HB4166

LRB100 15530 HLH 30577 b

100TH GENERAL ASSEMBLY

State of Illinois

2017 and 2018

HB4166

by Rep. Gregory Harris

SYNOPSIS AS INTRODUCED:

New Act

Creates the Health Insurance Claims Assessment Act. Imposes an assessment of 1% on claims paid by a health insurance carrier or third-party administrator. Provides that the moneys received and collected under the Act shall be deposited into the Healthcare Provider Relief Fund and used solely for the purpose of funding Medicaid services provided under the medical assistance programs administered by the Department of Healthcare and Family Services.

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FISCAL NOTE ACT
MAY APPLY

A BILL FOR

AN ACT concerning revenue.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 1. Short title. This Act may be cited as the Health Insurance Claims Assessment Act.

Section 5. Definitions. As used in this Act:

"Carrier" or "insurer" means:

(1) a company authorized to do business in this State or accredited by this State to issue policies of health or dental insurance, including but not limited to, self-insured plans, group health plans (as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are by statute, contract, or agreement legally responsible for payment of a claim for a health care item or service;

(2) a group health plan sponsor, including, but not limited to, one 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;

and

(C) the association, committee, joint board of trustees, or other similar group of representatives of the parties that establish or maintain a plan if the plan is established or maintained by 2 or more employers or jointly by one or more employers and one or more employee organizations.

"Claims-related expenses" means all of the following:

(1) cost containment expenses, including, but not limited to, payments for utilization review, care or case management, disease management, medication review management, risk assessment, and similar administrative services intended to reduce the claims paid for health and medical services rendered to covered individuals by attempting to ensure that needed services are delivered in the most efficacious manner possible or by helping those covered individuals maintain or improve their health;

(2) payments that are made to or by an organized group of health and medical service providers in accordance with managed care risk arrangements or network access agreements, which payments are unrelated to the provision of services to specific covered individuals; and

(3) general administrative expenses.

"Department" means the Department of Revenue.

"Excess loss" or "stop-loss" means coverage issued by a carrier 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 one individual.

"Federal employee health benefit program" means the program of health benefits plans, as defined in 5 U.S.C. 8901, available to federal employees under 5 U.S.C. 8901 to 8914.

"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, 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.

"Group insurance coverage" means a form of voluntary health and medical services insurance that covers members, with or without their eligible dependents, and that is written under a master policy.

"Health and medical services" means:

(1) services included in furnishing medical care, dental care, pharmaceutical benefits, or hospitalization, including, but not limited to, services provided in a hospital or other medical facility;

(2) ancillary services, including, but not limited to, ambulatory services and emergency and nonemergency transportation;

(3) services provided by a physician or other

practitioner, including, but not limited to, health professionals, other than veterinarians, marriage and family therapists, athletic trainers, massage therapists, and licensed professional counselors; and

(4) behavioral health services, including, but not limited to, mental health and substance abuse services.

"Paid claims" means actual payments, net of recoveries, made to a health and medical services provider or reimbursed to an individual by a carrier, third-party administrator, or excess loss or stop-loss carrier. "Paid claims" include payments, net of recoveries, made under a service contract for administrative services only, for health and medical services provided under group health plans, any claims for service in this State by a pharmacy benefits manager, and 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 this State. If a carrier or a third-party administrator is contractually entitled to withhold a certain amount from payments due to providers of health and medical services in order to help ensure that the providers can fulfill any financial obligations they may have under a managed care risk arrangement, the full amounts due the providers before that amount is withheld shall be included in "paid claims". The term "paid claims" includes claims or

payments made under any federally-approved waiver or initiative to integrate Medicare and Medicaid funding for dual eligibles under the federal Patient Protection and Affordable Care Act or the federal Healthcare and Education Reconciliation Act of 2010. The term "paid claims" does not include any of the following:

(1) Claims-related expenses.

(2) 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.

(3) Claims paid by carriers or third-party administrators 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 claims paid under coverage issued as a supplement to liability insurance.

(4) Claims paid for services rendered to a nonresident of this State.

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

(6) Claims paid for services rendered outside of this State to a person who is a resident of this State.

