OFFICE OF THE
HEALTH INSURANCE COMMISSIONER

STATE OF RHODE ISLAND

Report to the General Assembly

A Study of Alternatives to Health Insurance Premium Assessments

In accordance with Article 11 of the Appropriations Act
for the 2012 Fiscal Year

April 20, 2012

Introduction

In Article 11, Section 2 of the Act Making Appropriations for the Support of the State for the Fiscal Year Ending June 30, 2012, the General Assembly directed the Office of the Health Insurance Commissioner ("OHIC") to study alternatives to assessments levied upon health insurance premiums in Rhode Island. See Attachment A.

OHIC is specifically directed by the Legislature to analyze and study alternatives to the current special assessments levied upon health insurance premiums, including the child immunization assessment, the adult immunizations assessment, and the children's health account assessment. The Legislature directed OHIC to evaluate a range of alternatives, including but not limited to a claims surcharge on hospital services. Such a hospital claims surcharge as envisioned by the legislation would be levied on self-insured as well as fully insured health plans. OHIC was further directed to report on how other states addressed these issues, the strengths and weaknesses of alternative approaches, and whether these alternative approaches should be considered applicable to Rhode Island.

Article 11, Section 2 did not expressly direct OHIC to study alternatives to the 2% premium tax assessed on health insurance, as well as all other lines of insurance. The 2% premium tax is different in nature from the special assessments that support immunization and children's programs, because the revenue generated by the 2% premium tax is deposited into the General Fund. As a result of comments by interested parties, alternatives to the 2% premium tax will also be evaluated in this report.

Methodology

Information relating to the administration of the assessments, and premium assessment revenue received from health insurance carriers, was collected through interviews with program personnel at the Department of Health (adult and children's immunization programs), and at the Department of Human Services (children's health account program). Information concerning enrollment, health insurance premiums, and health services claims (insured and self-insured) was requested from the following health insurance carriers: Blue Cross Blue Shield of Rhode Island, United HealthCare, Tufts Health Plan, Aetna, and CIGNA. All carriers provided OHIC the requested data on a template developed by OHIC. OHIC was not able to research other states' experience with start-up and on-going administrative costs, or other administrative issues. OHIC's expertise relates to health insurance regulation and public policy. OHIC does not have the capacity or expertise to evaluate and analyze assessment alternatives from a broad tax policy perspective. Consequently, the focus of this report is only from the perspective where OHIC has expertise and experience.

Revenue derived from health insurance premiums

Rhode Island law imposes three special assessments on health insurance premiums, and one general revenue tax on health insurance premiums.

1. The **children's health account assessment** generates revenue to fund Medicaid programs for children with special needs, in accordance with R.I. Gen. Laws § 42-12-29. Services funded through this assessment include: pediatric home health services programs, comprehensive, evaluation, diagnosis, assessment, referral and re-evaluation (CEDARR) services, Home Based Therapeutic Services (HBTS), Personal Assistance Services and Supports (PASS), Kids Connect, Child and Adolescent Intensive Treatment Services (CAITS) program, Private Duty Nursing (PDN), and personal care services. The annual assessment rate is calculated on the basis of the total annual Medicaid spending for the services listed above (not to exceed $7,500 per child, per year) for children who also have some form of comprehensive third-party liability (TPL) insurance. The assessment is based on direct premiums for commercial health insurance plans written in the previous year and excludes Medicare Supplement Policies, Medicare managed care, Medicare, Federal Employees Health Plan, Medicaid/RIte Care, or dental premiums. For the fiscal year 2010-2011, total applicable program expenses were determined to be $7,509,386.00, based on the methodology described above. The annual assessment rate on health insurance premiums for that year was 0.492918%. For the fiscal year 2011-2012 the program expenses were determined to be $11,153,192 and the assessment rate was set at 0.754275%. The increased assessment rate can be attributable in part to the increase in the assessment cap for the children's health account assessment from $6,000 to $7,500 per child per service per year, in accordance with Fiscal Year Budget Article 11, Section 1.

