State of New Jersey
DEPARTMENT OF BANKING AND INSURANCE
OFFICE OF THE COMMISSIONER
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RICHARD J. CODEY
Acting Governor

TEL (609) 292-5360

HOLLY C. BAKKE
Commissioner

November 29, 2004

Honorable Richard J. Codey
Acting Governor
State House
125 West State Street
Trenton, NJ 08625

Re: CBT/Premium Tax Report

Dear Acting Governor Codey:

Section 2 of P.L. 2004, c. 49 directs the State Treasurer and the Commissioner of Banking of Insurance to conduct a comparative study of the revenues received under the Corporate Business Tax from health maintenance organizations and other health care delivery systems or health care providers subject to that tax, and those insurers, health service corporations and other health care delivery systems paying the insurance premium tax pursuant to NJSA 54:18A-1 et seq. The study was to evaluate the equities of those tax schemes and was to be completed no later than September 1, 2004.

On July 20, 2004, a report was submitted in response to the statutory directive. By letter dated September 22, 2004, you asked that the report be expanded to address additional items. The attached supplemental report is in response to your request. As statutorily required, the initial and supplemental reports are being shared with Assembly Speaker Sires, Republican Leaders Lance and DeCroce, the chairpersons of the pertinent legislative committees, as well as the remaining members of the legislature.

Please advise if you require any further information.

Very truly yours,

Holly Bakke

Holly C. Bakke, Commissioner

C: Albio Sires, Assembly Speaker

Leonard Lance, Senate Republican Leader
Alex DeCroce, Assembly Republican Leader
Louis D. Greenwald, Chairman, Assembly Budget Comm.
Neil M. Cohen, Chairman, Assembly Financial Institutions Comm.
Loretta Weinberg, Chairwoman, Assembly Health & Human Services Comm.
Wayne R. Bryant, Chairman, Senate Budget Committee
Byron M. Baer, Chairman, Senate Commerce Committee
Joseph F. Vitale, Chairman, Senate Health, Human Services & Senior Citizens Committee
Members of the Assembly and Senate
John E. McCormac, Treasurer

Supplement to July 20, 2004 Report

Purpose

S1781/A3116, passed as part of the SFY 2005 Budget, directs the State Treasurer and the Commissioner of the Department of Banking and Insurance (DOBI) to study the taxation of health maintenance organizations (HMOs) and other health carriers. Subsequent to the passage of this law, staff of the Treasury and DOBI undertook a study of these issues. A report, dated July 20, 2004, was submitted by the Treasurer, focusing on the taxation of HMOs. By letter dated September 22, 2004 Senate President Codey asked the State Treasurer and DOBI to expand the report by discussing, among other things, taxation of other health carriers, the possible reasons for the development of the current systems, and an evaluation of the impact of this system on tax revenues and the funding of health care. The within report expands on and supplement the original report of the Treasurer as requested by Senate President Codey.

Introduction

Different types of providers of health and dental coverage in New Jersey are subject to significantly different systems of taxation at the state level. Below, we describe the present situation, along with the historical reasons that may have led to the current system of taxation of these entities. This report finds that the differences and policy considerations which are the root of the non-uniform treatment have largely disappeared, and that a uniform system of taxation of health carriers is appropriate.

The Health and Dental Coverage Market in New Jersey

In New Jersey, health and dental coverage is offered by six types of regulated carriers: Life or Property Casualty Insurers, Fraternal Benefit Organizations (Fraternals), Health Service Corporations (HSCs), Health Maintenance Organizations (HMOs), Dental Service Corporations (DSCs), and Dental Plan Organizations (DPOs). DSCs and DPOs are authorized only to issue dental plans.

"Insurer" is commonly used to designate any type of carrier. But, in this report, we will use the term "insurer" in its exact sense, and use the general term "carrier" for any entity, including an insurer, that is authorized to issue health or dental coverage. Note that an insurer may be organized as a life insurer or a non-life insurer; either type can be authorized to issue health coverage.

