NORTH CAROLINA GENERAL ASSEMBLY

LEGISLATIVE FISCAL NOTE

BILL NUMBER: House Bill Committee Substitute 103

SHORT TITLE: Insurance Fraud

SPONSOR(S): Representative Brawley

FISCAL IMPACT: **Expenditures:** **Increase ( )** **Decrease ( )**

Revenues: **Increase ( )** **Decrease ( )**

No Impact (X)

No Estimate Available ( )

FUNDS AFFECTED: **General Fund ( )** **Highway Fund ( )**

Local Fund ( ) **Other Fund ( )**

BILL SUMMARY: "TO STRENGTHEN THE INSURANCE FRAUD LAW." Rewrites G.S. 58-2-161 ("False statement to procure benefit of insurance policy or certificate"). Makes it a Class I felony for any person, with intent to injure, defraud, or deceive an insurer, to (1) present insurer a written or oral statement (defined in bill) as part of or in support for a claim for benefits pursuant to an insurance policy, knowing the statement contains false, incomplete, or misleading information concerning any material fact or (2) assist, abet, solicit, or conspire with another to prepare or make such a statement. Upon conviction, requires court to order defendant to pay restitution, including reasonable costs and attorneys' fees incurred by insurer as a condition of probation or parole. Provides that in a civil action for recovery based on a claim for which a defendant has been convicted under the section, defendant is estopped from denying elements of the violations for which he or she was convicted. If insurer prevails in civil action, court may award insurer its damages, attorneys' fees, costs, and reasonable investigative costs. If insurer can demonstrate to court that defendant has engaged in a pattern of violations, the court may award treble damages.

AMENDMENTS/COMMITTEE SUBSTITUTES (March 13, 1995)

Introduced 2/2/95. House committee substitute replaces 1st edition. Adds employers or group of employers that insure workers' compensation liability to definition of "insurer" under G.S. 58-2-161(a)(1). Includes applications in definition of "statement" under G.S. 58-2-161(a)(2). Adds provisions making it a Class H felony to make a false statement in opposition to a claim under an insurance policy or to assist, solicit, abet, or conspire with another in making such a statement. Revises provision concerning order of restitution to make it applicable only when restitution is ordered as a condition of probation (was,

probation or parole). Substitutes provision that allows criminal conviction of insurance fraud to be entered as evidence in civil cause of action. Previous version provided that a criminal conviction stops defendant from denying elements of the violations for which he was convicted. Adds provision allowing whichever party prevails, rather than solely the insurer, to recover compensatory damages, attorneys fees, costs, reasonable investigative costs, and, if the defendant has engaged in a pattern of violations, treble damages.

EFFECTIVE DATE: Effective October 1, 1995; applies to violations occurring on or after that date.

PRINCIPAL DEPARTMENT(S)/PROGRAM(S) AFFECTED: Judicial Branch; Department of Correction

FISCAL IMPACT

	FY 95-96	**FY** 96-97	**FY** 97-98	**FY** 98-99	**FY**99-00
EXPENDITURES					**RECURRING**
NON-RECURRING					
REVENUES/RECEIPTS		NO FISCAL IMPACT			
RECURRING					
NON-RECURRING					

POSITIONS:

ASSUMPTIONS AND METHODOLOGY:

The amended version of House Bill 103 rewrites the insurance fraud law to strengthen its provisions. The current law applies to fraud against insurers, hospital and medical service corporations, HMOs, and the State Health Plan. The proposed legislation extends coverage to multiple employer welfare arrangements (MEWAs) and to employer groups self-insured for workers' compensation. The bill applies, as well, to insurers that fraudulently deny payment of benefits and claims to policyholders and third party claimants.

The proposed bill increases the penalty for insurance fraud from a Class I to a Class H felony. The judge may order restitution as a condition of probation in cases where a defendant is convicted of insurance fraud. In addition, the judge may include the investigative and legal costs incurred in investigating and attempting to collect on the claim in determining the amount of damages for which restitution is to be made.

