

Funding the Children’s Health Account and Immunization Programs for Adults and Children through a Claims Assessment



Executive Office of Health and Human Services

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Introduction

The General Assembly directed the Executive Office of Health and Human Services (EOHHS) through H-7410 and S-2362 to study and report on new methods for funding the children's health account and the immunization programs for children and adults. Those programs are currently funded by an assessment on fully insured lives. The General Assembly wanted to assess alternative funding mechanism from premiums to "a surcharge based on health care claims." An underlying assumption of that directive was to create a broad-based, equitable means of funding programs from which all Rhode Islanders benefit. EOHHS is required deliver its findings not later than February 15, 2013. In fulfilling those statutory and policy requirements, this report builds upon and grows out of research previously conducted by the Office of the Health Insurance Commissioner.¹

Changes in the composition of Rhode Island's health insurance market have resulted in calls by some to develop new approaches to funding the children's health account and the immunization programs for adults and children. Only those Rhode Islanders covered by commercial insurance contribute to this assessment. Their numbers are dropping. Over the past seven years, the number of fully insured Rhode Islanders has decreased by almost 23%. The number of self-insured lives has increased 13% during that same time period. Those with coverage through self-insured plans do not contribute to the cost of funding the children's health account or the immunization programs, but are eligible to reap the benefits of those initiatives.

¹ Rhode Island General Assembly, *An Act Relating to Health and Safety—Taxation of Healthcare Services*, 8 February 2012; Office of the Health Insurance Commissioner (OHIC), *A Study of Alternatives to Health Insurance Premium Assessments*, April 2012.

In addition, self-insured lives are now the single largest group in the Rhode Island insurance market, accounting for over 43% of the total.²

This report is divided into four sections. The first section summarizes developments in the health insurance market over the last seven years and explains the operation of the health insurance premium tax. The second section, discusses the claims assessment and its potential to fund public health programs more equitably than the current tax structure allows. The third section addresses the potential options available for shifting from a health insurance premium tax to a claims-based assessment. Without advocating for one option over the others, this report also includes a brief analysis of the advantages and disadvantages of each of the three options. A final section focuses on the methods by which the state could collect the claims assessment.

The Past Seven Years—a Health Insurance Premium Tax

Rhode Island's health insurance market is divided into two categories: insured and self-insured. *Insured* refers to those who have obtained commercial insurance either through a large group, small group, or on an individual basis.³ Under these plans, insurance companies collect premiums from subscribers and assume the risk for paying covered medical claims. *Self-insured* describes groups or employers that function, in effect, as their own insurance companies. These companies collect insurance premiums from their employees to cover the cost of future medical claims and the administrative service charges assessed by commercial insurers for the administration of the health care network and processing of claims.

The children's health account and the immunization programs for adults and children are funded through an assessment on fully insured lives. Rhode Island General Law § 23-1-46 directed that insurers be assessed an annual fee to support the immunization programs. The tax

² OHIC, *Private Market Enrollment Report*, April 2012; Idem, *Commercial Market Enrollment Report*, June 2012.

³ Large groups are defined by OHIC as possessing more than fifty employees while small groups consist of fifty or less. OHIC, *Private Market Enrollment Report*, April 2012.

funding the children’s health accounts was created through Rhode Island General Law § 42-12-29. These charges are only paid by people holding commercial health insurance. Self-insured groups are exempt from the health insurance premium tax but are able to reap the full benefits of the immunization programs. An additional 2% tax on health insurance was created through Rhode Island General Laws § 44-17-1 et. seq. This tax is deposited directly in the state’s General Fund.⁴ Approximately \$52 million is raised through these tax and assessments on health insurance.

