COMMITTEE ON LEGISLATIVE RESEARCH
OVERSIGHT DIVISION

FISCAL NOTE

L.R. No.: 6265-09
Bill No.: Truly Agreed To and Finally Passed SS for SB 982
Subject: Emergencies; Health Care; Hospitals; Insurance - Health; Medical Procedures and Personnel
Type: Original
Date: June 18, 2018

Bill Summary: This proposal enacts provisions relating to payments for health care services.

FISCAL SUMMARY

ESTIMATED NET EFFECT ON GENERAL REVENUE FUND			
FUND AFFECTED	FY 2019	FY 2020	FY 2021
Total Estimated Net Effect on General Revenue	**$0**	**$0**	**$0**

ESTIMATED NET EFFECT ON OTHER STATE FUNDS			
FUND AFFECTED	FY 2019	FY 2020	FY 2021
Insurance Dedicated Fund	Up to $1,030,157	$2,210,314	$2,210,314
Total Estimated Net Effect on Other State Funds	**Up to $1,030,157**	**$2,210,314**	**$2,210,314**

Numbers within parentheses: ( ) indicate costs or losses.
This fiscal note contains 9 pages.

ESTIMATED NET EFFECT ON FEDERAL FUNDS			
FUND AFFECTED	FY 2019	FY 2020	FY 2021
Total Estimated Net Effect on <u>All</u> Federal Funds	**$0**	**$0**	**$0**

ESTIMATED NET EFFECT ON FULL TIME EQUIVALENT (FTE)			
FUND AFFECTED	FY 2019	FY 2020	FY 2021
Total Estimated Net Effect on FTE	**0**	**0**	**0**

☐ Estimated Net Effect (expenditures or reduced revenues) expected to exceed $100,000 in any of the three fiscal years after implementation of the act.

ESTIMATED NET EFFECT ON LOCAL FUNDS			
FUND AFFECTED	FY 2019	FY 2020	FY 2021
Local Government	**$0**	**$0**	**$0**

FISCAL ANALYSIS

ASSUMPTION

Officials from the **Department of Insurance, Financial Institutions and Professional Registration (DIFP)** assume the following:

Sections 354.150, 354.495, 374.150 and 374.230

This proposal increases certain fees authorized under state law that are paid by insurance companies to do business in Missouri. Based upon FY2017 counts, the department expects to collect an additional $2,210,314 in revenue per fiscal year in the Insurance Dedicated Fund.

Section 376.690

This proposal requires DIFP to ensure access to an arbitration process when a health care professional objects to applications of established payments for certain out of network emergency services described in the bill.

In order to facilitate this process as directed in this legislation, the department's Consumer Affairs Division will need to receive and review requests in order to verify that the dispute is subject to the provisions of the bill. Those provisions include;

- If the complaint is related to an emergency medical condition
- If an offer to pay the health care professional a reasonable rate was made
- If after declining payment the health care professional and health carrier negotiated in good faith

Staff will also need to determine if the health benefit plan and the unpaid bill or claim are subject to state regulation and the requirements of this legislation. For instance;

- Is the health benefit plan issued in Missouri or was it issued in another state, but covering Missouri residents; and
- Is the health benefit plan fully insured or is it a self-funded health benefit plan that is exempted under federal ERISA laws

DIFP believes existing FTE can absorb the increase in workload resulting from the provisions of this legislation; however should the workload be more than anticipated, additional FTE and/or appropriation may be requested through the budget process.

ASSUMPTION (continued)

In addition, this legislation will necessitate access to a database of health care service reimbursement rates by procedure costs with the ability to query by various reimbursement levels so that the arbitrators will have the information outlined in the proposal. This is not information currently available to DIFP. DIFP believes that it can subscribe to an external service to obtain this information and estimates the costs for this to be less than $5,000 per year.

In addition to these costs, DIFP would need to bid a contract for an external arbitration services. It is expected these costs are to be split equally between the health care professional and health carrier. These costs will not impact the Insurance Dedicated Fund, but may be passed along to consumers through health insurance premiums.

This section would have an estimated fiscal impact of approximately $80,000 in Insurance Dedicated Funds.

Section 376.1350 and 376.1367

These sections may require policy amendments be submitted to the department for review along with a $50 filing fee. The department expects to see a filing influx of 100 filings. One time additional revenues to the Insurance Dedicated Fund are estimated to be up to $5,000 (100 x $50). Additional staff and expenses are not being requested with this single proposal, but if multiple proposals pass during the legislative session which require policy form reviews the department will need to request additional staff to handle increase in workload

Officials from the **Department of Health and Senior Services**, the **Department of Social Services**, **Office of Administration** - **Administrative Hearing Commission** and the **Missouri Consolidated Health Care Plan** each assume the proposal will have no fiscal impact on their respective organizations.

