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S T A T E O F R H O D E I S L A N D

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2014

A N A C T

RELATING TO HEALTH AND SAFETY -- EQUITABLE FUNDING FOR ESSENTIAL HEALTH SERVICES

Introduced By: Representatives Silva, and Serpa

Date Introduced: March 06, 2014

Referred To: House Finance

It is enacted by the General Assembly as follows:

SECTION 1. Section 23-1-46 of the General Laws in Chapter 23-1 entitled "Department of Health" is hereby amended to read as follows:

23-1-46. Insurers. -- (a) ~~Beginning in the fiscal year 2007, each insurer licensed or regulated pursuant to the provisions of chapters 18, 19, 20, and 41 of title 27 shall be assessed a child immunization assessment and an adult immunization assessment for the purposes set forth in this section. The department of health shall make available to each insurer, upon its request, information regarding the department of health's immunization programs and the costs related to the program. Further, the department of health shall submit to the general assembly an annual report on the immunization programs and cost related to the programs, on or before February 1 of each year. Annual assessments shall be based on direct premiums written in the year prior to the assessment and for the child immunization program shall not include any Medicare Supplement Policy (as defined in section 27-18.2-1(g)), Medicaid or Medicare premiums. Adult influenza immunization program annual assessments shall include contributions related to the program costs from Medicare, Medicaid and Medicare Managed Care. As to accident and sickness insurance, the direct premium written shall include, but is not limited to, group, blanket, and individual policies. Those insurers assessed greater than ten thousand dollars ($10,000) for the year shall be assessed four (4) quarterly payments of twenty five percent (25%) of their total assessment. Beginning July 1, 2001, the annual rate of assessment shall be determined by the~~

~~director of health in concurrence with the primary payors, those being insurers assessed at greater than ten thousand dollars ($10,000) for the previous year. This rate shall be calculated by the projected costs for the Advisory Committee on Immunization Practices (ACIP) recommended and state mandated vaccines after the federal share has been determined by the Centers for Disease Control and Prevention. The primary payors shall be informed of any recommended change in rates at least six (6) months in advance, and rates shall be adjusted no more frequently than one time annually. For the childhood vaccine program the director of the department of health shall deposit these amounts in~~

Beginning July 1, 2015, a portion of the amount collected pursuant to § 42-7.4-3, up to the actual amount expended or projected to be expended by the state for vaccines for children that are recommended by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and/or mandated by state law, less the federal share determined by the Centers for Disease Control and Prevention, less any amount collected in excess of the prior year's funding requirement as indicated in subsection (b) (the "child immunization funding requirement") shall be deposited into the "childhood immunization account"~~.~~ described in § 23-1-45(a). These ~~assessments~~ funds shall be used solely for the purposes of the "childhood immunization programs" described in §23-1-44, and no other. ~~For the adult immunization program the director of the department of health shall deposit these amounts in the "adult immunization account".~~ Beginning July 1, 2015, a portion of the amount collected from the healthcare services funding method described in § 42-7.4-3, up to the actual amount expended or projected to be expended by the state for adult immunizations recommended by ACIP and/or mandated by state law, less the federal share determined by the Centers for Disease Control and Prevention, less any amount collected in excess of the prior year's funding requirement as indicated in subsection (b) (the "adult immunization funding requirement") shall be deposited into the "adult immunization account" described in § 23-1-45(c). These funds shall be used solely for the purposes of the "adult immunization programs" described in § 23-1-44 and no other.

(b) The department of health shall submit to the general assembly an annual report on the immunization programs and costs related to the programs, on or before February 1 of each year. Any funds collected in excess of funds needed to carry-out ACIP recommendations, taking into account a reasonable annual carry forward surplus, shall be deducted from the subsequent year's ~~assessments.~~ funding requirements.

SECTION 2. Section 42-12-29 of the General Laws in Chapter 42-12 entitled "Department of Human Services" is hereby amended to read as follows:

42-12-29. Children's health account. -- (a) There is created within the general fund a

restricted receipt account to be known as the "children's health account". All money in the account shall be utilized by the department of human services to effectuate coverage for the following service categories: (1) home health services, which include pediatric private duty nursing and certified nursing assistant services; (2) comprehensive, evaluation, diagnosis, assessment, referral and evaluation (CEDARR) services, which include CEDARR family center services, home based therapeutic services, personal assistance services and supports (PASS) and kids connect services and (3) child and adolescent treatment services (CAITS). All money received pursuant to this section shall be deposited in the children's health account. The general treasurer is authorized and directed to draw his or her orders on the account upon receipt of properly authenticated vouchers from the department of human services.