Table 1: Historical Funding Data⁵

	Adult Immunization	Child Immunization	Premium Tax (2%)	Children's Health Account
FY2008	\$ 2,074,831	\$ 3,957,323	\$ 15,299,480	3,585,322
FY2009	\$ 3,082,501	\$ 10,990,671	\$ 29,398,545	5,098,437
FY2010	\$ 2,521,792	\$ 9,729,703	\$ 33,660,017	6,277,495
FY2011	\$ 5,216,296	\$ 15,405,257	\$ 33,391,096	7,239,580
FY2012	\$ 5,523,683	\$ 12,240,060	\$ 36,690,603	12,352,798

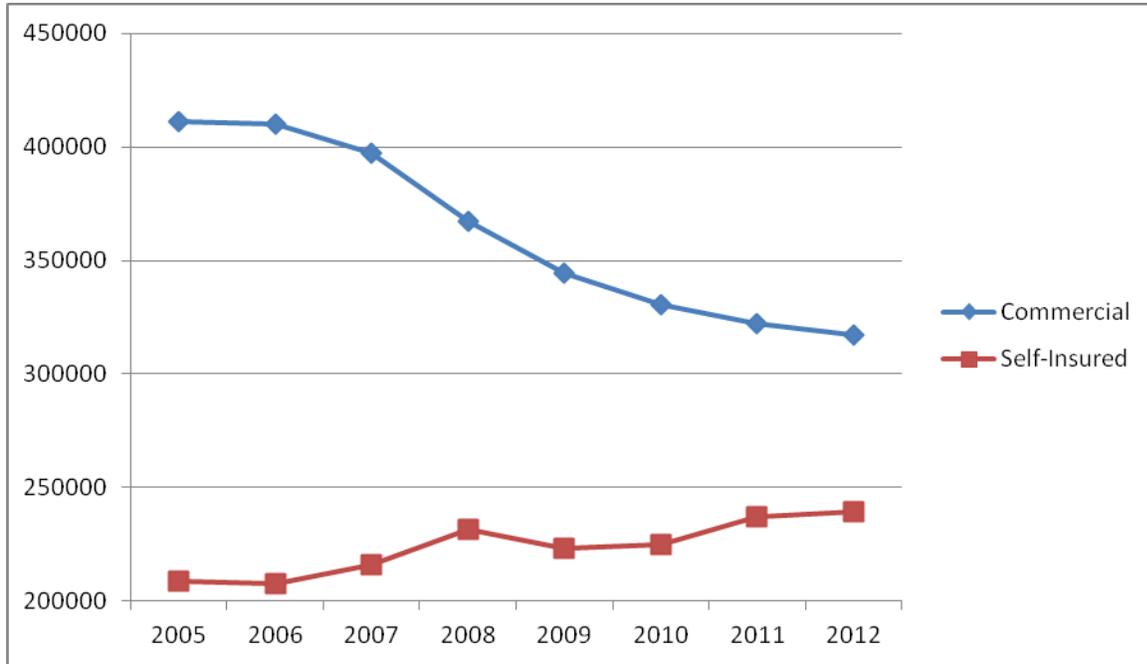
Shifts in Rhode Island’s health insurance market have magnified the inequitable distribution of this tax burden between the fully and self-insured groups. The numbers of commercially insured Rhode Islanders have been declining over the past seven years. The number of fully-insured lives being taxed to fund these programs has decreased from 411,044 in December 2005 to 317,243 in June 2012. This represents an almost 23% drop in payers contributing to the public health programs for adults and children. In contrast, the number of self-insured Rhode Islanders has increased steadily over this same period. Their numbers have

⁴ OHIC, *A Study of Alternatives to Health Insurance Premium Assessments*, April 2012.

⁵ Alterations in methodology account for the changes between 2009 and 2001. P.L. 2010, ch. 23, art 19 enabled each service to be counted separately and increased the cap from \$5,000 to \$6,000 per child, per service, per year. P.L. 2011, ch. 151, art 11 added additional language that allowed for counting of each service separately and increased cap from \$6,000 to \$7,500 per child, per service, per year.

grown from 208,949 lives in December 2005 to 239,476 lives in June 2012. This is a 13% growth in size.