There are approximately 300 carriers of all types issuing health coverage in New Jersey. About 100 of these carriers issue insignificant amounts of coverage (less than $100,000 annual premium) but are included in the totals

below. The total health premium in 2003 was about $12.9 billion. This premium includes all health coverages, such as dental, disability income and accident only. However, comprehensive health coverage constitutes the majority of the market – about $6.7 billion commercial, and another $2.5 billion for Medicaid, Medicare Advantage, and Federal Employees. This coverage is written in significant amounts by only 20 carriers. Since some of these carriers are under common ownership, there are fewer actual competitors in the market.

For 2003, a summary of the market is:

Type of Carrier	Number of Carriers	Premium ($ millions)	Net After Tax Profits ($millions)
Insurer	263	$ 3,458	Not available
HSC	1	$ 3,149	$ 142.2
HMO	12	$ 5,961	$ 151.8
Fraternal	5	$ 5	Not available
DSC	2	$ 219	$ 12.8
DPO	20	$ 84	$ 5.0
Total	303	$12, 876	Not Available

Business Models of Health Carriers -- Historical

Each form of health carrier operates under different statutory authority. Historically, these statutory distinctions reflected different roles for the carriers in the delivery of health care. A discussion of these historical business models follows.

Insurers

Insurers provided health coverage on an indemnity basis, that is reimbursement for an amount or portion of medical expenses incurred. Most insurers offered other health coverages in addition to hospital and medical expenses, for example, disability income and accidental only coverage. For an insurer, health was typically only one line of business, complementing life and annuity business (if a life insurer) or personal and commercial casualty lines (if a property-casulty insurer). Insurers were for profit, and were organized on either the stock (owned by stockholders) or mutual (owned by policyholders) principle.

Hospital, Medical, and Health Service Corporations

Hospital, Medical, and Health Service Corporations (primarily but not exclusively Blue Cross and Blue Shield plans) were formed to provide hospital and medical care on a pre-paid basis. To the covered person, the distinction between this model and insurance was nearly invisible - the prepayment was the equivalent of a premium, and the service corporation paid the hospital or doctor if services were needed. The distinguishing elements between service corporations and insurers were agreements between the service corporation and the providers concerning the payments to be made, limitations on the ability of the service corporation to rate or reject unhealthy risks, non-profit status of the service corporation, and limitations on the ability to engage in other lines of business. However, service corporations also gained, and used, the authority to issue indemnity health insurance contracts similar to those issued by insurers.

Health Maintenance Organizations (HMOs)

Health Maintenance Organizations were first formed, and gained market acceptance, on the West Coast at about the time of World War II, with Kaiser-Permanente as the initial example. HMOs (like service corporations) were not characterized as insurance, but as pre-paid health care. The care was provided by hospitals and doctors actually owned and employed by the HMO (in the Kaiser model) or under contract to the HMO (in other models). It may be surprising that the basis for formation of HMOs was not simply control of health care costs, but the provision of coordinated health care. Most visibly, HMOs emphasized the importance of (and payment for) preventive care. In New Jersey, laws permitting HMOs took effect in 1973, and were codified in the Health, not the Insurance statute. HMOs were not permitted to issue other insurance coverages, or to issue health insurance indemnity contracts. New Jersey HMOs were organized on both the staff model (Kaiser) or contracted provider model, and were both not-for-profit and for profit. As permitted by law, some HMOs were affiliated with insurers or service corporations, as HMOs were seen as an alternative to other, more traditional, means of providing health benefits.

Fraternal Benefit Societies (Fraternals)

Fraternals most closely resemble mutual life insurance companies; they were formed and operated usually by religious or lodge organizations, to provide insurance at cost for their members and to further the goals of the founding organization. Fraternals are no longer active in the medical coverage market; the small amount of health coverage they write is largely disability income and long term care coverage complementing life and annuity products. Except to note their tax status, there will be no further discussion of fraternals in this report.

Evolution of the Health Carrier Business Model

Over the last 30 years, the development of the business model for health

carriers has been driven by two primary factors: 1) the emergence of a new type of managed care contract, the Preferred Provider Organization (PPO) or Point of Service (POS) contract, providing both in-network and out-of-network benefits, as the dominant form of health coverage, and 2) relaxation of restrictions on business to allow all three types of carriers to issue, and thus directly compete for, PPO/POS contracts. Thus, an industry which thirty years ago was characterized by three types of carriers writing three types of coverages (although the distinction between insurers and service corporations was already blurred) has evolved to three types of carriers, all able to write at least one version of the PPO/POS product, in addition to other products. Furthermore, the fact that HMOs and insurers or service corporations can be affiliated means that, on an affiliated basis, virtually every carrier in New Jersey can offer a full range of products under a single brand name.