2. The **child immunization assessment** generates revenue to fund the costs of the Advisory Committee on Immunization Practice (ACIP)-recommended and state-mandated vaccines for insured Rhode Islanders under age 18, in accordance with R.I. Gen. Laws § 23-1-46. Under Rhode Island's universal vaccine purchase program, all routine vaccinations recommended for children up to age 18 are provided to RI health care providers at no cost to vaccinate the children they serve. Federal funding provides recommended vaccines for uninsured and underinsured children, while the assessment statute requires insurers to provide funding to purchase recommended vaccine for insured children. The assessment is based on direct premiums for commercial health plans written in the previous year and excludes Medicare, Medicaid and Medicaid Managed Care premiums. For fiscal year 2011-2012, $12,195,834 was assessed, at a rate of 0.825% of written premiums on applicable health insurance products.

3. The **adult immunization assessment** generates revenue to fund the costs of Advisory Committee on Immunization Practice-recommended (ACIP) vaccines for insured adults, in accordance with R.I. Gen. Laws § 23-1-46. State law requires insurers to provide funding to purchase vaccine for insured adults. Unlike with the child immunization assessment, the adult assessment includes all Medicaid and certain Medicare premiums. For the fiscal year 2011-2012, $5,268,625 was assessed, at a rate of 0.2% of written premiums on applicable health insurance products.

4. The **general insurance premium tax**. Rhode Island also imposes a 2% premium tax on all lines of insurance, including health insurance, in accordance with R.I. Gen. Laws § 44-17-1 et seq. Revenue from the 2% premium tax is deposited into the state's General fund, rather than used for a special purpose as is the case with the immunization premium assessments and the children's health account premium assessment. In Calendar Year 2011 $30.5 million was deposited into the state's general fund based from the health insurance premium portion of the general insurance premium tax.[1] The general insurance premium tax is a common way for states to raise revenues from insurers in all lines of businesses.[2]

The annual assessment rates for the children's health account and for the two immunization assessments are determined based on the costs of each program as reported by the RI Office of Health and Human Services and the RI Department of Health, respectively. The annual assessment amount for each program is then allocated proportionately among health insurance companies doing business in Rhode Island, based on their relative market share as calculated by annual health insurance premiums, and as reported to OHHS and DOH by OHIC and the Department of Business Regulation.

As shown in Figure 3 of this report, the carriers that provided claims data in this survey represented approximately 85% of total assessed premium. There are approximately 200 carriers who are part of the assessment pool, but some of them pay very small amounts.

The Rhode Island Health Insurance Market

The Rhode Island health insurance market is divided into two important categories: the insured market, and the self-insured market. This is an important distinction for purposes of this report because the current special assessment,

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[1] This premium tax amount differs from the premium tax amounts used for purposes of modeling in this report because of differences between revenue calculation requirements and health insurance-related premium tax data reported by a selected number of health insurance carriers. See pages 10-11.

[2] A federal tax will be imposed on health insurance premiums and TPA fees beginning in 2014 for calendar year 2013 premiums and fees. See PPACA § 9010; and Reconciliation Act § 1406. The federal tax excludes premium equivalents or claims paid by self-insured plans, in general. An evaluation or quantification of the federal tax is beyond the scope of this report.

and the general premium tax, raise revenue from the insured market only, not from the self-insured market (i.e. a plan that provides coverage from its own funds, rather than by the purchase of health insurance).

The percentage of Rhode Island individuals enrolled in an insured health coverage plan (as compared to Rhode Island individuals enrolled in a self-insured insured health coverage plan) has decreased significantly from 2005 to June 2011. As shown in Figure 1, in 2005 66% of Rhode Island enrolled individuals were covered in an insured health coverage plan. In June 2011 that percentage had dropped to 58%. This trend is not unique to Rhode Island, but is common in other states.[3]

Figure 1. Rhode Island enrollment data: insured vs. self-insured (reported by carriers on special request by OHIC, June 2011)

	2005	2006	2007	2008	2009	2010	June 2011
Insured Market	441,044 66%	409,963 66%	397,055 65%	367,432 61%	344,534 61%	330,581 60%	326,609 58%
Self-Insured Market	208,949 34%	207,604 34%	216,069 35%	231,806 39%	223,195 39%	224,778 40%	232,354 42%
Total	619,993	617,567	613,124	599,238	567,729	555,359	558,963

Three health insurance carriers issue small employer health insurance policies in Rhode Island (Blue Cross Blue Shield of Rhode Island, United HealthCare, and Tufts Health Plan). These three carriers also issue large employer health insurance policies and administer coverage for self-insured plans. In addition, other carriers offer large employer health insurance policies and administer coverage for self-insured plans. Third Party Administrators, which may or may not be affiliated with a health insurance carrier, also administer coverage for self-insured plans. In addition, Blue Cross issues coverage directly to individuals through its Direct Pay products in Rhode Island, and is the only carrier to do so at this time. Another carrier, Neighborhood Health Plan of Rhode Island, provides coverage primarily to RIteCare members under a Medicaid managed care program.

