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Client Alert:
Employee Benefits

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New State Tax on Health Care Claims Affects Employer-Sponsored Health Plans

Overview of the New Law

The Michigan legislature approved a bill imposing a 1% tax on certain paid health care claims, for health care services and items beginning on or after January 1, 2012. Governor Snyder is expected to soon sign the bill into law. The tax is capped at $10,000 per individual per year, and expires January 1, 2014. The tax would apply to claims paid by an employer-sponsored group health plan, group and individual health insurance companies, stop loss insurers, and third party administrators of self-insured health plans, with limited exceptions. Insurers and third party administrators are permitted to pass along the associated tax to their employer-sponsored health plan clients.

What Types of Payments Are Taxed?

The new tax applies to payments for items and services that provide medical, dental, or hospitalization care, or pharmacy benefits for employees and their dependents. It applies whether the items or services are provided through insurance, reimbursement, or otherwise (*e.g.*, through an on-site clinic). The tax also encompasses some types of payments that may not always be considered to be health care claims. These include:

- ambulatory services, emergency and nonemergency transportation; and
- behavioral mental health and substance abuse services.

Among other things, the tax **does not** apply to payments for:

- cost containment expenses (such as utilization review, case management, disease management, risk assessment, and similar services);
- payments to a managed care risk arrangement or network access provider, where the payments are not related to providing services to a specific individual;
- general administrative services;
- specified accident, accident-only, credit, disability income, long-term care, automobile, homeowners, farm, commercial multi-peril, worker's compensation, or supplemental liability insurance;
- services and items provided outside of Michigan to a resident of Michigan;
- services and items provided to individuals who are not residents of Michigan;

- reimbursements under a flexible spending account, health savings account, Archer medical savings account, or health reimbursement arrangement; and
- amounts paid by an individual as a premium, deductible, coinsurance, or copay;
- marital or family therapists, athletic trainers, massage therapists, licensed professional counselors, or sanitarians.

It is important to note that "paid claims" means the actual payment amounts, net of any recoveries from third parties. Since recoveries are typically received on a lagging basis, a reconciliation process will be necessary. Similarly, if the tax generates more than $400,000,000 (adjusted annually for inflation), payors will be entitled to a pro rata credit of amounts they paid. The credit is applied to offset future tax payments, but if no further tax amounts are owed it will be rebated to the payor.

Who is Responsible for the Tax?

The tax is assessed against group health plan sponsors, insurance companies, HMOs, non-profit health care corporations, nonprofit dental care corporations, and specialty prepaid health plans. If a group health plan use the services of a third party administrator, insurance policy, or stop loss insurer to pay health care claims, however, the tax will apply to the applicable third party administrator or insurer, and will only apply against the group health plan if those parties fail to pay. Payors must file a tax return with the state Treasury and pay the tax assessment on April 30, July 30, October 30, and January 30 of each year for the preceding calendar year quarter. While insurers and third party administrators can (and almost certainly will) pass along the associated cost to their employer-sponsored health and welfare plan clients, they cannot add any administrative charge. This means that the cost of implementing a reconciliation process and credit tracking process is intended to be borne by the insurer or third party administrator.

What Should Group Health Plan Sponsors Do Now?

The new law will add to the cost and administrative burdens of group health plan sponsors, and it is coming at a point in time when many plan sponsors have already made decisions on group health plan structure and cost for 2012. Group health plan sponsors should immediately contact their insurers and third party administrators to discuss the financial impact the new law will have on their plans. Additionally, group health plan sponsors should ensure that their insurers and third party administrators are able to timely comply with the administrative aspects of the bill, such as determining a participant's state of residence, segregating claims paid (and related recoveries) for services and items provided within Michigan from other claims, and submitting tax filings to the State of Michigan regardless of whether the insurer or third party administrator is located within Michigan. Contact an attorney from the Butzel Long Employee Benefits Practice Group to discuss changes that should be negotiated into insurance policies and third party service provider agreements effective on or after January 1, 2012, in order to ensure compliance with the law and to fully protect the plan sponsor.

If you have any employee benefit questions, please contact your regular Butzel Long attorney, a member of the Butzel Long Employee Benefits Practice Group, or the author of this Client Alert.

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