The PPO/POS product offers two levels of benefits (that is, required cost sharing in the form of copays, coinsurance, deductibles, or other uncovered amounts) depending on whether medically necessary and covered services are rendered in-network (with a provider contracted with the carrier) or out-of-network (by a non-contracted, but licensed, provider). The level of benefits is higher for in-network, both as an incentive, and because the contracted rates in-network generally result in lower cost.

Distinguishing between the PPO and POS models is difficult, and becomes more difficult as carriers add additional options. The PPO model is based on the traditional indemnity insurance model, which pays a specified percentage of the provider's allowable charge after deductible. The PPO pays more (a higher percentage, for example) if the service is in-network. A POS contract has an in-network benefit that more closely resembles a traditional HMO, and, like an HMO, may require referrals for services. The POS out of network benefit resembles the out of network PPO benefit.

In the 1970s, no carrier, with the possible exception of a service corporation, had the explicit authority to issue a PPO/POS type of contract. HMOs were clearly restricted from doing so. Subsequent regulatory changes explicitly authorized insurers and HMOs to offer these contracts, and did not restrict service corporations in doing so.

Any discussion of the business model for different types of carriers should point out that, in practice, the business is not written by a single carrier such as an insurer or an HMO, but a group of carriers under common ownership offering a complete range of products. Aetna, Amerihealth, CIGNA, Horizon, Oxford/United, and WellChoice all offer products through both HMOs and Insurers (or a service corporation) under a common name. Of major carriers, only Health Net is currently an exception, and it has an application pending for an affiliated insurer to be permitted to offer a product with in network and out of network benefits. Furthermore, in certain markets, the POS product may be

offered by the HMO (Aetna) or the Insurer/Service Corporation (Horizon, Oxford).

The distinctions between different types of carriers are not as apparent today as they were in the past. The reform legislation in the early 1990s for the individual and small group markets imposed uniform rating and loss ratio requirements on all carriers. This reform legislation also significantly reduced the role of service corporations as "carriers of last resort". Recent rules adopted by the Department (NJAC 11:22-5) allowing benefit designs with greater cost sharing were drafted to impose uniform requirements on all threetypes of carriers. All health carriers (with the exception of property casualty insurers who do not primarily issue health insurance) now file a common form of financial statement; formerly the statement varied by type of carrier.

Business Model for Dental Carriers

Models for dental coverage are not as complex as those for health coverage. Dental coverage is a relatively recent innovation, and it is neither as expensive nor as subject to variability as health coverage. Some health carriers, described above, participate in the dental market. Insurers and health service corporations can offer dental coverage on an indemnity or PPO basis. HMOs, on the other hand, are not allowed to offer "stand-alone" dental benefits.

New Jersey law also allows two types of carriers that can offer only dental benefits – Dental Service Corporations (DSCs) and Dental Plan Organizations (DPOs). A DSC offers indemnity (and PPO) dental coverages similar to those of insurers and service corporations. As a service corporation, it must be non-profit. DPOs can be for-profit, but they are limited to providing benefits through a specific panel of dentists. DPOs can be very small, consisting of one or more dentists providing care to a local group of patients for a pre-paid fee. However, some DPOs are larger and are affiliated with major health carriers. For example, Aetna, CIGNA, and Horizon all own DPOs, allowing them to supplement their other health and dental products with an in-network only dental benefit.

Current Taxation of Health and Dental Carriers

Insurers

nsurers pay premium tax of 2% of New Jersey premium for all lines (including Individual Accident & Health) other than Group Accident & Health, where the tax rate is 1%. (There is an additional tax of .1% or .05% dedicated to DOBI operations). Premium tax is, like a sales tax, a tax on gross revenues and is paid by insurers in lieu of state tax on income such as the corporate business tax (CBT).

An insurer whose New Jersey premium is greater than 12.5% of its national premium can be taxed on 12.5% of national premium (N.J.S.A.

