GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2009

Legislative Actuarial Note

HEALTH BENEFITS

BILL NUMBER: House Bill 1485 (Third Edition)

SHORT TITLE: Insurance/Health Care Provider Relationship.

SPONSOR(S):

SYSTEM OR PROGRAM AFFECTED: State Health Plan for Teachers and State Employees (Plan).

FUNDS AFFECTED: State General Fund, State Highway Fund, other State employer receipts; premium payments for dependents of active employees and retired employees of State agencies and universities, local public schools and local community colleges; premium payments for coverages selected by eligible former employees; premium payments for coverages selected by firefighters, rescue squad workers, members of the National Guard, and certain authorized local governments.

BILL SUMMARY: House Bill 1485 (Third Edition) amends the prompt payment law, under G.S. 58-3-225, to change requirements with respect to claims payment recoveries involving overpayments between insurers and health care providers and facilities. The proposed changes include increasing the notice requirement an insurer must give a health care provider or facility regarding a potential overpayment recovery and limiting the recovery of overpayments to claims where the insurer can identify the specific patient, date of service, claim amount, etc. The proposed changes would also require an insurer to provide a brief explanation of why a proposed change in the original claim amount paid is necessary. For overpayment recoveries sought by an insurer as a result of documented fraud the proposed requirements do not apply.

The proposed change applies to the Plan by cross reference under G.S. 135-44.4(28) which applies the prompt payment law to the Plan as if it were an insurer regulated under G.S. 58-3-225.

EFFECTIVE DATE: When it becomes law.

ESTIMATED IMPACT ON STATE:

Aon Consulting, the consulting actuary for the State Health Plan for Teachers and State Employees, estimates that the proposed legislation will increase annual administrative costs to the Plan by $160,000 (excluding impact to cash flow) based on information provided by the Plan's Claims Processing Contractor. Aon Consulting further expects the legislation will have an impact to annual medical claims costs incurred by the Plan, but notes that these costs are not quantifiable based on available information.

Hartman & Associates, the consulting actuary for the General Assembly's Fiscal Research Division, comments that annual administrative costs (including impact to cash flow) for the Plan may increase in a range of $180,000 to $260,000 based on information provided by the Plan's Claims Processing Contractor. Hartman notes that potential impact on the Plan's annual medical claims costs, as a result of the proposed extended time line for the Plan's Claims Processing Contractor to initiate an action to seek overpayment recoveries, is not quantifiable based on available information.

ASSUMPTIONS AND METHODOLOGY: The actuarial analyses used by each respective consulting actuary are on file with the Fiscal Research Division. Copies of each respective consulting actuary's analysis, including assumptions, are also attached to the original copy of this Legislative Actuarial note.

Based on information provided by the Plan's Claims Processing Contractor, Blue Cross Blue Shield of North Carolina, the Plan's claims overpayment recovery experience for calendar year 2008 indicates that 14% of total recoveries, or $2.2 million, occur beyond 365 days of the original date of claims payment. For the Plan's claims in the 2008 calendar year subject to an overpayment recovery, approximately $16 million in total overpayment recoveries were collected within the two year period currently allowed under G.S. 58-3-225. Of this total amount an estimated $12 million, or 75% of total recoveries, are cash recoveries and the other 25% is from offsetting future reimbursements to affected providers or facilities (approximately $1.7 million).

The current statutory requirement allowing an insurer a period of up to two years from the date of an original claim to recover a potential overpayment remains unchanged.

Of the range of potential administrative costs impacts assumed (i.e., $180,000 to $260,000 annually), $100,000 is attributed to a negative impact on cash flow.

Given that the bill affects the legal and administrative relationship between the Claims Processing Contractor (CPC) and medical providers under contract with the CPC, no independent actuarial analysis of data was possible. All assumptions and cost estimates are provided by the Plan and its Claims Processing Contractor.