Insurance carriers are licensed and regulated by OHIC primarily, and by the Department of Health secondarily in connection with utilization review matters.

[3] Kaiser Family Foundation and HRET, "Employer Health Benefits", 2011 Annual Survey, Section 10, Exhibit 10.1. http://ehbs.kff.org/pdf/2011/8225.pdf

Third Party Administrators are registered by the Department of Business Regulation, in accordance with R.I. Gen. Laws §27-20.7-1 et seq.

The federal Employee Retirement Income Security Act ("ERISA")[4] creates a legal framework that legislators should address in considering alternatives to premium assessments or taxes. A state law is not pre-empted by ERISA merely because it raises revenue and thereby affects employer-sponsored health benefit plans. See New York State Conference of Blue Cross and Blue Shield Plans v. Travelers Insurance Company, 514 U.S. 645, 650 (1995); Connecticut hospital Association v. Weltman, 66 F.3d 413, 414-415 (2nd Cir. 1995); De Buono v. NYSA-ILA Medical and Clinical Services Fund, 520 U.S. 806 (1997); and (Hatten v. Schwarzenegger, 449 F.3d 423, 426 (2nd Cir. 2006). Care must be taken in drafting such legislation, however, to ensure that it is not subject to a legal challenge.

Because of the shift from insured coverage to self-insured coverage, the premium assessment amount allocated to each insured member has been increasing; a similar increase is not applicable to the general health insurance premium tax because the tax rate is fixed at 2%. Because not all carriers that administer coverage in the self-insured market also offer coverage in the insured market, premium assessment revenue is collected only from carriers with members enrolled in insured coverage plans.

Assessment alternatives

Broadly speaking, this report has evaluated three general mechanisms of assessing health care services to generate revenues for state government programs.

> **1. Assessments on health insurance premiums:** Assessments on health insurance premiums are a common way for states to raise revenues from insurers in all lines of businesses. In 2008, 46 states generated revenue from the general premium taxes. The most common general premium tax rate is 2.0%, the general premium tax rate set in Rhode Island. The majority of this tax revenue went to states' General Funds.[5] The 2% general premium tax is typically imposed on insurance premiums related to all lines of insurance: i.e. life insurance, property and casualty insurance, annuities, health insurance, etc.
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> Special premium assessments, distinct from the general premium tax, may be established to generate revenues for specific, state program expenses. In Rhode Island, for example the children's health account assessment, and the child and adult immunization account assessments are premium assessments applied to health insurance premiums only.

[4] 29 U.S.C. §

[5] Graham, John R. "Assessing Health Insurance: How Much Do States Earn?" Pacific Research Institute, Mar. 2010. Web. 13 Feb. 2012. <http://www.pacificresearch.org/publications/assessmenting-health-insurance-how-much-do-states-earn>. http://www.pacificresearch.org/docLib/20100316_PremiumTax_Final.pdf

2. Assessments on health care provider revenue*:* A provider assessment is a state law that authorizes collecting revenue from a specified group of health care providers. Most commonly, the revenues are used to generate funds for Medicaid services; however, states can impose such an assessment on providers and dedicate the revenue for any specific purpose. State provider assessments are important sources of state Medicaid revenue; they exist in 46 states and generate billions of dollars in revenues each year. In 2009, 23 states levied provider assessments on inpatient hospitals, 28 states taxed intermediate care facility services for the mentally retarded or developmentally disabled (ICF/MR-DD), and 35 states taxed nursing facilities. Examples of provider assessments include assessments on a percentage of hospital or nursing facility revenues, as well as per-bed assessments on hospital or nursing facility revenues.[6] Because the revenue generated by a provider assessment is raised from everyone who uses medical services (including those who are covered by insured and self-insured plans), provider assessments can effectively draw from a significantly broader revenue base than premium taxes.[7]

3. Assessment on health services claims paid by health insurance carriers and third party administrators: A third kind of assessment levied on health care services is an assessment on health care claims paid to health care providers by both health insurers and third-party administrators. In a manner similar to the provider assessment described above, because the revenue generated by an assessment on health care claims is raised from everyone who uses medical services (including those who are covered by insured and self-insured plans), claims assessments can effectively draw from a significantly broader revenue base than premium taxes.

