

# HB5750



## 99TH GENERAL ASSEMBLY

### State of Illinois

2015 and 2016

HB5750

by Rep. Greg 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.

LRB099 17751 HLH 42113 b

FISCAL NOTE ACT  
MAY APPLY

A BILL FOR

1 AN ACT concerning revenue.

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

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

6 Section 5. Definitions. As used in this Act:

7 "Carrier" or "insurer" means:

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

18 (2) a group health plan sponsor, including, but not  
19 limited to, one or more of the following:

20 (A) an employer if a group health plan is  
21 established or maintained by a single employer;

22 (B) an employee organization if a plan is  
23 established or maintained by an employee organization;

1 and

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

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

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

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

23 (3) general administrative expenses.

24 "Department" means the Department of Revenue.

25 "Excess loss" or "stop-loss" means coverage issued by a  
26 carrier that provides insurance protection against the

1 accumulation of total claims exceeding a stated level for a  
2 group as a whole or protection against a high-dollar claim on  
3 any one individual.

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

7 "Group health plan" means an employee welfare benefit plan  
8 as defined in Section 3(1) of Subtitle A of Title I of the  
9 Employee Retirement Income Security Act of 1974, to the extent  
10 that the plan provides medical care, including items and  
11 services paid for as medical care to employees or their  
12 dependents as defined under the terms of the plan directly or  
13 through insurance, reimbursement, or otherwise.

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

18 "Health and medical services" means:

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

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

26 (3) services provided by a physician or other

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

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

7 "Paid claims" means actual payments, net of recoveries,  
8 made to a health and medical services provider or reimbursed to  
9 an individual by a carrier, third-party administrator, or  
10 excess loss or stop-loss carrier. "Paid claims" include  
11 payments, net of recoveries, made under a service contract for  
12 administrative services only, for health and medical services  
13 provided under group health plans, any claims for service in  
14 this State by a pharmacy benefits manager, and individual,  
15 nongroup, and group insurance coverage to residents of this  
16 State in this State that affect the rights of an insured in  
17 this State and bear a reasonable relation to this State,  
18 regardless of whether the coverage is delivered, renewed, or  
19 issued for delivery in this State. If a carrier or a  
20 third-party administrator is contractually entitled to  
21 withhold a certain amount from payments due to providers of  
22 health and medical services in order to help ensure that the  
23 providers can fulfill any financial obligations they may have  
24 under a managed care risk arrangement, the full amounts due the  
25 providers before that amount is withheld shall be included in  
26 "paid claims". The term "paid claims" includes claims or

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

7 (1) Claims-related expenses.

8 (2) Payments made to a qualifying provider under an  
9 incentive compensation arrangement if the payments are not  
10 reflected in the processing of claims submitted for  
11 services rendered to specific covered individuals.

12 (3) Claims paid by carriers or third-party  
13 administrators for specified accident, accident-only  
14 coverage, credit, disability income, long-term care,  
15 health-related claims under automobile insurance,  
16 homeowners insurance, farm owners, commercial multi-peril,  
17 and worker's compensation, or claims paid under coverage  
18 issued as a supplement to liability insurance.

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

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

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

26 (7) Claims paid under a federal employee health benefit

1 program, Medicare, Medicare Advantage, Medicare Part D,  
2 Tricare, by the United States Veterans Administration, and  
3 for high-risk pools established pursuant to the federal  
4 Patient Protection and Affordable Care Act or the federal  
5 Healthcare and Education Reconciliation Act of 2010.

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

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

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

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

24 (a) For dates of service beginning on or after January 1,  
25 2016, there is levied upon and there shall be collected from

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

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

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

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

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

18 (4) If there is both a third-party administrator and an  
19 excess loss or stop-loss insurer servicing the group health  
20 plan, the third-party administrator is responsible for all  
21 assessments for paid claims that are not reimbursed by the  
22 excess loss or stop-loss insurer and the excess loss or  
23 stop-loss insurer is responsible for all assessments for  
24 paid claims that are reimbursable to the excess loss or  
25 stop-loss insurer.

26 (c) The assessment under this Section shall not exceed



1 \$10,000 per insured individual or covered life annually.

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

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

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

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

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

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

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

1 additional amounts, such as related administrative  
2 expenses.

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

6 Section 20. Returns.

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

20 (b) If a due date falls on a Saturday, Sunday, State  
21 holiday, or legal banking holiday, the returns and assessments  
22 are due on the next succeeding business day.

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

1 Section 25. Records.

2 (a) Each carrier or third-party administrator liable for an  
3 assessment under this Act shall keep accurate and complete  
4 records and pertinent documents as required by the Department.  
5 Records required by the Department shall be retained for a  
6 period of 4 years after the assessment imposed under this Act  
7 to which the records apply is due or as otherwise provided by  
8 law.

9 (b) If the Department considers it necessary, the  
10 Department may require a person, by notice served upon that  
11 person, to make a return, render under oath certain statements,  
12 or keep certain records the Department considers sufficient to  
13 show whether that person is liable for the assessment under  
14 this Act.

15 (c) If a carrier or third-party administrator fails to file  
16 a return or keep proper records as required under this Section,  
17 or if the Department has reason to believe that any records  
18 kept or returns filed are inaccurate or incomplete and that  
19 additional assessments are due, the Department may assess the  
20 amount of the assessment due from the carrier or third-party  
21 administrator based on information that is available or that  
22 may become available to the Department. An assessment under  
23 this subsection (c) is considered prima facie correct under  
24 this Act, and a carrier or third-party administrator has the  
25 burden of proof for refuting the assessment.

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