54:18A-6), giving a lower total tax; however, no large New Jersey health insurer appears to qualify for this preferential treatment, although, as noted below, Horizon BCBS, a health service corporation, does. A carrier writing all of its business in New Jersey would consequently pay only 1/8 of its "normal" premium tax. This provision, which dates from the 1950s, was apparently intended to reward insurers for operating in New Jersey.

For 2003, health insurers paid $11.8 million in premium tax on individual Accident & Health premiums and $27.1 million in premium tax on group Accident & Health premiums. (These amounts do not include the DOBI operations assessment.) Total Insurer health premium in 2003 was reported to be $3,458 million, so the effective tax rate was about 1.1%.

Health Service Corporations (HSCs)

Horizon BCBS, as a HSC, is taxed similarly but not identically to insurers. Horizon is only taxed on premium from experience-rated group business (larger groups) at the rate of 1.05%. Unlike an insurer, it is not taxed on its individual or small group business. Furthermore, because all of its business is in New Jersey, it qualifies for 12.5% treatment, and is only taxed on 12.5% of its premium.

As a consequence, Horizon BCBS, with total taxable premiums of about $2,628 million ($122 million individual, $2,393 million group, and $113 million dental) paid total premium tax of $2.4 million, an effective tax rate of less than .1%.

Health Maintenance Organizations (HMOs)

HMOs are not subject to premium tax; like non-insurance corporations they pay CBT on net income. The approximate effective rate on taxable income is about 10%. In 2003, HMOs had net profit before federal income tax and CBT of about $ 211 million, and are estimated to have paid CBT of about $21.4 million.

In general, application of the CBT results in lower tax revenue than that resulting from premium tax. HMO commercial premiums in 2003 were $37.4 million. The ratio of CBT to commercial premiums is about .6%, a lower effective premium tax rate than that experienced by commercial insurers. Considering that 2003 was a year of high average profits, the effective premium tax rate in a typical year would be lower than .6%.

However, two HMOs with commercial business did have net losses in 2003, and consequently incurred no CBT. The premium tax revenue from these HMOs would have been about $10.8 million, which would increase the losses. This highlights the fact that CBT, as opposed to premium tax, places the burden on profitable carriers.

Fraternal

Not taxed

Dental Service Corporation (DSC)

Not taxed

Dental Plan Organization (DPO)

CBT on net income

The following table summarizes the tax revenues of different groups of carriers, compared to premium and net after tax profits.

Type of Carrier	Tax Revenue ($ millions)	Premium ($ millions)	Net After Tax Profits ($ millions)
Insurer	$ 38.9 (P)	$3,458	Not available
HSC	$ 2.4 (P)	$3,149	$ 142.2
HMO	$ 21.4 (C)	$5,961	$ 151.8
Fraternal	0	$ 5	Not available
DSC	0	$ 219	$ 12.8
DPO	$ .5 (C)	$ 84	$ 5.0
Total	$63.2	$12,876	Not Available

P = Premium Tax Revenue
C = Corporate Business Tax Revenue

Taxation of Gains from Administrative Services Only (ASO) business

Licensed carriers such as Insurers, HMOs, and HSCs, are permitted to provide administrative services to self-funded health plans (such as the State Health Benefits Plan or the plans of large corporations and unions). These plans are exempt from state regulation under federal law (ERISA), and the activities of carriers in providing these services is also unregulated. The required financial statements of these carriers do not report the results of this activity as a separate line of business; revenues from such activities are reported as an offset to expenses. An entity that is not licensed as a health carrier can do ASO business as well. The term TPA (third party administrator) is generally used for such an entity. TPAs (who are not health carriers) are subject to minimal regulation by DOBI.

HMOs, which are the only entity required to directly report ASO enrollment, administered benefits for approximately 580,000 enrollees. We estimate that other administrators, including carriers and TPAs, administer benefits for another 1,750,000 people. Finally, about 620,000 people in the New Jersey SHBP have benefits administered by Horizon on an ASO basis.

Because revenues from ASO business are not treated as premiums, insurers and HSCs pay no tax on their ASO activity, either on a gross revenue basis or a net income basis. HMOs, on the other hand, pay CBT on all of their activities, including any gains from ASO business. Any gains from ASO business by a TPA would also be subject to CBT.

