# LEGISLATIVE FISCAL ESTIMATE

SENATE COMMITTEE SUBSTITUTE FOR

# SENATE, No. 3756

# STATE OF NEW JERSEY
# 220th LEGISLATURE

DATED: JUNE 23, 2023

## SUMMARY

**Synopsis:** Permits SHBP and SEHBP to award contracts for more claims administrators for each program plan; requires claims data and trend reports to be provided to certain persons.

**Type of Impact:** Expenditure impact on State General Fund and local government and school district funds.

**Agencies Affected:** Division of Pensions and Benefits in the Department of the Treasury; certain local governments and school districts participating in SHBP and SEBHP.

**Office of Legislative Services Estimate**

| Fiscal Impact | Annual |
|---|---|
| **State** | Indeterminate |
| **Local** | Indeterminate |
| **School District** | Indeterminate |
| **Total** | Indeterminate |

- The Office of Legislative Services (OLS) finds that the fiscal estimate depends on whether additional vendors bidding on the contract to be a third-party administrator for the State Health Benefits Program and the School Employees' Health Benefits Program have the ability to affect costs because the State self-insures for the provision of health care benefits to public employees who are enrolled in the programs and because State law and State policy determine health benefits coverage, not the insurance carrier.

- The OLS concludes that the insurance carriers competing for the State and school health benefits business are competing to administer the plans, not to insure the plans.

- If the State were to contract with more than one third-party administrator, the State would have to pay for more than one administrative services contract, which would result in higher costs unless competitive differences in the vendor bids including employee-per month rates, the

number of employees enrolled in the vendors' plans, other administrative cost differentiating items, and separately the contractual provider reimbursement rates can result in overall lower costs.

- The OLS notes that the move to contract with one third-party administrator each for active health care benefits (2019) and retiree post-retirement medical benefits (2018) resulted in $30.9 million in third-party administrator savings.

## BILL DESCRIPTION

This bill would require the State Health Benefits Commission and the School Employees' Health Benefits Commission to contract with at least two third-party administrators who submit responsive proposals to provide administrative services for the health benefit plans offered to State Health Benefits Program and School Employees' Health Benefits Program employees and retirees unless only one vendor submits a responsive proposal. The bill would also require the Department of the Treasury to furnish de-identified aggregate claims experience data for participating employers in the State Health Benefits and School Employees' Health Benefits programs to such participating employers annually. The department will also make claims trend reports containing certain categories of information publicly available for each program and to all majority representatives of public employees for collective negotiation purposes with the State annually. Finally, the bill requires the department to provide a feasibility study of strategies to lower the cost of health care service for the participants of the programs to the State Health Benefits Plan Design Committee and the School Employees' Plan Design Committee no later than one year after the effective date of the bill.

## FISCAL ANALYSIS

### *EXECUTIVE BRANCH*

None received.

### *OFFICE OF LEGISLATIVE SERVICES*

The OLS finds that the fiscal estimate depends on whether additional vendors bidding on the contract to be a third-party administrator for the State Health Benefits Program and the School Employees' Health Benefits Program have the ability to affect costs because the State self-insures for the provision of health care benefits to public employees who are enrolled in the programs and because State law and State policy determine health benefits coverage, not the insurance carrier. A self-insured health plan is coverage offered by an employer in which the employer takes on the risk providing coverage, instead of purchasing coverage from an insurance company. Self-insured coverage means that the employer pays for enrollees' medical care directly. Fully insured coverage means that health insurance is being purchased from an insurance company by an employer and the insurance company will be the entity responsible for paying for medical care.

Under current law, the State Health Benefits Commission and the School Employees' Health Benefits Commission negotiate with and arrange for the purchase, from licensed carriers, of

contracts providing hospital, surgical, obstetrical, and other covered health care services and benefits covering employees of the State, participating local governments and school districts and their dependents. In addition, the State Health Benefits Commission and the School Employees' Health Benefits Commission have the authority to establish rules and regulations for the administration of the programs. Furthermore, the State Health Benefits and the School Employees' Health Benefits Plan Design Committees have the responsibility for and authority over the various plans and components of those plans, including medical benefits, prescription benefits, dental, vision and any other healthcare benefits, offered and administered by the programs. Finally, the committees have the authority to create, modify, or terminate any plan or component at their sole discretion.

The State actuary projects plan year costs published annually in Rate Renewal reports, which identify trends, project costs, and establish rates for each plan and plan type offered. Plan design committees monitor, review, and analyze plan performance and, if necessary, recommend plan design changes to control costs, as evidenced by the annual resolutions adopted intended to control costs. Approved rates and plan designs are adopted by the commissions.