The Administrative Office of the Courts has no accurate data as to the number of new filings which would result from the implementation of this legislation. However, they predict the

number of new filings would be low, and therefore, anticipate no significant impact on the Judicial Branch.

Likewise, the proposed legislation is not anticipated to have a significant impact on the Department of Correction, assuming that the courts would order active sentences in a very minimal number of cases.

Subsequently, based on this information, no significant fiscal impact is anticipated for the Judicial Branch or the Department of Correction at this time.

SOURCES OF DATA: Administrative Office of the Courts; North Carolina Sentencing and Policy Advisory Commission

TECHNICAL CONSIDERATIONS: None

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NORTH CAROLINA GENERAL ASSEMBLY
LEGISLATIVE ACTUARIAL NOTE

BILL NUMBER: House Committee Substitute for House Bill 103

SHORT TITLE: Insurance Fraud

SPONSOR(S): Representative Robert Brawley

SYSTEM OR PROGRAM AFFECTED: Teachers' and State Employees' Comprehensive Major Medical Plan

FUNDS AFFECTED: State General Fund, State Highway Fund, Other State Employer Receipts, Premium Payments for Dependents by Active and Retired Teachers and State Employees

BILL SUMMARY: Strengthens the State's insurance fraud laws that apply to the Comprehensive Major Medical Plan for Teachers' and State Employees'. Currently, any member of the Plan who files false or misleading information with an intent to injure, defraud,

or deceive the Plan is guilty of a class H felony. Upon conviction, a defendant's probation may be contingent upon restitution to the Plan, including the Plan's recovery of reasonable legal fees, costs and other investigative costs.

EFFECTIVE DATE: October 1, 1995

ESTIMATED IMPACT ON STATE: The consulting actuary for the Teachers' and State Employees' Comprehensive Major Medical Plan, Alexander & Alexander Consulting Group, Inc., and the consulting actuary of the General Assembly's Fiscal Research Division, Dilts, Umstead & Dunn, both concur that **the bill will not measurably affect costs to the Plan.**

ASSUMPTIONS AND METHODOLOGY: The Comprehensive Major Medical Plan for Teachers and State Employees is divided into two programs. From October, 1982 through June, 1986, the Plan had only a self-insured indemnity type of program which covered all employees, retired employees, eligible dependents of employees and retired employees, and former employees and their eligible dependents authorized to continue coverage past a termination of employment other than for retirement or disability purposes. A prepaid program of coverage by health maintenance organizations (HMOs) was offered in July, 1986, as an alternative to the Plan's self-insured indemnity program. The benefits of the self-insured indemnity type of program are spelled out in Part 3 of Article 3 of Chapter 135 of the North Carolina General Statutes (i.e., $250 annual deductible, 20% coinsurance up to $1,000 annually, etc. paid by the program's members). HMOs are required to offer benefits that are comparable to those provided by the self-insured indemnity program. Employer-paid non-contributory premiums are only

authorized for the indemnity program's coverage for employees and retired employees. All other types of premium in the indemnity program are fully contributory. Premiums paid by employers to HMOs are limited to like amounts paid to the indemnity program with employees and retired employees paying any HMO amounts above the indemnity program's non-contributory rates. Both types of coverage continue to be available in the Plan with seven HMOs currently covering about 16% of the Plan's total population in about 70 of the State's 100 counties. The Plan's employees and retired employees select the type of program that they wish for themselves and their dependents during the months of August and September of each year for coverage beginning in October. The demographics of the Plan as of December 31, 1994, include:

Plan	Self-Insured Indemnity Program	Alternative HMOs	Total
Number of Participants			
Active Employees	203,200	43,700	246,900
Active Employee Dependents	117,500	33,600	151,100
Retired Employees	78,500	3,300	81,800
Retired Employee Dependents	14,000	800	14,800
Former Employees & Dependents with Continued Coverage	2,600	400	3,000
Total Enrollments	415,800	81,800	497,600
Number of Contracts			
Employee Only	211,800	30,700	242,500
Employee & Child(ren)	32,800	10,200	43,500
Employee & Family	39,100	6,400	45,500
Total Contracts	283,700	47,300	331,000
Percentage of Enrollment by Age			
0-29	29.1%	43.8%	31.5%
30-44	23.8	29.3	24.7
45-54	18.8	17.1	18.5
55-64	12.8	7.0	11.9
65+	15.5	2.8	13.4
Percentage of Enrollment by Sex			
Male	40.0%	40.3%	40.1%
Female	60.0	59.7	59.9

