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PURPOSE OF SB 122

To create the Healthcare Cost-Sharing Collections Act.

ACTUARIAL STATEMENT

The Fiscal Impact Statement was prepared according to generally accepted actuarial principles and practices, in compliance with ACT 112. The Statement provides an estimate of the financial and actuarial effect of the proposed change(s) on the Plans, if possible. The Statement makes no comment or opinion with regard to the merits of the measure for which the Statement is prepared; however, any identified technical or mechanical defects have been noted.

We have reviewed the input and results of our analysis for reasonableness and relied upon the data and information provided by the Plans and their Claims Processing Contractors.

3/13/2023

Patrick Klein, FSA, MAAA
Vice President

Date

3/13/2023

Matthew Kersting, FSA, MAAA
Vice President

Date

PROJECTED COSTS

Plan	Annual Estimated Cost	Estimated Cost as a Percentage of Total Claims Spend
EBD	$14,187,000 - $31,526,000	2.1% - 4.6%
UOA	$1,931,000 - $4,291,000	1.2% - 2.7%
ASU	$300,000 - $668,000	1.2% - 2.6%
UCA	$111,000 - $246,000	0.9% - 1.9%
AHEC	$62,000 - $138,000	0.9% - 2.1%
NWACC	$53,000 - $117,000	1.7% - 3.8%
SAU	$29,000 - $65,000	0.7% - 1.5%

PRICING APPROACH AND COMMENTS

Senate Bill 122 establishes the Healthcare Cost Sharing Collections Act. This act mandates that a healthcare insurer will pay a healthcare provider the full amount due for healthcare services under the terms of a health benefit plan, including any cost sharing and have the sole responsibility for collecting cost sharing from an enrollee. In addition, the enrollee is able to request to a cost sharing collection plan with the healthcare insurer, where payments are made over time in increments.

Our understanding is that the healthcare insurer will pass on all financial liability accrued from uncollected medical and pharmacy copays, coinsurance, and deductibles to the health benefit plans. For the purposes of this analysis, EBD and the university systems would be impacted by this legislation. We received actual historical member cost share data from the plans and applied developed factors based on how much of the cost share is assumed to be uncollected. The uncollected cost share factors were developed utilizing publicly available data and actuarial judgement.

On the low end, it was assumed that 9% of the participant cost share goes uncollected, and on the high end, 20% of the participant cost share goes uncollected. If the entire participant cost share is collected, the legislation would have no impact on current health plan claim costs. If more of the participant cost share goes uncollected, the impact on current health plan claim costs would be greater. The factors used in our analysis are meant to be illustrative of the potential impact to the health plans and likely to change over time from plan to plan, depending on various socio-economic factors.

In our cost analysis presented above, there is no assumption for potential increase in utilization of healthcare services due to the removal of participants having to pay their cost share at the time of service. Having participants pay a cost share at a the time-of-service acts as potential financial

mechanism against participants seeking unnecessary care. Given the unknown potential for an increase in utilization due to the removal of participant costs shares being paid at the time of service, we cannot quantify this impact.

There is also no assumption in our provided cost estimates about the increased administrative costs of having third party administrators and insurers collect cost shares from participants after services have been rendered. The additional administrative cost is unknown but could be considerable given the lack of current cost share collection mechanisms and the need for new teams to be developed to handle the collection of cost shares from participants. If collection responsibility falls to the employer, additional employees will likely need to be hired.