Summary Information and Data about the Plan

The Plan administers health benefit coverage for active employees from employing units of State agencies and departments, universities, local public schools, and local community colleges. Eligible retired employees of authorized employing units may also access health benefit coverage under the Plan. Eligible dependents of active and retired employees are authorized to participate in the Plan provided they meet certain requirements. Employees and retired employees of selected local governments may also participate in the Plan under certain conditions. Members of fire, rescue squads, and the National Guard may also obtain coverage under the Plan provided they meet certain eligibility criteria.

As of July 1, 2008, the State finances the Plan on a self-funded basis and administers benefit coverage under a Preferred Provider Option (PPO) arrangement. The Plan's receipts are derived through premium contributions, investment earnings and other receipts. Premiums for health benefit coverage are paid by (1) employing agencies for active employees, (2) the Retiree Health Benefit Fund for retired employees, and (3) employees and retirees who elect dependent coverage. Total requirements for the Plan are estimated to be $2.6 billion for FY 2008-09. The Plan's PPO benefit design includes three alternative benefit levels offered to plan members. The three alternative benefit levels include the following:

1) The "Basic" 70/30 plan that offers higher out-of pocket requirements in return for lower fully contributory dependent premiums;

2) The "Standard" 80/20 plan; and

3) The "Plus" 90/10 plan with enhanced benefits via lower out-of pocket requirements as compared to the other PPO plan alternatives offered.

As of July 1, 2009, the State will continue to finance the Plan on a self-funded basis and administers benefit coverage under a Preferred Provider Option (PPO) arrangement. The Plan's receipts will be derived through premium contributions, investment earnings and other receipts. Premiums for health benefit coverage will be paid by (1) employing agencies for active employees, (2) the Retiree Health Benefit Fund for retired employees, and (3) employees and retirees who elect dependent coverage. Total requirements for the Plan are estimated to be $2.5 billion for FY 2009-10 and $2.7 billion for FY 2010-11. The Plan's PPO benefit design will include two alternative benefit levels listed below:

1) The "Basic" 70/30 plan that offers higher out-of pocket requirements in return for lower fully contributory dependent premiums; and

2) The "Standard" 80/20 plan.

The Basic and Standard plans offer coverage to employees and retired employees on a noncontributory basis. Coverage for dependents under both plans is offered on a fully contributory basis.

Financial Condition

Financial Projection (Revised Summer 2008) for FY 2008-09 -- For the fiscal year beginning July 1, 2008, the Plan began its operations with a beginning cash balance of $139.8 million. Receipts for the year were projected to be $2.3 billion from premium collections, $53.9 million from Medicare Part D subsidies, and $2.7 million from investment earnings, for a total of slightly over $2.3 billion in receipt income for the year. Projected disbursements from the Plan were expected to be $2.4 billion in claim-payment expenses and $168.7 million in administration and claims-processing expenses for projected total expenses of nearly $2.6 billion for FY 2008-09. The Plan's net operating loss was projected to be approximately $264.4 million for the fiscal year, assuming a 9% annual claims growth trend.

Projected operating losses were expected to deplete the Plan's cash balance of $139.8 million and leave it without sufficient operating resources to continue operations for the fiscal year.

Financial Projection (Revised April 2009) for FY 2008-09 -- For the fiscal year beginning July 1, 2008, the Plan began its operations with a beginning cash balance of $139.8 million. Receipts for the year are projected to be $2.3 billion from premium collections, $49.0 million from Medicare Part D subsidies, $3.3 million from investment earnings, and $250.0 million from a direct General Fund appropriation from the Rainy Day Fund (Savings Reserve Account) for a total of approximately $2.6 billion in receipt income for the year. The $250 million from a direct General Fund appropriation was provided by Session Law 2009-16 (Senate Bill 287) to finance a shortfall in funds available to pay health care benefits, administrative costs, and adequately fund the Plan's beginning cash balance on July 1, 2009. Projected disbursements from the Plan are expected to be $2.4 billion in claim-payment expenses and $180.7 million in administration and claims-processing expenses for projected total expenses of nearly $2.6 billion for FY 2008-09. The Plan's net operating income is projected to be approximately $7.1 million for the fiscal year, assuming a 9% annual claims growth trend.

