.1731 to 550.1741.

(c) For the 2019-2020 state fiscal year, to appropriate an amount not to exceed $240,000,000.00 to offset the net revenue lost under the health insurance claims assessment act, 2001 PA 142, MCL 550.1731 to 550.1741.

(d) To pay administrative and compliance costs in accordance with section 15.

(e) The balance of the fund remaining after the appropriations described in subdivisions (a), (b), (c), and (d) shall be transferred to a separate restricted account within the insurance provider fund and only used as appropriated by the legislature.

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

Sec. 15. For administration and compliance requirements created by this act, in the 2018-2019 state fiscal year and each fiscal year thereafter, the department shall receive from the insurance provider fund created in section 13 an amount not to exceed 1/2 of 1% of the annual remittances under this act in the 2018-2019 state fiscal year, subject to annual appropriation by the legislature.

Sec. 17. The department shall provide the director of the department of insurance and financial services with written notice

of any final determination that an insurance provider has failed to pay an assessment, interest, or penalty when due. The director of the department of insurance and financial services may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state, or the license to operate in this state, of any insurance provider that fails to pay an assessment, interest, or penalty due under this act. A suspension of a certificate of authority to transact insurance in this state or a license to operate in this state under this section shall not be withdrawn unless any delinquent assessment, interest, or penalty has been paid.