Assessments in other states

While provider assessments to support state Medicaid programs are common in other states, special provider assessments or claims assessments to raise revenue for specific state programs other than Medicaid are less common. OHIC has been unable to locate a comprehensive, multi-state survey of special health care-related assessments. In the absence of a multi-state survey, this report describes and analyzes claims and provider assessments in Vermont, Michigan, and Massachusetts as illustrative of alternatives to a premium-based assessment.[8]

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[6] *Health Care Provider and Industry Assessments/Fees*. Rep. National Conference of State Legislatures, 10 Nov. 2011. Web. 20 Jan. 2012. http://www.ncsl.org/issues-research/health/health-provider-and-industry-state-taxes-and-fees.aspx

[7] Wicks, Elliot K. "Can a Sales Assessment on Medical Services Help Fund State Coverage Expansions?" *State Coverage Initiatives*. Robert Wood Johnson Foundation, July 2008. Web. 21 Feb. 2012. <

[8] As an example of other non-premium based assessments, New York has established an assessment system that is partially claims-based, and partially provider-based. See "New York State Health Care Reform Act (HCRA)." *New York State Department of Health*. Web. 05 Apr. 2012. <http://www.health.ny.gov/regulations/hcra/>.

Vermont: In 2007, Vermont instituted a claims assessment on health insurers to generate revenue for the state's Health Information Technology (IT) Fund, to be used for the purposes of helping primary care practitioners build electronic health record (EHR) systems and to support the creation of a statewide health information exchange network. Under this law, health insurers must pay 0.199% of all health insurance claims paid by the insurer for its Vermont members. "Health insurer" is defined under this statute as "any individual who offers, issues, renews or administers a health insurance policy in [the] state" and includes third-party administrators and pharmacy benefit managers who provide administrative services only for a health benefit plan offering coverage in Vermont. The law excludes Medicaid and Vermont Health Access Plan (VHAP) along with other state health insurance programs, as well as insurers with less than 200 members in the state.[9] There is no specific exclusion in the statute for claims paid by state and municipal health plans. The assessment applies to all services provided by Vermont insurers for Vermont members, regardless of where the service was provided. Therefore, health care services paid for by a Vermont insurer, but provided in other states to Vermont members, are included in the calculation of the assessment fees.[10] In 2011, the state instituted a 0.8% Health Care Claims Assessment which builds off the similar Health IT assessment.[11] For both assessments, the annual fee calculation is determined using the Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES), a state-maintained all payer claims database. In Vermont, the state Department of Banking, Insurance, Securities, and Health Care Administration (BISHCA) has a statutory mandate to collect claims data from health insurers, which include Third Party Administrators, pharmacy benefit managers, and other entities with claims data related to health care provided to Vermont residents.[12] [13]

Michigan: The Health Insurance Claims Assessment Act (HICA), signed by Michigan's governor on September 20, 2011, established a 1% assessment on health insurance claims beginning January 1, 2012. The assessment will be used to provide revenue for the state's Medicaid program and to obtain federal matching funds. The assessment applies to all commercial health plans, including TPAs, self-funded policies, and Medicaid managed care plans. There is no specific exclusion in the statute for claims paid by state and municipal health plans. The assessment applies only to services provided to Michigan residents for services rendered in the state of Michigan; unlike

[9] *Health Care-Related Assessment Study Report*. Rep. Pacific Health Policy Group, Jan. 2012. Web. 21 Feb. 2012. <http://dvha.vermont.gov/budget-legislative/2health-care-related-assessment-study-report-01-12-12.pdf>.
[10] "VERMONT HEALTH CARE INFORMATION TECHNOLOGY REINVESTMENT FEE: GUIDELINES FOR INSURERS." Vermont Health Care Reform Agency of Administration, Sept. 2008. Web. 26 Feb. 2012. <http://hcr.vermont.gov/sites/hcr/files/elines_for_Insurers_September_2008_Update_1_.pdf>.
[11] *Health Care-Related Assessment Study Report*. Jan 2012.
[12] "FREQUENTLY ASKED QUESTIONS AND RESPONSES ABOUT THE FEE CALCULATION FOR HEALTH CARE CLAIMS ASSESSMENT (HCCA) & HEALTH INFORMATION TECHNOLOGY ASSESSMENT (HIT)." *Vermont's Health Care Reform Agency of Administration*. Web. 26 Feb. 2012.
[13] Vt. Stat. Ann. tit. 28.8, § 4089l

with the Vermont assessments, services provided to Michigan residents outside Michigan are not included in the fee calculation.[14] In December 2011, the Self-Insurance Institute of America, Inc. filed a suit in federal court claiming that the new assessment is preempted by federal law (ERISA) and that the law should be struck down as it relates to self-insured plans.[15]