(b) ~~Beginning in the fiscal year 2007, each insurer licensed or regulated pursuant to the provisions of chapters 18, 19, 20, and 41 of title 27 shall be assessed for the purposes set forth in this section. The department of human services shall make available to each insurer, upon its request, information regarding the department of human services child health program and the costs related to the program. Further, the department of human services shall submit to the general assembly an annual report on the program and cost related to the program, on or before February 1 of each year. Annual assessments shall be based on direct premiums written in the year prior to the assessment and shall not include any Medicare Supplement Policy (as defined in section 27-18-2.1(g)), Medicare managed care, Medicare, Federal Employees Health Plan, Medicaid/RIte Care or dental premiums. As to accident and sickness insurance, the direct premium written shall include, but is not limited to, group, blanket, and individual policies. Those insurers assessed greater than five hundred thousand dollars ($500,000) for the year shall be assessed four (4) quarterly payments of twenty-five percent (25%) of their total assessment. Beginning July 1, 2006, the annual rate of assessment shall be determined by the director of human services in concurrence with the primary payors, those being insurers likely to be assessed at greater than five hundred thousand dollars ($500,000). The director of the department of human services shall deposit that amount~~ Beginning July 1, 2015, a portion of the amount collected pursuant to § 42-7.4-3, up to the actual amount expended or projected to be expended by the state for the services described in § 42-12-29(a), less any amount collected in excess of the prior year's funding requirement as indicated in § 42-12-29(c), but in no event more than the limit set forth in § 42-12-29(d) (the "child health services funding requirement"), shall be deposited in the "children's health account". The ~~assessment~~ funds shall be used solely for the purposes of the "children's health account", and no other.

(c) The department of human services shall submit to the general assembly an annual

report on the program and costs related to the program, on or before February 1 of each year. The department shall make available to each insurer required to make a contribution pursuant to § 42-7.4-3, upon its request, detailed information regarding the children's health programs described in subsection (a) and the costs related to those programs. Any funds collected in excess of funds needed to carry out the programs shall be deducted from the subsequent year's ~~assessment.~~ funding requirements.

(d) The total ~~annual assessment on all insurers~~ amount required to be deposited into the children's health account shall be equivalent to the amount paid by the department of human services for all services, as listed in subsection (a), but not to exceed seven thousand five hundred dollars ($7,500) per child per service per year.

(e) The children's health account shall be exempt from the indirect cost recovery provisions of section 35-4-27 of the general laws.

SECTION 3. Section 44-17-1 of the General Laws in Chapter 44-17 entitled "Taxation of Insurance Companies" is hereby amended to read as follows:

44-17-1. Companies required to file -- Payment of tax -- Retaliatory rates. -- Every domestic, foreign, or alien insurance company, mutual association, organization, or other insurer, including ~~any health maintenance organization, as defined in section 27-41-1,~~ any medical malpractice insurance joint underwriters association as defined in section 42-14.1-1, and any nonprofit dental service corporation as defined in section 27-20.1-2, ~~and any nonprofit hospital or medical service corporation, as defined in chapters 27-19 and 27-20, except companies mentioned in section 44-17-6, and organizations defined in §27-25-1,~~ transacting business in this state, shall, on or before March 1 in each year, file with the tax administrator, in the form that he or she may prescribe, a return under oath or affirmation signed by a duly authorized officer or agent of the company, containing information that may be deemed necessary for the determination of the tax imposed by this chapter, and shall at the same time pay an annual tax to the tax administrator of two percent (2%) of the gross premiums on contracts of insurance, ~~except for ocean marine insurance, as referred to in section 44-17-6,~~ covering property and risks within the state, written during the calendar year ending December 31st next preceding, but in the case of foreign or alien companies, except as provided in section 27-2-17(d) the tax is not less in amount than is imposed by the laws of the state or country under which the companies are organized upon like companies incorporated in this state or upon its agents, if doing business to the same extent in the state or country. Provided, however, that this section shall not apply to companies mentioned in or ocean marine insurance as referred to in § 44-17-6; and provided, further, that this section shall not apply to organizations defined in § 27-25-1, health maintenance organizations as defined in § 27-

41-2, nonprofit hospital or medical service corporations as defined in chapters 19 and 20 of title 27, or insurers as defined in § 42-62-4, except to the extent of gross premium on contracts for dental services.