Financial Projection 2009-11 Biennium (April 2009) – Session Law 2009-16 (Senate Bill 287) appropriates funds from various sources, authorizes annual premium rate increases, makes various benefit and provider related changes to achieve financial savings, and directs other various changes to the Plan. The enacted law also appropriates the sum of $250 million from the Savings Reserve Account ("Rainy Day

Fund") of the General Fund for the 2008-09 fiscal year. The following summarized financial projections by fiscal year for the 2009-11 biennium assume the changes enacted in Session Law 2009-16 (Senate Bill 287).

For the fiscal year beginning July 1, 2009, the Plan is projected to begin its operations with a beginning cash balance of $146.9 million. Receipts for the year are projected to be $2.4 billion from premium collections, $56.3 million from Medicare Part D subsidies, and $8.0 million from investment earnings for a total of approximately $2.5 billion in receipt income for the year. Projected disbursements from the Plan are expected to be $2.3 billion in claim-payment expenses and $185.6 million in administration and claims-processing expenses for projected total expenses of nearly $2.5 billion for FY 2008-09. The Plan's net operating income is projected to be approximately $14.8 million for the fiscal year, assuming a 9% annual claims growth trend and an annual premium increase of 8.9% effective July 1, 2009.

For the fiscal year beginning July 1, 2010, the Plan is projected to begin its operations with a beginning cash balance of $146.9 million. Receipts for the year are projected to be $2.7 billion from premium collections, $50.4 million from Medicare Part D subsidies, and $8.8 million from investment earnings for a total of approximately $2.7 billion in receipt income for the year. Projected disbursements from the Plan are expected to be $2.5 billion in claim-payment expenses and $191.7 million in administration and claims-processing expenses for projected total expenses of nearly $2.7 billion for FY 2010-11. The Plan's operating income is projected to be approximately $30.6 million for the fiscal year, assuming a 9% annual claims growth trend and an annual premium increase of 8.9% effective July 1, 2010.

Other Information

Historically, the Plan has applied a premium increase in October of the first fiscal year of a biennium. However, the annual premium increases authorized in Session Law 2009-16 (Senate Bill 287) changes that methodology to an annual increase at the beginning of each fiscal year of the 2009-11 biennium.

Additional assumptions include Medicare benefit "carve-outs," cost containment strategies including prior approval for certain medical services, utilization of the "Blue Options" provider network, case and disease management for selected medical conditions, mental health case management, coordination of benefits with other payers, a prescription drug benefit manager with manufacturer rebates from formularies, and fraud detection, and other authorized actions by the Executive Administrator and Board of Trustees to manage the Plan to maintain and improve the Plan's operation and financial condition where possible. Claim cost trends are expected to increase at a rate of 9% annually according to the Plan's consulting actuary. Investment earnings are based upon a 4.5% return on available cash balances.

Enrollment Data as of December 31, 2008

I. No. of Participants	Basic	Standard	Plus	Total	Percent of Total
Actives					
Employees	11,623	271,243	47,687	330,553	49.6%
Dependents	20,454	115,875	28,156	164,485	24.7%
Sub-total	32,077	387,118	75,843	495,038	74.2%
Retired					
Employees	1,726	127,081	17,967	146,774	22.0%
Dependents	1,117	14,935	3,476	19,528	2.9%
Sub-total	2,843	142,016	21,443	166,302	24.9%
Former Employees with Continuation Coverage					
Employees	60	1,349	344	1,753	0.3%
Dependents	61	501	182	744	0.1%
Sub-total	121	1,850	526	2,497	0.4%
Firefighters, Rescue Squad & National Guard					
Employees	-	3	2	5	0.0%
Dependents	-	3	-	3	0.0%
Sub-total	-	6	2	8	0.0%
Local Governments					
Employees	72	1,577	319	1,968	0.3%
Dependents	141	637	218	996	0.1%
Sub-total	213	2,214	537	2,964	0.4%
Total					
Employees	13,481	401,253	66,319	481,053	72.1%
Dependents	21,773	131,951	32,032	185,756	27.9%
Grand Total	**35,254**	**533,204**	**98,351**	**666,809**	**100%**
Percent of Total	**5.3%**	**80.0%**	**14.7%**	**100.0%**	