Administrative Services Only Fee

Vendors bid, in a competitive bidding process, to secure an administrative services contract as a third-party administrator with the State to provide the healthcare plans at the approved rates. Third-party administrators are paid on the basis of an "administrative services only fee." The fee is the only compensation due to the vendor under the contract unless otherwise mutually agreed to by the vendor and the State contract manager. The vendor's monthly compensation is a function of the vendor's fee multiplied by the number of participating public subscribers during the applicable month.

What is Included in the Administrative Only Fee?

In the responses to the OLS FY 2019-2020 Discussion Points regarding third-party administrator fees, the Division of Pensions and Benefits clarified administrative services only fees. "The fees paid by the State Health Benefits Program and the School Employees Health Benefits Program to the third-party administrators include fees for general administration, claim administration, network management, medical management (precertification, concurrent review, discharge planning, case management), and disease management (coronary artery disease, heart failure, COPD, asthma, chronic kidney disease, diabetes, etc.). Administrative services only fees are paid on an "employee-per-month rate." In addition, the State Health Benefits Program and the School Employees Health Benefits Program pay third-party administrators for a number of other administrative services including: a 24-hour nurse line, which aids in reducing non-emergent use of the emergency room; radiology management which directs members to the most cost effective radiology service settings; pain management to reduce misuse of pain management services; medical supply drug management services to guide injectable drug administration to the most economic and clinically appropriate site of services; care coordination assistance to physician group partners to manage better patient care to avoid acute episodes; and wellness program support."

The Size of the Administrative Services Only Fee

In the responses the division provided a chart of the administrative service only fees paid to the third-party administrators of the programs. At that time, of the actuarially equivalent 14 plans offered by Aetna and the 13 plans offered by Horizon to active employees of State and local governments and school districts, 83.4 percent of enrolled members (190,911 individuals) were enrolled in Horizon plans. Out of the nine actuarially equivalent plans offered by both Aetna and Horizon to State and local government and school district retirees 70 percent of the retired member population were enrolled in Aetna plans.

| Administrative Services Only Fees PY 2015 to 2018 | | | | |
|---|---|---|---|---|
| | Aetna ($) | | Horizon ($) | |
| Fiscal Year | ASO Fees | Other Fees | ASO Fees | Other Fees |
| 2015 | $ 21,495,374 | $ 855,659 | $ 96,284,366 | $ 29,639,998 |
| 2016 | $ 20,764,220 | $ 770,867 | $ 95,094,475 | $ 31,322,864 |
| 2017 | $ 21,434,003 | $ 992,131 | $ 82,933,366 | $ 33,012,000 |
| 2018 | $ 20,470,857 | $ 973,224 | $ 83,441,811 | $ 49,424,212 |

Subsequently, the State contracted with Aetna (2018) to administer the retiree plans and with Horizon (2019) for the active employee plans, saving $30.9 million in third-party administrative fees as given in FY 2022 responses to OLS budget questions.

Provider Reimbursement Rates

Current law requires the contract or contracts purchased by the commissions to base reimbursement and payments on reasonable and customary charges, meaning charges based upon the 90th percentile of the usual, customary, and reasonable fee schedule determined by the Health Insurance Association of America or a similar nationally recognized database of prevailing health care charges and must reflect the cost of the benefits provided based on principles which in the judgment of the commission are actuarially sound.

The rates charged are determined by the carrier on accepted group rating principles with due regard to the experience, both past and contemplated, under the contract, but within reasonable and customary charges. Differences in contracted provider reimbursement rates would be limited by the association's fee schedule and judgement of the commission.

Summary

In summary, the OLS concludes that the insurance carriers competing for the State and school health benefits business are competing to administer the plans, not to insure the plans. Nevertheless, differences in vendor bids affecting the cost to the State can include the "employee per month rate" charged by the carrier to administer the plans, other administrative services, and separately the effect on plan costs resulting from any slight differences in the contracted provider reimbursement rates paid to doctors for their services based on the carrier's network.

If the State were to contract with more than one third-party administrator, the State would have to pay for more than one administrative services contract, which would result in higher costs unless competitive differences in the vendor bids including employee-per month rates, the number of employees enrolled in the vendors' plans, other administrative cost differentiating items, and separately the contractual provider reimbursement rates can result in overall lower costs.

| | |
|---|---|
| *Section:* | *Legislative Budget and Finance Office* |
| *Analyst:* | *Kim Clemmensen*<br>*Assistant Legislative Budget and Finance Officer* |
| *Approved:* | *Thomas Koenig*<br>*Legislative Budget and Finance Officer* |

This fiscal estimate has been prepared pursuant to P.L.1980, c.67 (C.52:13B-6 et seq.).