Figure 1: Trends in the Rhode Island Health Insurance Market⁶

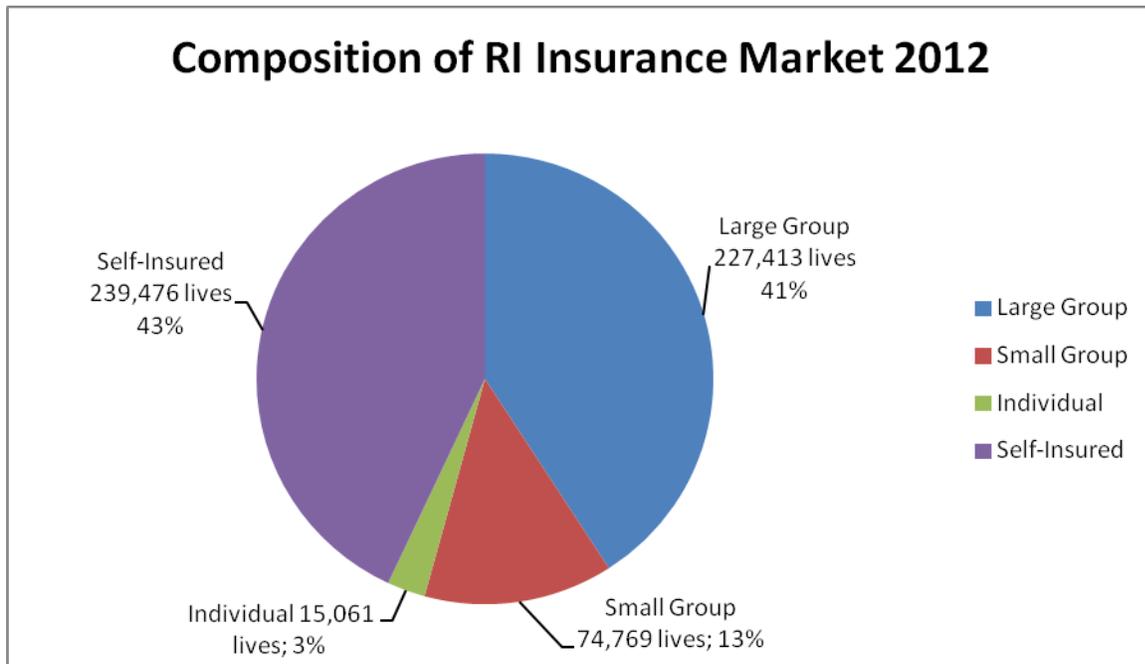


Self insured now constitutes the single largest group – among the individual, small group, large group, and self-insured markets – in the Rhode Island health insurance market, accounting for over 43% of the total. Meaning the cost of the immunization and children’s health account programs are being spread over a diminishing number of lives.⁷

⁶ The numbers displayed represent a snapshot of the market taken in December of each year. 2012’s numbers come from June of that year—the most current data available at the time of this writing. OHIC, *Commercial Market Enrollment Report*, June 2012.

⁷ OHIC, *Commercial Market Enrollment Report*, June 2012.

Figure 2: Composition of the Market⁸



Alternative—a Tax on Health Care Claims

An assessment on health care claims, or claims assessment, is a fee levied on claims made for certain health-related services. The base on which the assessment is levied can be defined either narrowly or broadly. A claims assessment could cover in-patient and out-patient hospital claims; claims from non-hospital medical facilities such as free-standing radiology centers, surgery centers, labs, and clinics. This new fee could also be applied to prescription drug claims in the state. Claims originating within the state of Rhode Island could be subject to the new assessment regardless of the patient's state of residence or status of insurance. In other words, a portion of the assessment could be exported to non-Rhode Island residents. For example, if a person from Massachusetts visits an emergency room in Rhode Island, then the claim resulting from that visit will be subject to the new assessment. Medicaid managed care claims could also be subject to this new assessment and contribute to the funding of the public health programs.

⁸ Ibid.

Some have argued that a claims assessment will be a more equitable means for funding the children's health account and the adult and child immunization programs. Funding those initiatives through a new claims assessment will distribute the costs across all those utilizing medical services in Rhode Island. By distributing the claims assessment across all health care claims in the state, revenues could be generated for the immunization programs at a low cost to the individual Rhode Islander. This new assessment would need to supersede Rhode Island General Law § 23-1-46.