It is difficult to estimate the foregone taxes from untaxed ASO activity. We would be surprised if ASO profits, if taxed at a 10% rate, would generate more than $10 million.

Although beyond the scope of this report, a similar situation exists in New Jersey regarding life insurance company gains from operations on annuity contracts. Annuities (essentially an investment business) have grown over time to be a major contributor to life insurer gains from operations. However, funds deposited with the life insurer for annuity contracts are not subject to premium tax, nor are the gains from annuities taxed. This is a significant line of business that is essentially free from state taxation.

Analysis and Explanation

The approximate tax revenue on health premium ranges from 0% to 2.1%, depending on the type of coverage and the carrier providing the coverage. Significant portions are taxed at 0% (DSC, HSC individual and small group), .125% (HSC large group), .5% (HMO estimate based on a target profit margin), 1.05% (most insurer group) and 2.1% (most insurer individual).

This lack of uniformity is a concern for two reasons. Considering these taxes as a source of revenue, the burden clearly does not fall evenly on all carriers. Considering these taxes as a component of the rate that is paid by the policyholder, they create a potential competitive difference between carriers. However, consumers do not seem to be very sensitive to variations in rates of the order of magnitude of 2%. Therefore, the fairness, rather than the market impact, issue should probably be of greater concern.

How could carriers offering such similar benefits be subject to such differences in taxation? As indicated in the above discussion, different health carriers began with very different "operating models", and a tax treatment was developed consistent with the original models. Tax treatment has not evolved as quickly as the methods of operation of these carriers.

Historically, there were insurers and Blues plans, the precursors of HSCs. Insurers were taxed on gross revenue (premium), either as a form of sales tax or as a proxy for an income tax, since allocation of net income by state for a multi-state carrier would be difficult or subject to manipulation. The maximum tax (12.5%) rule, which was apparently put in place in the 1950's, was intended to encourage companies to write business in New Jersey.

Blues plans, the precursors of HSC's, were formed on a non-profit basis, and performed a public function as insurer of last resort. They were also closely aligned with the hospital and medical associations. Therefore, they were generally exempt from premium tax (and, originally, federal income tax as well). As these plans evolved to become directly competitive with insurers in the large group market, they were subjected to premium tax for this competitive business, leaving the business (small and individual) where they performed a public duty untaxed. In addition, the single state nature of the New Jersey Blues plan made it eligible for maximum tax (12.5%) treatment. While individual and small group reform in the early 1990s put HSCs on essentially the same footing as other carriers, no corresponding adjustment was made to the premium tax treatment.

HMOs, which began with Kaiser on the West Coast in the 1940's were originally structured to be very different from insurers. They tended to be not for profit, and to provide services through hospitals and medical groups that were owned by or closely affiliated with the HMO. Therefore, an HMO appeared to have more of the characteristics of a medical group providing pre-paid benefits than an insurer assuming risk. In addition, HMOs tended to be local. Using the model that an HMO was more like a service business than an insurer, tax based on NJ net income seemed both computable and appropriate. This also provided an incentive for HMOs to remain not for profit (which would not have been the case if they were subject to premium tax).

The taxation of dental plans probably did not receive much thought when these plans were authorized by law, and they received the tax treatment of similar health carriers. DSCs were exempt from all tax, the original treatment of HSCs. And, DPOs were subject to CBT, like the HMOs on which they were modeled.

Other States

Premium taxation of insurers is typical in other states, although the rates vary. We have not studied the taxation of health service corporations or their equivalent in other states. We note that in many states, the Blue Cross/Blue Shield plan has converted to a for-profit stock insurer.

We have looked into the ways in which different states tax HMOs. The most common method of taxation is a premium tax. Twenty seven (27) states tax the premiums of HMOs, and thirteen (13) of these have a tax rate of 2% or

higher. Eight states, including New York (and New Jersey) tax HMOs through a net profits, income, corporate, or franchise tax. Fourteen (14) states do not have a tax on premiums, but it is not clear if they are taxed on some other basis. Four (4) states do not tax HMOs at all. (The 53 "states" include DC, etc.)