SECTION 4. Transition period. The department of taxation shall create a process to facilitate the transition to the contribution and avoid overlapping tax liability. An entity that paid a premium tax or made an estimated tax payment pursuant to § 44-17-1 for a time period during which it would also be liable for a contribution described in § 42-7.4-3(a)(2), shall receive credit against its contribution liability in an amount equal to any premium tax paid for that period.

SECTION 5. Title 42 of the General Laws entitled "STATE AFFAIRS AND GOVERNMENT" is hereby amended by adding thereto the following chapter:

CHAPTER 7.4

THE HEALTHCARE SERVICES FUNDING PLAN ACT

42-7.4-1. Short title. -- The Healthcare services funding plan act. -- This chapter shall be known and may be cited as "The Healthcare Services Funding Plan Act."

42-7.4-2. Definitions. -- The following words and phrases as used in this chapter shall have the following meaning:

(1) "Secretary" means the secretary of health and human services.

(2)(i) "Insurer" means all persons offering, administering, and/or insuring healthcare services, including, but not limited to:

(A) Policies of accident and sickness insurance, as defined by chapter 18 of title 27:

(B) Nonprofit hospital or medical service plans, as defined by chapters 19 and 20 of title 27;

(C) Any person whose primary function is to provide diagnostic, therapeutic, or preventive services to a defined population on the basis of a periodic premium;

(D) All domestic, foreign, or alien insurance companies, mutual associations and organizations;

(E) Health maintenance organizations, as defined by chapter 41 of title 27;

(F) All persons providing health benefits coverage on a self-insurance basis;

(G) All third-party administrators described in chapter 20.7 of title 27; and

(H) All persons providing health benefit coverage under Title XIX of the Social Security Act (Medicaid) as a Medicaid managed care organization offering managed Medicaid and the state's Medicaid fee-for-service plan.

(ii) "Insurer" shall not include any nonprofit dental service corporation as defined in § 27-20.1-2, nor any insurer offering only those coverages described in §42-7.4-14.

(3)(i) "Contribution enrollee" means an individual residing in this state, with respect to whom an insurer administers, provides, pays for, insures, or covers health care services, unless excepted by this section.

(ii) "Contribution enrollee" shall not include an individual whose healthcare services are paid or reimbursed by Part A or Part B of the Medicare program, a Medicare supplemental policy as defined in section 1882(g)(1) of the Social Security Act, 42 U.S.C. 1395ss(g)(1), or Medicare managed care policy, the federal employees' health benefit program, Tricare, CHAMPUS, the Veterans' healthcare program, the Indian health service program, or any local governmental corporation, district, or agency providing health benefits coverage on a self-insured basis.

(4) "Person" means any individual, corporation, company, association, partnership, limited liability company, firm, state governmental corporations, districts, and agencies, joint stock associations, trusts, and the legal successor thereof.

(5) "Healthcare services funding contribution" means per capita amount each contributing insurer must contribute to support the programs funded by the method established under this section, with respect to each contribution enrollee.

42-7.4-3. Imposition of healthcare services funding contribution. -- (a) Each insurer is required to pay the healthcare services funding contribution for each contribution enrollee of the insurer at the time the contribution is calculated and paid, at the rate set forth in this section.

(1) Beginning July 1, 2015, the secretary shall set the healthcare services funding contribution each fiscal year in an amount equal to: (i) The child immunization funding requirement described in § 23-1-46; plus (ii) The adult immunization funding requirement described in § 23-1-46; plus (iii) The children's health services funding requirement described in § 42-12-29; and all as divided by (iv) The number of contribution enrollees of all insurers.

(2) Beginning January 1, 2016, the secretary shall set the healthcare services funding contribution each fiscal year in an amount equal to: (i) The child immunization funding requirement described in § 23-1-46; plus (ii) The adult immunization funding requirement described in § 23-1-46; plus (iii) The children's health services funding requirement described in § 42-12-29; plus (iv) An amount, calculated by the division of taxation, and reported to the secretary, equivalent to the amount of tax revenue described in § 44-17-1, excluding gross premiums for dental services contracts, that would have imposed on health maintenance organizations as defined in § 27-41-1, nonprofit hospital or medical service corporations as defined in chapters 19 and 20 of title 27, and insurers as defined in § 42-62-4, during the calendar year ending December 31, 2013; and all divided by (v) The number of contribution enrollees of all insurers.

(3) The contribution set forth herein shall be in addition to any other fees or assessments upon the insurer allowable by law.