Implementation Options

Should policy-makers choose to pursue this alternative funding structure, the Assembly faces two choices regarding the claims assessment's implementation: adopting either an immediate or phased introduction. With an immediate introduction of a new claims assessment, the existing health insurance premium tax and assessments could be closed that same year. If phased implementation is selected, then there are two choices here for the General Assembly as well: phase in by medical service or by insurance type. In this scenario, a two-year phase-in period appears to be ideal. A successful phased implementation hinges on maintaining the uninterrupted flow of the approximately \$52 million in revenue needed to meet the children's health account, immunization program, and General Fund obligations. It should be noted that the total revenue needed to fund the programs will fluctuate due to the changing demands of the immunization programs, such as vaccine cost, population size, and demand, and the utilization patterns within the Children's Health Account services. A two-year implementation will allow for the gradual replacement of the health insurance premium tax and the assessments without disrupting the needed revenue streams.

Option 1: Immediate implementation

This option, if enacted, would immediately apply the claims assessment to all medical service claims rendered within the state at a rate of approximately 1.5% to generate the necessary funding. Medical services claims would include in-patient hospital, out-patient hospital, other in-state out-patient facilities/services, other in-state medical surgical, and in-state prescription drug claims. The claims assessment would apply to all insurance types regardless of the person's state of residence (including large group, small group, direct pay, Medicaid, self-insured non-municipalities, self-insured municipalities, state of Rhode Island, and out-of-state insured). In this scenario, the claims assessment would immediately replace the existing health insurance premium tax and assessments. This option would shift a proportional burden of the assessment to the self-insured markets, including the State of Rhode Island employee plan and the self-insured municipalities.

Advantages:

- Equitable. Distributes the new assessment across all users.
- Carries the potential to minimize the duration of opposition by implementing new tax quickly.

Disadvantages:

- Unforeseen issues with implementation could be potentially disruptive to collection of revenue.
- Greatest strain on systems for collecting revenue and information.

Option 2: Phased implementation by health care claims type

This option calls for a two-year phase in by health care claims type. In year one, the hospital claims—both in-patient and out-patient claims—would be subject to the new tax. The existing health insurance premium tax will be phased out in this year. If the hospital claims (in-patient and out-patient) are taxed at a rate of approximately 1.25% in this first year, it would generate the same revenue as the health insurance premium tax. During the second year, the claims assessment would be expanded to cover non-hospital out-patient claims, non-hospital medical/surgical claims, and prescription drug claims in the state. In the second year, the

existing assessments would be phased out. The tax rate on all health care claims will then be approximately 1.5%. This rate would be sufficient to fund the children's health account and immunization programs for adults and children.

Year 1: Hospital (in-patient and out-patient) claims assessment at approximately 1.25%—could replace the health insurance premium tax. The current assessments would remain in place.

Year 2: Claims assessment would be applied to other instate out-patient facility claims, other instate medical/surgical claims, and in-state prescription drug claims (in addition to hospitals).

All health care claims assessment at approximately 1.5%—could replace the health insurance premium assessments. This option would lessen the impact in year 1 to the State Employee health plan and self-insured municipalities, providing two years to fully adjust to the implementation of the assessment.

Advantages:

- Equitable. Taxes would be paid as people utilize services.
- There is a clear cause-and-effect relationship visible to the users/payers.

Disadvantages:

- Groups not currently paying premium tax will begin paying claims assessment. Could create opposition.
- Phased approach could lead to accounting and/or revenue problems as transition between claims and premium tax/assessments occurs.

Figure 3: Phase In by Claims Type⁹

Claims Type	Year 1	Year 2
In patient	1,396,000,000	1,396,000,000
Out patient	905,000,000	905,000,000
Rx	n/a	348,556,640
other med fac	n/a	169,695,226
other surgery	n/a	714,852,021
total claims	2,301,000,000	3,534,103,887
claims tax rate	0.01250	0.01500
total generated	28,762,500	53,011,558
total needed	28,000,000	52,000,000

Option 3: Phased implementation by insurance type

This option calls for a two-year phase in by insurance type. In year one, the current payers of the health insurance premium tax (large group, small group, direct pay, and Medicaid) would begin paying the health care claims assessment on all services at a rate of approximately 2.3%. The premium tax would phased out this year as the new tax will raise the necessary revenues. In the second year, the remaining insurance categories (municipal and non-municipal self-insured, state of Rhode Island, out-of-state insured) would begin paying the claims assessment as well. The claims assessment rate in the second year would be approximately 1.5%.