Massachusetts: The Massachusetts Health Care Safety Net Surcharge is an assessment on payments to hospitals and ambulatory surgical centers used to fund the Massachusetts Health Care Safety Net, which funds health care services for uninsured and underinsured Massachusetts residents. This assessment is levied on all entities that make payments for hospital and ambulatory surgical center services, including TPAs administering self-funded health plans. There is no specific exclusion in the statute for claims paid by state and municipal health plans. Unlike the assessments implemented in Vermont and Michigan, this assessment applies to all services rendered in Massachusetts hospitals and ambulatory surgical centers without regard for the patient's state of residence. Additionally, this assessment includes a fee levied on an individual person's self-pay claims above a $10,000 threshold; for these claims, the patient is considered the payer and is liable for the surcharge.[16] [17] The surcharge rate for FY2012 is 1.75% of claims paid to Massachusetts hospitals and ambulatory surgery centers.[18] In Massachusetts, there exists a similar assessment for the child immunization program also levied on payments to hospitals and ambulatory surgical centers. The assessment rate for FY2012 is 1.90% and is based upon claims paid to these entities between Feb 1 – April 30 of each year.[19]

Hypothetical assessment alternatives in Rhode Island

In order to evaluate assessment alternatives, OHIC asked RI health insurers to provide data on all paid claims for the period between November 2010 and October 2011 in five categories: hospital inpatient claims, hospital outpatient claims, other instate outpatient facility claims, other instate medical/surgical claims, and instate prescription drug claims. In each category only data relating to claims paid to hospitals, other facilities and other service providers located in Rhode Island was collected. OHIC received data from Blue Cross and Blue Shield of RI, Tufts Health Plan, Aetna, CIGNA, and United HealthCare.[20] *Figure 2* shows the aggregated claims data provided by these five carriers for the 2010-

[14] Mich. Comp. Laws § 550.1731
[15] "Trade Group Sues over Michigan Health Claims Tax." *CBSNews*. 22 Dec. 2011. Web. 26 Feb. 2012. <http://www.cbsnews.com/8301-505245_162-57347138/trade-group-sues-over-michigan-health-claims-tax/>.
[16] Mass. Gen. Laws ch. 118E, § 57
[17] 114.6 Code Mass. Regs. § 14.00
[18] "Health Safety Net (HSN)." Massachusetts Health and Human Services. Web. 26 Feb. 2012. <http://www.mass.gov/eohhs/provider/client-eligibility/health-safety-net/surcharge.html>.
[19] "Administrative Bulletin 12-03: 114.5 CMR 20.00 Pediatric Immunization Program Assessment." The Commonwealth of Massachusetts Executive Office of Health and Human Services, 12 Jan. 2012. Web. 26 Feb. 2012. <http://www.mass.gov/eohhs/docs/dhcfp/g/ab/12-03.pdf>.
[20] Claims data from Neighborhood Health Plan, as well as Medicare Advantage claims data from United HealthCare, were not collected for the purposes of this study. Neither was claims data collected from Third Party Administrators that are not one of these five carriers; however, these omissions do not affect the validity of the observations and conclusions of this report.

2011 period. Reported claims data includes claims paid by RI insurers for all services provided in RI regardless of the state of residence of the plan member. Members enrolled in the plans insured or administered by the carriers shown in *Figure* 2 include both plans located in Rhode Island, and plans located in other states. The categories “self-insured municipalities” and “self-insured non-municipalities” include all self-insured or self-funded business administered by these RI health insurers. The category “other instate outpatient facility claims” includes free-standing diagnostic radiology centers, surgery centers, and labs. In all categories, paid claims data includes global payments, capitation, and other arrangements.

