FIS Actuarial Form 6-03

Kentucky Department of Insurance
Financial Impact Statement

Health Benefit Mandate Statement
19 RS BR 477/SB 24

I. Mandating health insurance coverage of SB 24, will increase administrative expenses of insurers, based upon our analysis of the proposed mandate and our experience with similar health insurance benefits. The following is a description of the proposed mandates:

a) Requires insurers to annually report to the Department of Insurance (DOI) all billed charges from both participating and Non-participating providers for each health care service. The DOI will provide the reported information to a nonprofit organization to maintain a database of the billed charges to be used as a benchmark for determining the UCR for health care services. UCR is defined as the 80th percentile of all charges for a particular health care service performed by a health care professional in the same or similar specialty and in the same geographical area;

b) Requires insurers to have a process, including written policies and procedures for review & approval, for the selection of providers who will be on each Health Benefit Plan's (HBP) list of participating providers. The insurer must also establish minimum professional requirements for participating health care providers, not discriminate against providers solely on the basis of the provider's license by the state and to ensure that each HBP's network of participating providers are adequate to meet the health care needs of covered persons and provides an appropriate choice of providers at each In-Network health facility;

c) Mandates new provider directory requirements of insurers offering HBPs;

d) Requires insurers to provide covered persons access to nonparticipating provider coverage, with prior authorization, when the HBP does not have a participating provider that is geographically accessible or has the appropriate training/experience of the covered person. Insurers must allow for direct access, without a need for referral, to primary and preventive obstetric and gynecologic services from a qualified provider. Upon request, insurers must also provide access to a specialist if the covered person has a condition that requires ongoing care from the specialist. If the covered person has a life-threatening condition/disease or disabling condition that requires specialized health care services, insurers must provide access to a specialist and a specialty care center;

e) Mandates new provider network adequacy requirements that must be filed and approved by the Commissioner at least every 3 years or upon expansion of any service area;

f) Requires insurers that offer group HBPs, including coverage from nonparticipating providers, to make available at least 1 option for comprehensive coverage of health care services provided by nonparticipating providers at a rate of at least 80% of UCR for each covered health care service, after deductible or any permissible benefit maximums;

g) Requires insurers to ensure that covered persons do not incur greater Out of Pocket (OOP) costs for emergency health services provided by a nonparticipating provider than the covered person would have incurred if the services had been provided by a participating provider;

h) Mandates new utilization review and appeal requirements on insurers regarding nonparticipating providers;

i) Mandates that insurers must provide notices on its website for 1) notice of coverage and procedures for obtaining that coverage, 2) a clear description of the methodology used to determine reimbursement for nonparticipating providers, 3) a description of the amount the insurer will reimburse for services by nonparticipating providers as a % of UCR, 4) examples of anticipated nonparticipating care OOP costs and 5) information that reasonably allows a covered person to estimate anticipated OOP costs.

Upon request by a covered person and no more than 48 hours after the person has received the preadmission certification for Non-emergency services at a facility, the bill also requires insurers to provide electronic or written correspondence stating whether the provider is a participating provider, whether non-emergency services are covered and the applicable cost sharing requirements

j) Mandates that the Commissioner creates an independent dispute resolution program for disputed charges, including balance billings, for covered services provided by nonparticipating providers to covered persons. The bill allows the Commissioner to charge the parties involved in the dispute a fee to cover costs

k) Mandates new disclosure requirements to covered persons regarding balance billing.

Our estimated increase in administrative expenses for health benefit plans, not including state employee plans, is approximately $0 to $2.68 per member per month (PMPM). This represents an increase of approximately 0 % to 2.5% or approximately $0 to $13.9 million for all fully insured policies in Kentucky, not including state employees, due to the increased costs for health plans.

The proposed SB 24, as described above, will increase premiums, based upon our analysis of the proposed mandate and our experience with similar health insurance benefits. Our estimated increase in premiums for health benefit plans, not including state employee plans, is approximately $2.47 to $13.73 per member per month (PMPM). This represents an increase of approximately 0.5% to 3.0% or approximately $12.8 to $71.2 million for all fully insured policies in Kentucky, not including state employees, due to the increased costs for health plans.

The proposed SB 24, as described above, will increase the total cost of health care in the Commonwealth, based upon our analysis of the proposed mandate and our experience with similar health insurance benefits. Our estimated increase in the total cost of health care in the Commonwealth for health benefit plans, is approximately $2.47 to $13.73 per member per month (PMPM). This represents an increase of approximately 0.4% to 2.4% or approximately $12.8 to $71.2 million for all fully insured policies in Kentucky, not including state employees, due to the increased costs for health plans.

Our analysis included the use of data and statistics from an article by Yale Institution for Social and Policy Studies “Surprise! Out-of-Network Billing for Emergency Care in the United States”, L&E’s medical manual, actuarial judgement and a 2017 Annual Data Report provided by The Kentucky Department of Insurance (KY DOI).

We have estimated Insurer administrative costs could increase by up to 2.5% due to the additional requirements and time restrictions being mandated regarding utilization reviews, prior authorization, provider networking and new disclosure requirements, which was based on actuarial judgement. We acknowledge that some of these estimated increases in administrative costs may likely be reduced over

the long term after Insurers develop the necessary procedures and documentation needed to become compliant.

Our estimated increase in claim costs is primarily driven by the mandate requiring insurers to ensure OOP Insured costs for emergency services are no more for a nonparticipating provider than a participating provider and the requirement that allows group HBP policyholders to designate at least 1 nonparticipating provider for each covered health care service to be reimbursed by the Insurer at least 80% UCR.

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LEWIS & ELLIS, INC.
February 6, 2019

Commissioner, Department of Insurance
February 11, 2019