(b) The contribution shall be paid by the insurer; provided, however, a person providing health benefits coverage on a self-insurance basis that uses the services of a third-party administrator shall not be required to make a contribution for a contribution enrollee where the contribution on that enrollee has been or will be made by the third-party administrator.

42-7.4-4. Returns and payment. -- (a) Subject to subsection (b), every insurer required to make a contribution shall, on or before the last day of July, October, January and April of each year, make a return to the secretary together with payment of the quarterly healthcare services funding contribution for the preceding three (3) month period.

(b)(1) Upon request of the director of the department of health or the director of the department of taxation, the secretary shall develop a process whereby an insurer required to make the contribution may be directed to make estimated payments for the related portion(s) of the liability arising under § 42-7.4-3(a) and the secretary shall make that pre-paid amount available to the department of health or the department of taxation, as requested.

(2) Unless requested to make an estimated payment as described in subsection (b)(1) above, any insurer required to make the contribution that can substantiate that the insurer's contribution liability would average less than twenty-five thousand dollars ($25,000) per month may file returns and remit payment annually on or before the last day of June each year; provided, however, that the insurer shall be required to make quarterly payments if the secretary determines that:

(i) The insurer has become delinquent in either the filing of the return or the payment of the healthcare services funding contribution due thereon; or

(ii) The liability of the insurer exceeds seventy-five thousand dollars ($75,000) in healthcare services funding contribution per quarter for any two (2) subsequent quarters.

(c) All returns shall be signed by the insurer required to make the contribution, or by its authorized representative, subject to the pains and penalties of perjury.

(d) If a return shows an overpayment of the contribution due, the secretary shall refund or credit the overpayment to the insurer required to make the contribution, or the insurer may deduct the overpayment from the next quarterly or annual return.

(e) The secretary, for good cause shown, may extend the time within which an insurer is required to file a return, and if the return is filed during the period of extension no penalty or late filing charge may be imposed for failure to file the return at the time required by this section, but the insurer shall be liable for interest as prescribed in this section. Failure to file the return during

the period for the extension shall void the extension.

42-7.4-5. Set-off for delinquent payment. -- If an insurer required to make the contribution pursuant to this chapter shall fail to pay a contribution within thirty (30) days of its due date, the secretary may request any agency of state government making payments to the insurer to set-off the amount of the delinquency against any payment or amount due the insurer from the agency of state government and remit the sum to the secretary. Upon receipt of the setoff request from the secretary, any agency of state government is authorized and empowered to set-off the amount of the delinquency against any payment or amounts due the insurer. The amount of set-off shall be credited against the contribution due from the insurer.

42-7.4-6. Assessment on available information -- Interest on delinquencies -- Penalties -- Collection powers. -- If any insurer shall fail to file a return within the time required by this chapter, or shall file an insufficient or incorrect return, or shall not pay the contribution imposed by this section when it is due, the secretary shall assess the contribution upon the information as may be available, which shall be payable upon demand and shall bear interest at the annual rate provided by § 44-1-7, from the date when the contribution should have been paid. If the failure is due, in whole or part, to negligence or intentional disregard of the provisions of this section, a penalty of ten percent (10%) of the amount of the determination shall be added to the contribution. The secretary shall collect the contribution with interest. The secretary may request any agency to assist in collection, including the tax administrator, who may collect the contribution with interest in the same manner and with the same powers as are prescribed for collection of taxes in title 44.

42-7.4-7. Claims for refund -- Hearing upon denial. -- (a) Any insurer required to pay the contribution may file a claim for refund with the secretary at any time within two (2) years after the contribution has been paid. If the secretary shall determine that the contribution has been overpaid, he or she shall make a refund with ten percent (10%) interest from the date of overpayment.

(b) Any insurer whose claim for refund has been denied may, within thirty (30) days from the date of the mailing by the secretary of the notice of the decision, request a hearing and the secretary shall, as soon as practicable, set a time and place for the hearing and shall notify the person.

42-7.4-8. Hearing by secretary on application. -- Any insurer aggrieved by the action of the secretary in determining the amount of any contribution or penalty imposed under the provisions of this chapter may apply to the secretary, within thirty (30) days after the notice of the action is mailed to it, for a hearing relative to the contribution or penalty. The secretary shall fix a

time and place for the hearing and shall so notify the person. Upon the hearing the secretary shall correct manifest errors, if any, disclosed at the hearing and thereupon assess and collect the amount lawfully due together with any penalty or interest thereon.