Figure 2. Aggregated Claims Data (Nov 2010-October 2011)

Coverage Type	Hospital Claims for Services delivered in Rhode Island Nov 2010 - Oct 2011 (or similar period)			Other Instate Outpatient Facility Claims	Other Instate Med/Surg Claims	Instate Prescription Drug Claims
	Inpatient	Outpatient	Total Hospital			
Fully Insured Large Group	$97,989,923	$89,532,469	$187,522,392	$24,433,572	$106,293,129	$58,529,115
Fully Insured Small Group	$61,078,646	$61,693,387	$122,772,033	$15,137,888	$75,498,782	$48,047,999
Direct Pay	$9,321,565	$7,172,035	$16,493,599	$2,526,527	$10,417,830	$7,558,168
Medicare Supplement	$17,765,790	$5,905,890	$23,671,680	$2,840,140	$16,078,732	$1,723,852
Self Insured Non-Municipalities	$89,547,863	$96,103,219	$185,651,082	$18,075,398	$106,338,650	$35,082,059
Self Insured Municipalities	$64,977,183	$68,900,251	$133,877,434	$24,231,405	$101,499,481	$52,053,259
State of Rhode Island	$47,090,881	$44,190,702	$91,281,583	$5,470,102	$45,303,593	$32,982,518
Medicare Advantage	$238,337,588	$88,411,240	$326,748,828	$55,012,806	$161,233,989	$107,675,088
Other	$92,889,435	$69,662,716	$162,552,151	$21,967,388	$92,187,835	$4,904,580
Grand Total	**$718,998,874**	**$531,571,907**	**$1,250,570,781**	**$169,695,226**	**$714,852,021**	**$348,556,640**

OHIC asked the Department of Health and Health and the Department of Human Services to provide data on the premium assessments paid by all carriers in the fiscal year 2012. There are over 200 carriers that are part of the assessment pool, but the majority of the premium assessments are paid by the 5 carriers that provided claims data for this study. Figure 3 shows data on the premium assessments and tax paid by these 5 carriers for FY2012 (Blue Cross and Blue Shield of RI, United HealthCare, Tufts Health Plan, Aetna, and CIGNA) in the row labeled “All Modeled Companies.” Figure 3 also provides data on the premium assessments paid by other carriers not included in the survey in the row labeled “All Other Companies.” The premium tax data reported by the "Modeled Companies" in the aggregate is consistent in aggregate with premium data reported on the Modeled Companies' financial statements. The reported data is used for purposes of this report because of limitations inherent in the financial

statement data. Premium tax revenue paid by the Modeled Companies represent approximately 85% of health insurance premium tax revenue."

Figure 3. Premium Assessments and Premium Tax Paid in FY2011

	Premium Tax CY 2011	RI Childrens Immunization Assessment 2012 based on 2011 Premium	RI Adult Immunization Assessment 2012 based on 2011 Premium	RI Childrens Health Account Assessment 2012 based on 2011 Premium
All Modeled Companies	$26,856,461	$10,389,983	$4,470,973	$9,509,586
All Other Companies		$1,805,851	$797,651	$1,643,606
Total Reported by Agency		$12,195,834	$5,268,625	$11,153,192

The above data was then used to estimate how a claims assessment might be used to create a revenue-neutral alternative to the present premium assessments. The calculation was performed in the following manner: first, a calculation was made of the total amount paid for the three assessments (Child Immunization, Adult Immunization, and Children's Health Account) in FY2012, and the total amount raised from the general premium tax on health insurance premiums only. A calculation was then performed to determine the percent of claims that would have to be assessed for the State to achieve the same revenue generated by the premium assessments.

In Michigan and Vermont, claims assessments have been levied broadly on all paid health care-related claims, while in Massachusetts, claims assessments have been levied on specified categories of health care claims. OHIC evaluated both possibilities in this report: first, a claims assessment levied solely on the basis of hospital inpatient and outpatient claims, and second, a claims assessment levied on the basis of a more broadly defined set of health-care related claims. As shown in *Figure 4*, a claims assessment to replace the current premium assessments levied solely on the basis on hospital inpatient and outpatient claims would require a 1.95% assessment rate, while claims assessment levied on the basis of all hospital and medical claims, including prescription drug claims would require a 0.98% assessment rate. These calculations assume that claims from all categories listed in Figure 2 would be included in the assessment, including Medicare Supplement, Self-insured non-municipalities and municipalities, the State of Rhode Island, and Medicare Advantage.

