



STATE HEALTH PLAN PRIMER

A BRIEF EXPLANATION OF THE TREASURER'S
PROPOSED CHANGES TO THE STATE
EMPLOYEE HEALTH PLAN

State Health Plan Primer: A Brief Explanation of the Treasurer's Proposed Changes to the State Employee Health Plan

Research Report

Jordan Roberts

John Locke Foundation, Raleigh, North Carolina

INTRODUCTION

The North Carolina State Health Plan provides health care coverage to more than 720,000 teachers, state employees, retirees, and their dependents. The office of the State Treasurer, currently held by Dale Folwell, is in charge of managing the State Health Plan. A board of 10 trustees, which consists of experts in the health field, assists the Treasurer with the creation of state employee benefit plans. Blue Cross Blue Shield of North Carolina (BCBSNC) administers the plan, which means they process all of the claims and make payments on behalf of the State Health Plan.

Dating back to the financial crisis in 2008, the state has faced serious problems funding the health plan. Budget shortfalls and rising health care costs have put the State Health Plan at risk for long-term sustainability. This means the state can pay for care today, but not for the future care of employees. When costs for the State Health Plan increase, there is less money for education, public safety, and legitimate services for which state government is responsible.

State employees and their families depend on the State Health Plan for their health insurance. The Treasurer is challenged with addressing the budgetary problems of operating a severely underfunded plan. In order to address these issues, the Treasurer has proposed changing the way the State Health Plan pays for state employee health care. The General Assembly could face a serious budget problem if the state doesn't get spending for the plan under control. The goal of switching to the proposed provider reimbursement model is to increase transparency, reduce costs, and rein in the spending of the State Health Plan.

HOW IS THE PLAN ADMINISTERED?

Currently, the State Health Plan uses Blue Cross Blue Shield of North Carolina to administer the plan. The Treasurer and the board of trustees design a benefit plan for the state employees of North Carolina. Blue Cross Blue Shield, a commercial based insurer, uses a network of providers that are

considered "in-network" for state employees accessing medical care. BCBSNC and its network of providers establish a reimbursement rate that the plan will pay the provider for services. For example, let's say a teacher who is a member of the State Health Plan needs to seek care for a broken arm. The teacher will go to an in-network provider to get his or her arm examined. The teacher may need to meet some deductible or pay some form of co-payment before the treatment. Following the treatment, the provider will send a bill to BCBSNC. The state will then reimburse for the service based on the pre-negotiated rate with the provider.

WHAT ARE A COMMERCIAL BASED-PLAN AND A REFERENCE-BASED PLAN?

Treasurer Folwell recently announced his proposal to switch the reimbursement method from a commercial-based model to a transparent reference-based model.

In a commercial-based plan, the insurance plan – here, the State Health Plan – contracts with a commercial insurance company such as Blue Cross Blue Shield. The commercial insurance company and the provider network negotiate a fee schedule that determines the amount the insurer – the taxpayers of North Carolina – will pay for each service. The fee schedule has remained confidential between the commercial insurer and the providers in the network. The state of North Carolina does not have access to these contracted rates.

In a reference-based plan, the entity in charge of the plan – again, the State Health Plan – sets the maximum amount that the plan will pay for a service. In the case of the State Health Plan, Medicare serves as the "reference" point for the rates that will be paid for services. The provider then must decide whether or not to accept the determined rates. Transparent, reference-based plans can provide exact data on the number of claims paid and the amount paid for each claim. The state would, therefore, know the rates to which it is committing.

The proposed new reference-based model

would pay providers, on average, 77% above what Medicare pays for the same service.

WHAT DOES MEDICARE HAVE TO DO WITH THE STATE HEALTH PLAN AND WHY DOES THIS REIMBURSEMENT RATE MATTER?

The State Health plan will use the rates Medicare uses as a reference point for the amount each service will be reimbursed (on average 77% higher than the Medicare rate). The benefit of this reimbursement model is that it decreases the variability that the State Health Plan pays for the same services around the state. There is reimbursement variability between providers, meaning that a provider could be charging a completely different rate for the same service as a similar provider, the only difference being the location. There is also reimbursement rate variability between private and public insurers. These are problems that are addressed in a reference-based model.

HOW MUCH DO WE CURRENTLY SPEND?

Over the past 10 years, the amount spent on the State Health Plan has increased significantly. In 2008, expenses were roughly \$2.2 billion. Expenses have climbed to a projected \$3.5 billion in 2018. In 2009, the State Health Plan received a \$250 million general fund appropriation in order to address a budget shortfall. In three of the years from 2008-2018, the State Health Plan operated at a loss.

DO WE KNOW HOW MUCH EACH SERVICE COSTS?

No. Currently, the plan uses the BCBSNC's commercial provider network for the state employees' health plan. BCBSNC sets the rates that the State Health Plan will pay for services by negotiating directly with health providers in their network. The state now has no idea what it costs for each service,

only the final payment for all claims. The total payments, in the end, have often been over budget.

WHY IS IT IMPORTANT THAT THE FUTURE LIABILITIES BE FUNDED?