(7) 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 the federal Patient Protection and Affordable Care Act or the federal Healthcare and Education Reconciliation Act of 2010.

(8) Reimbursements to individuals under a flexible spending arrangement, as that term is defined in Section 106(c)(2) of the Internal Revenue Code; a health savings account, as that term is defined in Section 223 of the Internal Revenue Code; an Archer medical savings account as defined in Section 220 of the Internal Revenue Code; a Medicare Advantage medical savings account, as that term is defined in Section 138 of the Internal Revenue Code; or other similar health reimbursement arrangement authorized under federal law.

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

"Third-party administrator" means an entity that processes claims under a service contract and that may also provide one or more other administrative services under a service contract.

Section 10. Assessment; levy; limitation; adjustment; credit; notice; carrying forward unused credit; refund.

(a) For dates of service beginning on or after January 1, 2018, there is levied upon and there shall be collected from

every carrier and third-party administrator an assessment of 1% on that carrier's or third-party administrator's paid claims.

(b) All of the following apply to a group health plan that uses the services of a third-party administrator or excess loss or stop-loss insurer:

(1) A group health plan sponsor is not responsible for an assessment under this Section for a paid claim if the assessment on that claim has been paid by a third-party administrator or excess loss or stop-loss insurer.

(2) Except as otherwise provided in paragraph (4), the third-party administrator is responsible for all assessments on paid claims paid by the third-party administrator.

(3) Except as otherwise provided in paragraph (4), the excess loss or stop-loss insurer is responsible for all assessments on paid claims paid by the excess loss or stop-loss insurer.

(4) If there is both a third-party administrator and an excess loss or stop-loss insurer servicing the group health plan, the third-party administrator is 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 is responsible for all assessments for paid claims that are reimbursable to the excess loss or stop-loss insurer.

(c) The assessment under this Section shall not exceed

$10,000 per insured individual or covered life annually.

(d) To the extent an assessment paid under this Section for paid claims for a group health plan or individual subscriber is inaccurate due to subsequent claim adjustments or recoveries, subsequent filings shall be adjusted to accurately reflect the correct assessment based on actual claims paid.

Section 15. Carrier required to file rates; methodology. A carrier or third-party administrator shall develop and implement a methodology by which it will collect the assessment levied under this Act from an individual, employer, or group health plan, subject to all of the following:

(1) Any methodology shall be applied uniformly within a line of business.

(2) Except as provided in paragraph (4), health status or claims experience of an individual or group shall not be an element or factor of any methodology to collect the assessment from that individual or group.

(3) The amount collected from individuals and groups with insured coverage shall be determined as a percentage of premium.

(4) The amount collected from groups with uninsured or self-funded coverage shall be determined as a percentage of actual paid claims.

(5) The amount collected shall reflect only the assessment levied under this Act, and shall not include any

additional amounts, such as related administrative expenses.

(6) Each carrier shall notify the Department of the methodology used for the collection of the assessment levied under this Act.

Section 20. Returns.

(a) Every carrier and third-party administrator with paid claims subject to the assessment under this Act shall file with the Department on or before April 30, July 30, October 30, and January 30 of each year a return for the preceding calendar quarter, in a form prescribed by the Department, showing all information that the Department considers necessary for the proper administration of this Act. At the same time, each carrier and third-party administrator shall pay to the Department the amount of the assessment imposed under this Act with respect to the paid claims included in the return. The Department may require each carrier and third-party administrator to file with the Department an annual reconciliation return.

(b) 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.

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

Section 25. Records.

(a) Each carrier or third-party administrator liable for an assessment under this Act shall keep accurate and complete records and pertinent documents as 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.

(b) 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.

(c) If a carrier or third-party administrator fails to file a return or keep proper records as 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 assess the amount of the assessment due from the carrier or third-party administrator based on information that is available or that may become available to the Department. An assessment under this subsection (c) is considered prima facie correct under this Act, and a carrier or third-party administrator has the burden of proof for refuting the assessment.

Section 30. Distribution of receipts; Medicaid services. All moneys received and collected under this Act shall be deposited into the Healthcare Provider Relief Fund and used solely for the purpose of funding Medicaid services provided under the medical assistance programs administered by the Department of Healthcare and Family Services.