Figure 4. Health Assessment Charging Methods

Claims Assessment (as % of hospital inpatient and outpatient claims)	
Children's Health Account, Children/Adult Immunization Assessments	1.95%
Premium Tax Replacement	2.15%
Claims Assessment (as % of all hospital and medical claims, including prescription drug claims)	
Children's Health Account, Children/Adult Immunization Assessments	0.98%
Premium Tax Replacement	1.08%
Premium Assessment (as % of insured premium – current approach)	
Children's Health Account, Children/Adult Immunization Assessments	1.78%
Premium Tax	2.00%

These proposed claims assessment rates shown in Figure 4 are based on the reported claims data from five carriers between Nov 2010 and October 2011 and premium assessments from the same five carriers for FY2012. These calculated rates do not include all claims data from all paid health-care related claims in the state, nor do the premium assessment calculations include all premium assessments in FY2012.

The percentage needed to support a claims based assessment is based on an assumption that the five carriers included in this study represent a comparable proportion of overall state claims as the proportion they represent of Rhode Island assessable health premiums. While the authors of this report believe this is a reasonable assumption, the actual proportion may be higher or lower.

It is also important to note that the calculations made in this report are intended to provide the Legislature with a broad overview of the issues presented by different assessment methodologies. It is not intended to provide detailed guidance in how any proposed assessment should be designed, or how the rate of any new assessment should be set. Further research would be needed to determine the administrative start up and operational costs of an alternative assessment mechanism, the lead time needed to transition to an alternative assessment mechanism, and an accurate assessment rate needed to raise an assumed revenue objective.

As shown in Figure 5, by spreading the assessments more broadly (over all insured and self-insured Rhode Island membership), the estimated PMPM cost for those who now support the premium based assessments would be reduced

from $6.95 to $3.23. Similarly, the amount of revenue raised by the general premium tax is equivalent to approximately $7.66 PMPM among insured members. If that revenue were raised based on an assessment on all insured and uninsured claims, the equivalent charge effect would be approximately $3.56 PMPM.

In determining the PMPM cost for these assessments, we assumed approximately 3.5 million premium paying member months among the five carriers that provided data for this study, developed by dividing the reported premium tax by 2.0% and dividing the resulting estimate of premium by an assumed average PMPM premium of $383. That premium estimate was based on 2011 premium information provided in small employer health insurance informational reports. We also assumed approximately 6.6 million member months including all members covered under both insured by these carriers and uninsured contracts administered by the carriers. We developed that estimate based on dividing the reported claims by an assumed average PMPM claims of $329, again based on information provided in small employer health insurance informational reports.

Figure 5. PMPM Assessment Comparison

Premium Assessment (estimated PMPM on Premium Paying Members)	
Children's Health Account, Children/Adult Immunization Assessments	$ 6.95
Premium Tax	$7.66
Claims Assessment (estimated PMPM including both insured and self-insured members)	
Children's Health Account, Children/Adult Immunization Assessments	$ 3.23
Premium Tax Replacement	$3.56

Analysis, evaluation, and other considerations:

- **Covered member impact.** Because a provider assessment or a claims assessment raise revenue from a broader base than a premium assessment, the impact on each individual covered member in an insured plan is likely to be less under a provider assessment or a claims assessment than under a premium assessment. Conversely, and for the same reason, a provider or claims-based assessment impacts individuals covered under self-insured as well as insured plans, and those individuals would have an economic impact that does not exist under the current premium-based assessment. The analysis performed for this report estimates that using a broader base to raise the same amount of revenue

would reduce commercial insurance premiums by an estimated 1.5% of medical expenses.

Conclusion: There does not appear to be any policy or regulatory rationale for allocating these costs on covered individuals based on whether they are covered by an insured versus a self-insured plan; therefore, from a covered member impact perspective, OHIC views a claims or provider based assessment positively.

The above analysis assumes that any transition to a claims or provider-based assessment mechanism is revenue-neutral; otherwise, OHIC would be concerned about any change which might adversely affect the affordability of health insurance for Rhode Island individuals and businesses.

- **Insurance market Impact.** Because a provider assessment or a claims assessment raise revenue from a more diverse number of entities, such assessment alternatives can be considered competitively neutral, in that they do not advantage or disadvantage any type of entity based on whether they provide insured coverage or not. The existing premium-based assessment can be viewed as a competitive disadvantage to carriers in the insured market, and a competitive advantage to carriers and third party administrators doing business in the self-insured market.

  Conclusion: OHIC in general favors a regulatory environment that is competitively neutral, so as to afford all market participants a level playing field on which to offer value to their customers. This report does not attempt to evaluate any impact of alternative assessment mechanisms on economic development conditions in Rhode Island, as such considerations are not within the particular expertise of OHIC.

