



# Michigan Association of Health Plans

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March 24, 2011

Roger Kahn, M.D.  
State Senator  
Chairman, Senate Appropriations Committee  
P.O. Box 30036  
Lansing, Michigan 48909

Dear Senator Kahn:

RE: Michigan "Health Insurance Claims Assessment Act"

Thank you for providing the Michigan Association of Health Plans with an opportunity to comment to your office regarding the revised draft legislation for a Michigan "Health Insurance Claims Assessment Act." The revised draft includes several important clarifications, including the exclusion of Medicare Advantage Plans from consideration thus avoiding potential federal objections. We now have the advantage of our MAHP Board meeting on March 18<sup>th</sup> where we adopted a position on the Paid Claims Tax and a follow-up conference call with membership on March 22<sup>nd</sup> to review the revised draft and would like to offer the following commentary and suggestions.

Before, we do so; let me convey the position of the MAHP.

**MAHP supports the proposed Paid Claims Tax as an alternative to the current HMO use tax and which will be based on the following principles:**

- Any replacement tax should be broad based, low rate and applied equitably in order to achieve the Governor's objective of replacing the \$400 million raised by the current HMO Use Tax.
- To provide certainty for Medicare purposes, All Medicare products (including Medicare advantage and Special needs plans) must be excluded to assure to future federal penalties.
- Claims are only "taxed" once. If a plan has capitated arrangements, either the capitation or the underlying claims should be taxed—not both. Further, consideration should be given to the difference between incurred claims (paid now under the HMO use tax) and paid claims in order to protect against paying the same claim twice.
- Consideration should be given to claims incurred by out of state payers to residents in Michigan.

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Health Plans*

- The effective date of the Paid Claims tax should allow sufficient time for health plans and carriers to build administrative systems for compliance and factoring the cost into rates—and repeal of the current use tax should be adjusted as necessary to permit the additional time necessary as protect the state from financial loss. Furthermore, an expedited timeframe should be build into regulatory approval if the only change in rates is to accommodate the tax.
- Given the uncertainty regarding the overall base, the enabling statute should include provisions to provide for instances of “surplus” and limitations on the use of the surplus to Medicaid and/or rebate back to carriers/insurers.

As you may also know, MAHP has already testified in hearings before both the Senate and House Subcommittees on Community Health Appropriations in support of the Paid Claims Tax and encouraged all interest groups to do the same as Michigan cannot afford to reduce Medicaid spending by over \$1.2 billion (consequence if no alternative to the HMO use tax is enacted).

### **MAHP Comments on Draft Legislation**

Our comments of the revised draft legislation will be divided into three different sections. First, we will provide overall commentary. Second we will identify recommendations that should be made in the revised draft to improve clarity, and last we will identify operational concerns that our Commercial and Medicaid members and those who provide TPA services for self funded programs might have—the resolution of which may require statutory language.

#### **I. Overall Comments**

1. Keeping the Proposal Broad Based. While there may be some legitimate areas that should be excluded, it is important that the base of carriers and services be defined as broadly as possible in order to keep the underlying rate as low as possible.
2. Uncertainty regarding the overall Base. We understand that the proposal is based on an estimate of paid claims (non-Medicare) of \$40 billion in Michigan. Until we have validation of that number, we should take great caution in anticipating that the paid-claims revenue will exceed this target. We can move forward with the estimate, maintain the principle that the base must be as broad as possible and develop provisions as to what might occur if the yield exceeds some agreed upon threshold in excess of \$400 million. That threshold should be based on reasonable projections of annual inflation and provide a margin of perhaps no more than 25% above the threshold before, rebates or credits be established to return revenue to the carriers and TPAs.

Conversely, we could attempt to arrive at a solid figure based upon a “data call” that the OFIR Commissioner could issue under his regulatory powers of the Insurance code. Such a data call would be inclusive of regulated health plans and TPAs that are also regulated by OFIR. Data from this information could then be used to more accurately project what the rate or base should be. In the interim, MAHP will assume that the base is \$40 Billion.

3. Dedication of the funding to Medicaid. The support for this effort is in recognition of the harm that further erosion and cuts in Medicaid would have on access and overall costs and the collateral effect it may have on uncompensated care and costs absorbed by Commercial carriers. Therefore, it is important for all supporters of this package to provide assurance that it will be dedicated to Medicaid and not used elsewhere in the State Budget.