II. Enrollment by Contract	Basic	Standard	Plus	Total
Employee Only	2,684	328,635	49,246	380,565
Employee Child(ren)	4,958	36,903	8,589	50,450
Employee Spouse	2,274	18,145	4,469	24,888
Employee Family	3,565	17,570	4,015	25,150
Total	**13,481**	**401,253**	**66,319**	**481,053**

Percent Enrollment by Contract	Basic	Standard	Plus	Total
Employee Only	19.9%	81.9%	74.3%	79.1%
Employee Child(ren)	36.8%	9.2%	13.0%	10.5%
Employee Spouse	16.9%	4.5%	6.7%	5.2%
Employee Family	26.4%	4.4%	6.1%	5.2%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Enrollment Data Continued

III. Enrollment by Sex	Basic	Standard	Plus	Total
Female	18,837	334,917	61,752	415,506
Male	16,417	198,287	36,599	251,303
Total	**35,254**	**533,204**	**98,351**	**666,809**

Percent Enrollment by Sex	Basic	Standard	Plus	Total
Female	53.4%	62.8%	62.8%	62.3%
Male	46.6%	37.2%	37.2%	37.7%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

IV. Enrollment by Age	Basic	Standard	Plus	Total
29 & Under	17,390	136,277	27,211	180,878
30 to 44	8,125	107,375	17,315	132,815
45 to 54	5,164	94,548	18,277	117,989
55 to 64	3,195	102,901	23,452	129,548
65 & Over	1,380	92,103	12,096	105,579
Total	**35,254**	**533,204**	**98,351**	**666,809**

Percent Enrollment by Age	Basic	Standard	Plus	Total
29 & Under	49.3%	25.6%	27.7%	27.1%
30 to 44	23.0%	20.1%	17.6%	19.9%
45 to 54	14.6%	17.7%	18.6%	17.7%
55 to 64	9.1%	19.3%	23.8%	19.4%
65 & Over	3.9%	17.3%	12.3%	15.8%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

V. Retiree Enrollment by Category	Employee	Dependents	Total
Non-Medicare Eligible	49,534	12,080	61,614
Medicare Eligible	97,240	7,448	104,688
Total	**146,774**	**19,528**	**166,302**

Percent by Category (Retiree)	Employee	Dependents	Total
Non-Medicare Eligible	33.7%	61.9%	37.0%
Medicare Eligible	66.3%	38.1%	63.0%
Total	**100.0%**	**100.0%**	**100.0%**

SOURCES OF DATA:

-Actuarial Note, Hartman & Associates, "House Bill 1485 (3rd Edition): An Act to Reform the Process For Recovery of Overpayments to Providers By Insurers," June 17, 2009, original of which is on file in the General Assembly's Fiscal Research Division.

-Actuarial Note, Aon Consulting, " House Bill 1485 (3rd Edition): Reform Process of Overpayment to Providers", June 18, 2009, original of which is on file with the State Health Plan for Teachers and State Employees and the General Assembly's Fiscal Research Division.

"HB 1485, Insurance/Health Care Provider Relationship, Financial Impact Analysis", State Health Plan for Teachers and State Employees, June 18, 2009.

TECHNICAL CONSIDERATIONS: None

FISCAL RESEARCH DIVISION: (919) 733-4910

PREPARED BY: Mark Trogdon

APPROVED BY: Marilyn Chism, Director
Fiscal Research Division

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