The State Health Plan is paid for by taxpayers and by members of the State Health Plan through premiums. The plan is only three percent funded with \$35 billion in unfunded liabilities. The unfunded liabilities cover the costs of providing care long-term for retired state employees.

Funding the future liabilities for the State Health Plan is important because there would be a budgetary crisis if the plan became insolvent due a high number of claims as well as the increasing costs per claim. The state promised benefits to state employees and currently, no money has been set aside to provide care in the future for the members of the State Health Plan. If this issue is not addressed, the long-term viability of the plan is in jeopardy and will likely have to be addressed with new taxes, fewer benefits, or higher premiums for state employees.

TRANSPARENCY

Switching to a reference-based reimbursement system would create significantly more price transparency for expenses incurred through the plan. The change would also give the Treasurer and the legislature more predictability in what the plan will cost the state each year.

To know if moving from a commercial-based reimbursement model to a reference-based model will be more cost efficient, decision-makers need data. Without the data, i.e., what the cost of individual services are, the task of reining in spending and getting costs under control for the state insurance plan is exceptionally difficult.

BCBSNC refused to give the Treasurer's office complete claims data for the State Health Plan members and its costs. As for the hospitals, UNC Health Care spokesperson Alan Wolf told Carolina Journal that "All health care agreements between hospi-

tals, doctors and insurance companies are proprietary business agreements, and therefore considered confidential. In addition, independent audit firms routinely examine insurance contracts to ensure the correct contract rates are being applied.”

WILL PROVIDERS SEE A PAY INCREASE OR DECREASE UNDER THE PROPOSED PLAN?

Some providers will see a pay decrease, while some will see a pay increase. Among those who will see an increase are independent physicians, critical access hospitals, and mental health providers. An indexed reimbursement rate, based on a percentage above what Medicare pays, will lead to uniform payments for services across the state. The average price that the State Health Plan will pay under the new proposal is above what both Medicare and Medicaid pay on average for services.

This will also lead to savings of up to \$300 million in the first year for the State Health Plan’s payments, which is what the Treasurer hopes to accomplish. Predictability and savings in the State Health Plan mean up to \$60 million in savings for the plan members’ out-of-pocket costs.

WHO SUPPORTS THE CHANGE? WHO DOESN’T?

Among those who support the reform plan are the Treasurer, State Employees Association North Carolina, and the State Health Plan board of trustees. Blue Cross Blue Shield of NC hasn’t come out directly in favor of the proposed change but have said they are “committed to working with the treasurer to achieve his goal of reducing costs.”

The North Carolina Healthcare Association (NCHA), the industry group that represents hospitals, providers and health networks in the state, says that the proposal will decrease access to the provider network while also raising costs for some state employees. The NCHA also says that this pro-

posal will hurt rural hospitals who serve a disproportionate share of people with Medicaid and uninsured patients.

WHAT DO MEDICAID AND UNINSURED PATIENTS HAVE TO DO WITH THIS?

Medicaid and Medicare reimburse providers less than what they claim it costs to provide services. Uninsured patients who receive care will be covered under what’s known as “charity care” from the hospital. In both cases, the hospitals are not recouping all of their costs to the facility. Hospitals often charge commercial insurers, such as the State Health Plan, more for services in order to cross-subsidize the shortfall in revenue that is the result of accepting government payer rates and providing charity care.

WHAT WILL THE PROPOSAL DO TO REIMBURSEMENT RATES?

There is a disparity in the rates that providers are reimbursed for delivering the same services. Depending on the patient mix, some hospitals have the ability to charge much higher rates for the same services that are provided at similar facilities and are reimbursed for at a lower rate. Smaller practices are often at a disadvantage because they are reimbursed much less than hospitals or large facilities. By making the reimbursement rate more equal across the board, the providers will have to take more initiative in doing their part to cut costs. This also places some pressure on providers to create competitive advantage and thus attract patients.

WILL THIS PROPOSAL INCREASE PRICE TRANSPARENCY FOR THE COST OF SERVICES PAID FOR BY THE STATE HEALTH PLAN?

Yes, and this is especially important because reimbursement rates will determine premiums for members. It is also important to taxpayers and state employees to know

what they are paying for. It is important to note that the State Health Plan is “self-insured,” meaning that it pays for all of the claims out of its own funds, BCBSNC just processes all the claims. Because the State Health Plan is paid for by taxpayers, it makes it all the more important that the plan can account for every dollar that is spent and have the ability to determine if providers are overcharging.

WILL THIS PROPOSAL DECREASE ACCESS AND INCREASE COSTS FOR SOME STATE EMPLOYEES?

It’s possible. As of now, there has not been any indication that any providers are choosing not to participate in the State Health Plan because of the proposed changes. Access to care and costs are affected by other factors as well; North Carolina’s outdated Certificate of Need laws, limiting the scope of practice of medical professionals, and limiting innovations like telehealth measures.

CONCLUSION

The Treasurer’s decision to take the State Health Plan to a transparent reference-based reimbursement model is a change from the status quo. A status quo that has resulted in steadily increasing healthcare costs. Everyone involved in the delivery of health care needs to play a part in order to create a more sustainable system. It is critical for taxpayers and state employees that this issue is addressed.