## **II. Specific Comments on the Second Draft**

1. Sec. 2 (1) (a) would also include all of the alternative health care delivery programs licensed under the HMO section of the Insurance code, (Dental services, Behavioral programs, Podiatry, etc).
2. Sec 2 (1)(e) is new section defining “group health plan sponsor” and leaves no doubt of intent to be broad based and reach employers and various VEBA arrangements, including those sponsored by UAW and MESSA. Including this under definition of “carrier” now avoids the potential issue of claims being paid directly by the “sponsor” and not through arrangement with TPA or other carriers and those claims not being included. One cautionary note—inclusion of sponsor may also raise issues about ERISA exemption.
3. Sec 2 (5) is new section defining Excess Loss/Stop Loss. We believe this section should include provisions to clarify that premiums for such carriers paid by Health Plans, TPAs, etc are administrative expense, as the actual claim for services ceded to stop loss carrier is paid by the health plan and then reimbursed by the stop loss carriers.
4. Sec. 2 (6) OR Sec. 2 (12) (a) should be revised to specially classify as administrative expense the costs paid by Medicaid Health Plans for the supplemental pass through payments (HRA/GME, etc) voluntarily paid to Michigan Hospitals to cover uncompensated care and costs related to access, as these payment are not related to any utilization of services and may be limited in the future by the federal government thus reducing the available base.
5. Sec. 2 (9) (b) should be further clarified to include payments for emergency and non-emergency transportation related to health and medical services.
6. Sec. 2 (12) should be simplified by inserting language: “Paid Claims means any payment by a carrier or TPA including payments made pursuant to a service contract for administrative services only, cost plus or non-insured benefit plan arrangements.....” and deleting references to individuals and repayments to individuals. Members of MAHP were in agreement that the paid claims tax should not be extended to individuals for a number of reasons (ACA limits, Administrative costs to implement, enforcement, etc—and language in Sec. 2 (12) related to individuals should be deleted.
7. MAHP members recommend that the exclusion of claims for Vision and Specified disease be removed from Sec. 2 (12) (c) as there was no rationale for its exclusion from paid claims tax.
8. It was noted that the revised draft now excludes all Medicare (Sec. 2 (12)(g), including Medicare Advantage—however, we believe that while this likely includes

- Special Needs Plans, further clarification could be inserted to eliminate any doubt and suggest Sec 2. (12)(g) be amended to include ...Medicare Advantage, including Medicare Advantage Special Needs Plans...”
9. Under Sec. 3 (2), consideration should be given to starting the “Act” effective on January 1, 2012. There is need to have a ramp-up time for developing the process and details on administration. With parallel language on the repeal section of the HMO use tax (repeal effective 12/31/11) then the state would not be financially harmed, carriers and TPAs would have time to begin setting up systems for compliance, Treasury would not have to rush details, and the base would be at the start of a calendar year which would not have negative impact on carrier filings for rate adjustments or other ongoing reporting.
  10. The new language (Sec. 6 (3) was reviewed and consideration should be taken to include similar amendments/revisions to the Michigan Business Tax as it is undergoing changes.
  11. Sec. 8 outlines the use of the funds and while it is understood that some administrative costs to the state agencies will be taking place, concern was raised that this could be backdoor for removing general fund from the budget for Medicaid as well as excessively funding OFIR and MDCH administration. Consideration should be given for a clause for maintaining current levels of general fund is inserted and for having this subject to the annual appropriations process
  12. Similar to the above comment, Sec. 9 as drafted, provides a “blank check” for Dept of Treasury and could lead to the Paid Claims tax underwriting all or substantial amount of the general fund support for Treasury—so limitation must be inserted and subjected to annual appropriations. Any percent included in this section should be stated as a maximum and not a target.
  13. Similar to comment # 9 above, it is highly recommended that time be built into the act to provide for “ramping up”. As currently drafted, the paid claim tax applies to all “paid claims beginning October 1, 2011.” This language appears to require the tax to be paid on services that were rendered prior to October 1, 2011 but not paid until after October 1<sup>st</sup>. Consequently, plans may have a modest benefit of accelerating provider payment prior to October 1<sup>st</sup> in order to reduce the tax burden. Further, this date may present a challenge for plans to build this new cost into their 2011 premium rate
- We believe that we can continue to take advantage of the HMO use tax for a certain amount of time into FY 12 and a suggested effective date of January 1<sup>st</sup> is suggested. Then the effective date for repealing the HMO Use tax would be December 31, 2011.

### **III. Other Concerns and Operational Issues**

- The MAHP review resulted in a number of comments on how to define paid claims—health plans need to be assured that we mean “paid” and not “incurred”. This will be transition issue as the HMO use tax relies “incurred Claims”.
- There was broad agreement of MAHP members that we needed to insert language to guarantee that double taxation didn’t occur from health plans paying a paid claim and then delegated contracts with vendors such as PBM or Mental Health , etc also paid. (This may be issue to be amended in Sec. 3)

- Payments to providers for pay for performance are not subject to the tax unless included in the provider rates. For some health plans this may be an issue depending on how they structured P4P payments and may be issue requiring further review and language.
- While not in the legislation—but a factor in the Appropriations is the need for factoring the Paid Claims Tax exposure for Medicaid Health Plan actuarial soundness. The Executive Budget appropriately removed the premium associated with the HMO Use tax and created additional savings—however, the State Budget Office did NOT build back into the budget the exposure to Medicaid Health Plans for the 1% Paid claims tax. Our advocacy on the budget has raised this issue and we hope we have your support.

I hope that the commentary and suggestions above demonstrate that the MAHP is committed to being an active participant in the development and passage of the Paid Claims Tax. We hope to work very closely with your office and colleagues as this legislation—and the underlying support for the Department of Community Health Appropriations moves forward. Please feel free to contact my office for any additional assistance or information.

Thank you again for your consideration in sharing the revised draft with us and for your ongoing support for the services provided by our members.

Sincerely,

A handwritten signature in cursive script that reads "Richard Murdock".

Richard Murdock

cc. MAHP Board of Directors