Year 1: Current payers of premium tax (large group, small group, Medicaid) would begin paying the claims assessment at a rate of approximately 2.3%—health insurance premium tax could be phased out.

⁹ The hospital claims figures are estimates based upon the report, *Variation in Payment for Hospital Care in Rhode Island*, December 2012. Figures for the non-hospital claims are from OHIC, *Private Market Enrollment Report*, April 2012. For ease of presentation, this table assumes identical hospital claims in both years. In year one of the phase in, to raise the \$52 million needed to fund the children’s health account and immunization programs the claims assessment would only need to replace the revenue generated by the current health insurance premium tax (approx. \$28 million) as the current assessments paid by the insurance companies (approx. \$24 million) would remain in place. In year two, those assessments would be phased out and all \$52 million would be funded through the claims assessment.

Year 2: Claims assessment to be paid by all insurance types at a rate of 1.5%. Health insurance premium assessments phased out.

Advantages:

- Phased approach allows for controlled implementation
- Initial tax burden carried by groups already paying premium tax. Minimally disruptive to their finances—switching one tax for another.

Disadvantages:

- For one year, the unequal distribution of the current tax burden would continue. Commercially insured people utilizing certain medical services would pay the claims assessment instead of the health insurance premium tax.
- Fluctuations in insurance enrollment could negatively impact revenues collecting during the phase-in period. People could change insurance types to avoid paying the tax for one year.
- Carries greatest potential to elicit opposition. Groups not currently paying the premium tax may use the first year to organize opposition paying the new claims assessment.

Figure 4: Phase In by Insurance Type

Insurance Type	Year 1	Year 2
	Estimated Revenue	Estimated Revenue
Large group	12,950,000	9,600,000
Small group	8,500,000	6,300,000
Direct Pay	1,150,000	800,000
Self-insured non-muni	0	9,500,000
Self-insured muni	0	6,900,000
State of RI	0	4,700,000
Out of state	0	8,400,000
Medicaid	6,950,000	13,900,000
Estimated Total:	29,550,000	60,100,000

Tax Collection Methods

The claims assessment would be levied on all services rendered within the state of Rhode Island, regardless of patient’s state of residence. The claims assessment could be collected in the same manner in which the health insurance premium tax is currently collected. In effect, the state would bill insurance companies for their individual claims experience. The mechanisms for making these evaluations and collections are already in place, freeing the state from the necessity

of “chasing” individual facilities. For fully insured lives (large group, small group, and individual), the insurance companies would estimate the claims assessment expense and build those costs into annual rates. For self-insured and out-of-state insured, the assessment could be added to the claim on their bills.

If phased approach is selected by the General Assembly, then collection would look similar to the current model. During year one of the two-year phase-in, assessments would be collected as normal and the new claims assessment would be paid as the premium tax currently is: insurance companies would be sent a bill from the state for the claims they have covered. In year two, the assessment would be phase out and only the new claims assessment would be collected, as the revenues would sufficiently cover the children’s health account and the immunization programs for adults and children.

The Department of Health (HEALTH) would need to retain the flexibility to adapt to the changing demands of the immunization programs. Currently, HEALTH estimates the annual cost of running the immunization programs. Those forecasts are subject to fluctuations in availability, cost, and demand for the vaccines. Under the existing health insurance premium tax, HEALTH can compensate for any funding shortfalls by requesting additional funds from the insurance companies. With the transition to a health care claims assessment, HEALTH would need a mechanism that provides the flexibility to ensure the smooth financial operation of the programs. This could most effectively be accomplished by reserving money in a restricted account specifically for that purpose.

Conclusion

All Rhode Islanders can access the benefits of the immunization programs and the children’s health account. Recent changes in the state’s health insurance market have necessitated exploring new approaches to funding those programs. Currently, revenues are

generated through a tax on health insurance premiums. This tax on health insurance premiums is paid only those Rhode Islanders covered by commercial insurance. And their numbers are shrinking. Thus, the burden for funding those programs falls on a decreasing number of people. The number of self-insured lives in Rhode Island, however, has increased steadily over time. This second group reaps the benefits of the children's health account or the immunization accounts, yet, does not contribute to the cost of funding those programs. Therefore, there is a need to consider alternative funding options to address the shortcomings of the existing funding structure for these services.