Assumptions for the Self-Insured Indemnity Program: For the fiscal year beginning July, 1994, the self-insured program started its operations with a beginning cash balance of $287.1 million. Receipts

for the year are estimated to be $597 million from premium collections, $20 million from investment earnings, and $6 million in risk selection

and administrative fees from HMOs, for a total of $623 million in receipts for the year. Disbursements from the self-insured program are expected to be $545 million in claim payments and $18 million in administration and claims processing for a total of $563 million for the year beginning July, 1994. For the fiscal year beginning July, 1995, the self-insured indemnity program is anticipated to have an operating cash balance of over $347 million with a net operating gain of $60 million for the 1994-95 fiscal year. For the next few years, the self-insured indemnity program is assumed to be able to carry out its operations without any increases in its current premium rates or a reduction in existing benefits until the 1997-98 or 1998-99 fiscal years. This assumption is predicated upon the fact that the program's cost containment strategies (hospital DRG reimbursements, pre-admission hospital testing, pre-admission hospital inpatient certification with length-of-stay approval, hospital bill audits, required second surgical opinions, mental health case management, coordination of benefits with other payers, Medicare benefit "carve-outs", cost reduction contracts with participating physicians and other providers, and fraud detection) are maintained and improved where possible. Current non-contributory premiums rates are $110.08 monthly for employees whose primary payer of health benefits is Medicare and $144.60 per month for employees whose primary payer of health benefits is not Medicare. Fully contributory premium amounts for employee and child(ren) contracts are $68.50 monthly for children whose primary payer of health benefits is Medicare and $90.12 monthly for other covered children, and $164.30 per month for family contracts whose dependents have Medicare as the primary payer of health benefits and $216.18 per month for other family contract dependents. Claim cost trends are expected to increase about 10% annually. Total enrollment in the program is expected to increase about one-half of one percent (0.5%) annually. Growth in the number of enrolled active employees is expected to be a little less than 1% annually, whereas the growth in the number of retired employees is assumed to be a little more than 4% per year. The program is expected to lose about 2% of its number of active employee dependents each year, whereas the number of enrolled retiree dependents is assumed to show no appreciable change from year to year. Investment earnings are based upon a 6% monthly return on available cash balances. The self-insured indemnity program maintains a claim stabilization reserve for claim cost fluctuations equal to 7.5% of annual claim payments without reserving additional funds for incurred but unreported claims.

Assumptions for the Self-Insured Indemnity Program's Cost Recoveries: The State Attorney General's Office represents the Plan in cases of fraudulent claims that result in lawsuits and bills the Plan for this service. With the proposed change, these fees may be recovered and used to offset the fees of the Attorney General. However, very few fraud cases lead to lawsuits. Since 1991, there have been only two fraud cases that have resulted in court cases. Because the incidence of fraud cases resulting in lawsuits is so low, any savings to the Plan would be negligible.

SOURCES OF DATA:

o Actuarial Note, Dilts, Umstead & Dunn, House Committee Substitute for House Bill 103, April 3, 1995, original of which is on file in the General Assembly's Fiscal Research Division.

o Actuarial Note, Alexander & Alexander Consulting Group, Inc., House Committee Substitute for House Bill 103, April 7, 1995, original of which is on file with the Comprehensive Major Medical Plan for Teachers' and State Employees' and the General Assembly's Fiscal Research Division.

o Cost Recovery Data provided by the Teachers' and State Employees' Comprehensive Major Medical Plan.

TECHNICAL CONSIDERATIONS: None

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