Conclusions and Recommendations

This report suggests that the differential state tax treatment of different health carrier types is antiquated and serves no present purpose. A premium tax is the oldest and simplest form of taxation. It is also difficult to manipulate, and is predictable for both the taxpayer and the state. A system of taxation which taxes all health carriers (including dental-only carriers) on premiums at the same rate as insurers (2.1% for individual, 1.05% for group) is a practical option. This would involve moving HMOs and DPOs from a CBT to a premium tax basis, imposing taxation on DSCs, extending the premium tax base for HSCs to all premium, and eliminating the 12.5% limitation for any health carrier to which it applies. This would make health carriers (or more correctly, health products) subject to a uniform, simple, understandable, and predictable mode of taxation. It would also increase tax revenue from this industry.

We can anticipate a number of objections to this proposal, because it both changes the basis of taxation for many carriers, and increases the amount of tax imposed on these carriers.

One set of objections suggests that while additional taxes might be passed on to policyholders, such an increase is not inevitable. A carrier may be constrained by competition from raising rates to recover this tax. Or, for rates which are regulated, particularly those subject to minimum loss ratio requirements, a carrier may not be able to raise rates without violating this minimum loss ratio requirement. In any event, even if this increase is borne by the policyholder, it will be at most 1% of premium for group coverage and 2% of premium for individual coverage. For the last few years, carriers have been increasing rates at 10% -15% per year on the average. The minimal impact of a tax increase, if passed through, would be insignificant in comparison to the double digit increases that carriers have been implementing.

Another set of objections suggests that carriers that are losing money would not be able to pass this increased tax on to policyholders, and that the tax would thus worsen the carriers' financial woes. But, it is possible that such carriers are less likely to be constrained either by regulation or by competition from passing on the increase. Second, it is not clear why the tax system should be designed to favor carriers that consistently lose money. Third, it is not clear why a particular type of carrier (HMOs) requires a tax system that is linked to earnings, while insurers, also subject to gains and losses, are taxed on gross revenue. The property and casualty insurance industry has been, historically, subject to cyclical volatility in gains and losses due to price competition. This

business has been subject to premium taxes, rather than a net profits tax.

Finally, there will be objections that indicate that characteristics of the market for a particular carrier dictate preferential tax treatment. HMOs may argue that they should receive preferential treatment because they provide the lowest cost products. An HSC may argue that it bears a disproportionate burden in providing coverage in reform markets. Dental only carriers may argue that they do not have the ability to flexibly price by combining dental benefits with other health and non-health coverages. But, there are insurers who primarily write a single line of group coverage who are subject to premium taxes and face similar situations. In any event, being a single line carrier has both advantages and disadvantages, and there is no basis for addressing this in the system.

OFFICE OF THE TREASURER

DATE: 7/20/2004

TO: THE LEGISLATURE

FROM: TREASURER JOHN C. MCCORMAC

RE: REPORT TO THE LEGISLATURE REGARDING HMO TAXES

In the SFY 2005 Budget the Legislature passed a health maintenance organization (HMO) assessment (S-1781/A3116). A section of that bill directs the State Treasurer and the Commissioner of the Department of Banking and Insurance (DOBI) to complete a study comparing the HMO revenues received from under the Corporation Business Tax to the insurance premium tax paid by other insurers and health care service delivery corporations. In particular, the bill directs the study to consider the policy position behind the 1973 exemption of HMOs from taxation on enrollee charges, otherwise known as premiums. According to the legislation, the study should examine the various business models under which HMOs, health service corporations, insurers and other healthcare delivery systems operate; and allow the State to appropriately identify and capture revenues which adequately reflect both the volume of business conducted by those entities and the costs to the State of the operation of those businesses. In addition, the study should look briefly at the current and anticipated futures demands that the State's charity care obligation will place on the General Fund and on other State resources.

Background

When the "Health Maintenance Organizations Act" took effect in 1973, its purpose was the recognition and encouragement of the fledgling industry of HMOs as the emerging alternative model for health care delivery systems. Part of this encouragement by the Legislature was the authority granted to insurance companies and nonprofit service corporations to operate, either directly or through a subsidiary or affiliate, an HMO, to provide insurance or protection against the cost of health care. The act exempted HMOs from the provisions

of the insurance and service corporation laws under most circumstances, and excluded charges paid by or on behalf of enrollees of a health maintenance organization from the State's insurance tax premium. Now, more than 30 years later, there has been a proliferation of HMOs, organized and operated according to myriad business models and there are also various other business organizations designed to offer health care services. The regulatory and tax structures that have developed and evolved over this time span are essentially the same as those that were in place 30 years ago, even though the marketplace has been a dynamic one during that time.