- **Administrative issues.** The existing premium-based assessment is relatively simple to administer and collect. Alternative assessment mechanisms may add some complexity, or at least a change, to the administration of an assessment. If a change to a claims based assessment is made, additional entities will need to be included in the assessment system, such as health insurance carriers administering only self-insured coverage, and third party administrators. If a change to a provider-based assessment is made, the existing provider categories such hospitals will need to adjust their accounting systems to include the new assessment, and if a provider-based assessment is implemented for provider categories that do not currently pay an assessment, those provider categories will need to developing accounting systems to pay the assessment.

  Conclusions: This investigation which has produced this report did not quantify either the start up or operating costs of alternative assessment mechanisms, or the lead time needed to make a

transition to an alternative assessment mechanism; therefore OHIC is unable to evaluate whether a change to a provider or claims based assessment should be considered positively or negatively on these grounds.

- **Other considerations:**
  - **Availability of claims data:** Calculation of assessment fees on the basis of claims or provider revenue data would require a mechanism to collect claims or revenue data. The premium-based assessment uses readily available premium data from OHIC and the Department of Business Regulation. A process for assessing health care claims or provider revenue would require either a state-based claims database, as in Vermont, or self-reporting by payers and providers, as in Massachusetts. The availability of claims or provider data should not be viewed as either a positive or negative factor in deciding whether to change the assessment mechanism.

  - **Assessment of services provided outside RI to RI members/assessment of services provided in RI to non-members:** Some states instituting claims-based assessments have further expanded the assessment base by applying these assessments either 1) to healthcare services provided outside the state for individuals with an insurance policy based in-state or 2) to healthcare services provided in-state for individuals with an insurance policy based in another state. These options could broaden the revenue base for a new assessment, but could also increase the administrative complexity of collecting the assessment. The current premium-based assessment, in some circumstances (RI employer – out of state member), indirectly raises revenue attributable to coverage of non-RI residents insured by the RI insurance carrier, but the premium-based assessment has no revenue relationship to services provided in RI to a member covered by an out of state insured, or self-insured entity.

  - **Applying claims-based assessments to other payers:** Some states instituting claims-based assessments have included fees charged to payers other than health insurers. In Massachusetts, the Health Care Safety Net Surcharge states that, for certain self-pay claims, the patient is considered the payer and is liable for the surcharge. In evaluating any proposed claims-based assessment, it may be important to consider whether the definition of "paid claim" includes only those payments made by health insurers and TPAs to providers, or whether payments by patients to providers may also be liable.

- **Provider categories to include in the assessment calculation:** In some states, claims-based assessments have been calculated on the basis of claims paid to a designated group of providers. For example, the Massachusetts assessment described above applies only to payments made to hospitals and ambulatory surgical centers. In policies instituted in other states like Vermont and Michigan, "health care claims" includes a much more broadly defined set of health-care related services.

Conclusions and caveats

This report analyzes three alternative assessment mechanisms that can be used to fund Rhode Island's adult and children's immunization programs, and the children's health account programs. The three alternatives are:

1. The current premium-based assessment.
2. A provider revenue based-assessment.
3. A claims-based assessment.

Each alternative mechanism operates in different ways, and therefore can be said to have different strengths and weaknesses depending upon one's perspective and interests. OHIC is a health insurance policy and regulatory agency, and therefor OHIC views these options from the perspective of its statutory mission and purposes. From these health insurance policy-specific perspectives, and assuming that an alternative assessment does not adversely affect the affordability of health insurance, a claims or provider based assessment is viewed positively by OHIC. Ultimately, however, the Legislature and the Governor will need to make a public policy decision either to retain the current premium-based assessment mechanism, or to change to a provider-based or claims-based assessment mechanism.

Additional issues that should be evaluated before the public policy decision concerning assessment alternative is made include:

- What agency or agencies will be responsible for administration of the assessment.
- The cost of assessment administration, and the time need to make a transition.
- An accurate assessment rate needed to generate the desired revenue goal.
- How to ensure that the affordability of health insurance is not adversely impacted.
- How to ensure that any transition would not adversely affect existing human service program finances.

OHIC recommends that the Department of Revenue should be consulted for issues of administration and tax policy. OHIC also recommends that OHHS

be consulted for any potential impact on the finances of the programs supported by the special premium assessments.

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