42-7.4-9. Appeals. -- Appeals from administrative orders or decisions made pursuant to any provisions of this chapter shall be pursued pursuant to chapter 35 of title 42. The right to appeal under this section shall be expressly made conditional upon prepayment of all contribution, interest, and penalties unless the insurer demonstrates to the satisfaction of the court that the insurer has a reasonable probability of success on the merits and is unable to prepay all contribution, interest, and penalties, considering not only the insurer's own financial resources but also the ability of the insurer to borrow the required funds. If the court, after appeal, holds that the insurer is entitled to a refund, the insurer shall also be paid interest on the amount at the rate provided in § 44-1-7.1 of the Rhode Island general laws, as amended.

42-7.4-10. Records. -- Every insurer required to make the contribution shall:

(1) Keep records as may be necessary to determine the amount of its liability under this section;

(2) Preserve those records for a period of three (3) years following the date of filing of any return required by this section, or until any litigation or prosecution under this section is finally determined; and

(3) Make those records available for inspection by the secretary or his/her authorized agents, upon demand, at reasonable times during regular business hours.

42-7.4-11. Method of payment and deposit of contribution. -- (a) The payments required by this chapter may be made by electronic transfer of monies to the general treasurer.

(b) The general treasurer shall take all steps necessary to facilitate the transfer of monies to:

(1) The "childhood immunization account" described in § 23-1-45(a) in the amount described in § 23-1-46(a);

(2) To the "adult immunization account" described in § 23-1-45(c) in the amount described in § 23-1-46(a);

(3) To the "children's health account" described in § 42-12-29(a) in the amount described in § 42-12-29(b);

(4) To the general fund in the amount described in § 42-7.4-3(a); and

(5) Any remainder of the payments shall be proportionally distributed to those accounts and credited against the next year's healthcare services funding contribution.

(c) The general treasurer shall provide the secretary with a record of any monies

transferred and deposited.

42-7.4-12. Rules and regulations. -- The secretary is authorized to make and promulgate rules, regulations, and procedures not inconsistent with state law and fiscal procedures as he or she deems necessary for the proper administration of this healthcare services funding plan act and to carry out the provisions, policies, and purposes of this chapter including, but not limited to, data it must collect from insurers for the correct computation of the healthcare services funding contribution, collaboration with other state agencies for collecting necessary information, and the form of the return and the data that it must contain for the correct computation of the healthcare services funding contribution..

42-7.4-13. Allocation. -- An insurer required to make a healthcare services funding contribution may pass on the cost of that contribution in the cost of its services, such as its premium rates (for insurers), without being required to specifically allocate those costs to individuals or populations that actually incurred the contribution.

42-7.4-14. Excluded coverage from the healthcare services funding plan act. -- (a) In addition to any exclusion and exemption contained elsewhere in this chapter, this chapter shall not apply to insurance coverage providing benefits for, nor shall an individual be deemed a contribution enrollee solely by virtue of receiving benefits for the following:

(1) Hospital confinement indemnity;

(2) Disability income;

(3) Accident only;

(4) Long-term care;

(5) Medicare supplement;

(6) Limited benefit health;

(7) Specified disease indemnity;

(8) Sickness or bodily injury or death by accident or both; and

(9) Other limited benefit policies.

42-7.4-15. Oversight. -- The health insurance commissioner shall validate, through the rate review and approval process, that the rates filed for fully insured groups and individuals, pursuant to chapter 18.5, 18.6 or 50 of title 27, reflect the transition to the funding method described in this section.

SECTION 6. Sections 1 and 2 of this act shall take effect July 1, 2015, sections 3 and 4 of this act shall take effect January 1, 2016, and the remaining sections of this act shall take effect upon passage.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

A N A C T

RELATING TO HEALTH AND SAFETY -- EQUITABLE FUNDING FOR ESSENTIAL HEALTH SERVICES

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This act would phase-in a replacement of the current immunization and children's healthcare services assessments and premium tax with a healthcare services funding plan. The act includes a number of calculations for making contributions and distributions. The act would provide that health insurers would be required to make a healthcare services funding contribution in an amount calculated by taking several funding requirements and dividing by the number of contribution enrollees of all insurers. Finally, the act would include a process for insurers to have a hearing and appeal regarding the amount established for the contribution.

Sections 1 and 2 of this act would take effect July 1, 2015, sections 3 and 4 of this act would take effect January 1, 2016, and the remaining sections of this act would take effect upon passage.

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