In 1992 the State initiated a reimbursement that pays hospitals for care provided to indigent patients. These dollars, known as "charity care" are distributed according to a formula developed as part of the charity care enabling legislation and subsequent regulations. In New Jersey, the cost of charity care has grown exponentially as citizens lose insurance coverage and medical costs rise nationwide. Consequently the Legislature is seeking other sources of funding for charity care. The NJ Legislature seems to be implying that the New Jersey business community, including insurers, health service corporations and HMOs, contribute either directly or indirectly, to the costs of charity care.

Business Models for Health Care Delivery Systems

In 1973 there was a clear distinction between the business models of the three different types of health systems: Insurers, HMOs, and Service Corporations such as Blue Cross Blue Shield (BCBS). Insurers were generally for profit, and offered *indemnity* contracts providing full or partial reimbursement for covered services received from any licensed provider. HMOs were both profit and non-profit, and offered *closed panel HMO contracts* that provided full or substantially full reimbursement only for covered services received from providers in the network. In *staff model* HMOs, some network providers were employees of the HMO. Service corporations, chiefly BCBS of NJ, now known as Horizon Blue Cross, were also allowed to offer indemnity contracts. However, unlike an HMO network, the service corporation network typically included most providers.

In summary, the available contracts were closed panel contracts offered by HMOs, and indemnity and indemnity-like contracts offered by all other carriers. The most prevalent contracts offered today – point of service (POS) contracts by all three carriers and PPO contracts by insurers and service corporations – could not legally be offered by insurers or HMOs, and were not, in their present form, being offered by service corporations.

Today, this distinction in business models is almost non existent. There are no non-profit HMOs and no staff model HMOs in New Jersey. All types of carriers are allowed to offer POS and PPO contracts which can provide different benefit levels depending on whether the provider is in-network and whether services are referred. Although historically only HMOs could offer closed-panel contracts (covered benefits must be provided in network), that may change in the future as well.

Therefore, unlike the situation 30 years ago, HMOs cannot be distinguished from other carriers on the basis of business model. All HMOs are affiliated with an insurer or service corporation of similar name, and consumers are indifferent to, and often unaware of, the type of entity provides their coverage. Therefore, there would seem to be no basis for policy (including tax) distinctions based on differences in business model.

The Corporate Business Tax (The CBT)

The CBT was modified in SFY 2002 and is paid by various businesses including HMOs. In the year 2003, as reported on 2002 CBT returns the HMOs[1] paid a total of $22.96M in corporate business tax. This amount included $1.62M in Alternate Minimum Assessment. HMOs pay a variety of state taxes, including unemployment insurance, per head taxes to subsidize medical malpractice and various other taxes. Some HMOs have asserted that a new assessment only increases their tax burden and should be included in this report, however the Legislature directed us to look only at the CBT versus an insurance premium assessment.

In contrast to the CBT, if HMOs paid a 1% premium tax on members enrolled in a commercial plan, the state would obtain $37.4M in premium assessment

[1] The HMOs include Aetna, Health Net, Amerihealth, Oxford, Horizon, CIGNA, United, Empire (WellChoice) and Great West. The Medicaid only HMOs are Americhoice, Amerigroup, and University.

revenue, a gain of $14.5M. In addition, for Medicaid HMOs paying the tax the state will be able to collect the tax send it back to the HMOs in the form of an increased rate. The rate is matched by the federal government dollar for dollar. The Medicaid HMOs are expected to pay $14M in premium assessments, resulting in a net gain for the state (if matched) of $37 plus $14 M or $51 M.

Other tax policies

A number of other states assess a premium tax on HMOs; many of these are at a higher level than the 1% called for in New Jersey's special assessment. For example, Alabama has a 1.6% tax on premiums, Arkansas assesses at 2.7% and Arizona assesses at 2%.

- 27 states levy premium assessments on HMOs. Of premium assessments, 13 states have assessments of 2% or higher. There are various other state tax models. For example, in New York HMOs pay a corporate income tax. In contrast, Pennsylvania HMOs that are non-profit are exempted from all taxation.

- Eight states (including New York) tax HMOs on their profits or income including corporate or franchise taxes.

- 14 states have no tax on premiums and the four remaining states including California, Florida, Hawaii and Massachusetts do not tax HMO's.

Rationale for Premium Tax

As a general rule, insurers (in life and property, as well as health) have been taxed by the states as a percentage of gross revenue (premium tax) rather than net income (income or business tax), even when that state typically (as in the case of New Jersey) taxes the net income of non-insurance businesses.

This rule is based largely on practical considerations, rather than on a policy determination that insurers should be treated differently. The net income of

[2] 2004 data from the Natuonal Association of Insurance Commissioners

insurers is difficult to determine. Net income is uncertain (due to the need to set up reserves for future unknown events), and is subject to fluctuation from year to year. Therefore, a premium tax is a proxy for a tax on theoretical, rather than actual net income. For example, in a state that taxes the net income of most business entities at 10%, a 1% premium tax would represent a 10% tax on a profit margin of 10%.

HMOs, health insurers, and health service corporations prepare the same financial statements for state regulators, and as noted elsewhere, have similar business models. Therefore, the same practical considerations which lead to a premium tax for insurers and health service corporations are applicable to HMOs.

Policy Impact of Premium Tax

The legislation refers to a policy preference dating back to 1973, when the State Legislature wished to encourage the formation of HMOs. At that time, HMOs were rare in the Northeast (with the notable exceptions of non-profits HIP and GHI in New York) and health policy experts hoped that HMOs could rein in health care costs while more efficiently delivering care. The landscape is quite different today. In 2003 over 2 million New Jersey citizens, or 24% of the population, were enrolled in HMOs. (This includes Medicaid and FamilyCare enrollees of HMOs). In the commercial health coverage market, approximately 1.3 million people, or 55% of this market, are enrolled in HMOs. Therefore the original reason for exempting HMOs from a premium tax (that they were fundamentally different from other carriers, and required a subsidy to develop) no longer seems to exist.

[3] Data from Kaiser Family Foundation, State Health Facts 2002
[4] NJDOBI enrollment summaries

Impact of an Assessment

All insurance businesses, including property and casualty as well as health insurance, have cycles of profitability due to underwriting losses, claims lags and business cycles. In that respect the CBT, because it is based on net income, is more responsive to downturns, preserving cash for less profitable HMOs. The premium tax could be a hardship to plans with poor profitability. For example, according to DOBI, Healthnet lost money in 2003. In 2003 Healthnet paid no CBT nor did CIGNA. Had Healthnet been assessed the 1% premium tax in 2003 they would have paid $8.4M in taxes as they collected $841,151,000 in commercial premium dollars. CIGNA would have paid $2.5M in premium assessment. In is unclear how this loss of cash would affect the future viability of certain plans. In that respect the CBT might be a "gentler tax" and might forestall some plan closures. However, the insurance companies who offer indemnity coverage have been subject to the premium tax (actually 1.06%) for some time and it has not negatively impacted their business. This is likely because insurance companies have had time to adjust – that is to pass the premium tax onto their customer base including employers and individual purchasers.

The HMO premium tax may make insurance more expensive, which could in turn lead to fewer employers and individuals purchasing coverage. (New Jersey had 1.1M uninsured citizens in 2002[5]). Increases in premiums could cause people to drop coverage and therefore lead to higher utilization of charity care services in hospitals. This could result in higher demand for state charity care dollars which would produce for more searches for revenue. An HMO assessment tax could be counter-productive. The impact on future premiums would have to be calculated by actuaries. Future HMO premium costs are beyond the scope of this report.

Summary

A 1% premium assessment tax on commercial HMOs would generate $37M[6] in new revenue to the state. In contrast the CBT generated $22.96 from 2002 returns. If the CBT is backed out of future assessments the net gain in revenue

[5] Ibid.
[6] Based on material supplied by the NJ Department of Banking and Insurance, 2004

would be $14.5M annually. Medicaid HMOs could generate an additional $7M for the state if matched by federal dollars.