FISCAL IMPACT - State Government	FY 2019 (10 Mo.)	FY 2020	FY 2021
INSURANCE DEDICATED FUND			
Revenue - DIFP Increase in certain fees (§§354.150, 354.495, 374.150 & 374.230)	$1,105,157	$2,210,314	$2,210,314
Revenue - DIFP $50 Filing Fee (§§376.1350 & 376.1367)	Up to $5,000	$0	$0
Cost - DIFP administrative cost to ensure access to an arbitration process (§376.690)	($80,000)	($80,000)	($80,000)
ESTIMATED NET EFFECT ON THE INSURANCE DEDICATED FUND	**Up to $1,030,157**	**$2,130,314**	**$2,130,314**

FISCAL IMPACT - Local Government	FY 2019 (10 Mo.)	FY 2020	FY 2021
	$0	**$0**	**$0**

FISCAL IMPACT - Small Business

No direct fiscal impact to small businesses would be expected as a result of this proposal.

FISCAL DESCRIPTION

This act modifies provisions relating to payments for health care services.

This act creates a unified fee structure for filing fees paid by health services corporations and health maintenance organizations.

FISCAL DESCRIPTION (continued)

Additionally, the act specifies that fees paid under the insurance laws of this state shall be collected and deposited into the Insurance Dedicated Fund by the Director of the Department of Insurance, Financial Institutions, and Professional Registration rather than by the Director of the Department of Revenue, and eliminates a provision specifying that $500,000 from the fund shall be transferred annually to general revenue.

The act adjusts fees for companies filing insurance documents, and enacts fees for filing an own risk and solvency assessment (ORSA) summary report and for insurance holding company filings. The act eliminates fees charged for affixing the seal of the office of the Director of the Department of Insurance, Financial Institutions, and Professional Registration, and for accepting service of process upon the company.

This act also eliminates the requirement that insurance examiners appointed by the Director be compensated according to the applicable levels established by the National Association of Insurance Commissioners.

These provisions become effective January 1, 2019.

This act provides that the Director of the Department of Insurance, Financial Institutions and Professional Registration shall determine that a managed care plan's network is adequate if the managed care plan is being offered by a health carrier accredited by the Accreditation Association for Ambulatory Health Care.

This act provides that when a health benefit plan does not provide for payment to out-of-network providers for all or most services that are covered if provided in-network, including HMO plans and exclusive provider organization (EPO) plans, payment for all services shall be made directly to the health care providers when the health carrier has authorized for such services to be received from an out-of-network provider.

Within 180 days of providing unanticipated out-of-network care, health care professionals may send any claim for charges incurred for the care to the patient's health carrier in the format specified in the act. Within 45 processing days of receiving the claim, the carrier shall offer to pay the professional a reasonable reimbursement. If the professional participates in one or more of the carrier's networks, the offer shall be the amount from the network with the highest reimbursement.

FISCAL DESCRIPTION (continued)

If the professional declines the carrier's initial offer, the carrier and professional shall have 60 days from the initial offer to negotiate in good faith. If the carrier and professional do not agree to a reimbursement within 60 days, the dispute shall be resolved through an arbitration process as specified in the act. To initiate arbitration, either party must provide written notice indicating certain information to the Director of the Department of Insurance, Financial Institutions, and Professional Registration within 120 days of the end of the negotiation period. Claims may be settled prior to commencement of the arbitration, claims from similar circumstances may be combined in a single arbitration, and no health care professional that directly bills a health carrier for unanticipated medical care under the act shall send a bill to the patient for any difference in the billed charge and the reimbursement rate. The act specifies that patients' cost-sharing requirements shall be based on the payment amount determined under the act, requires health carriers to disclose cost-sharing requirements within 45 processing days of receiving a claim, and provides that the in-network deductible and out-of-pocket maximum cost-sharing requirements shall apply to the claim for unanticipated out-of-network care.

The Director of the Department of Insurance, Financial Institutions, and Professional Registration shall ensure access to an arbitration process as described in the act. Arbitration costs shall be split equally between, and shall be billed directly to, the professional and the carrier. At the conclusion of the process, the arbitrator shall issue a final decision that shall be binding on the parties. The arbitrator shall provide copies of the final decision to the Director. The arbitrator shall determine a dollar amount due that is between 120% of the Medicare allowed amount and the 70th percentile of the usual and customary rate for the unanticipated out-of-network care, as determined by benchmarks from independent nonprofit organizations not affiliated with insurance carriers or provider organizations.

The act specifies factors to be considered by the arbitrator, and specifies that the enrollee shall not be required to participate in the arbitration process. The health carrier and health care professional shall execute a nondisclosure agreement prior to the arbitration.

This act requires any health carrier engaged in the act of contracting with providers for the delivery of dental services, or in the act of selling or assigning dental network plans, to update their electronic and paper provider materials made available to plan members or other potential plan members upon receiving written notice of changes by providers.

The Department of Insurance, Financial Institutions, and Professional Registration shall consider violations of this provision when conducting a market conduct examination.

FISCAL DESCRIPTION (continued)

This act specifies that whether an ailment is considered an "emergency medical condition" depends on the person having sufficiently severe symptoms, regardless of what final diagnosis is given.

This act specifies that necessity of emergency services to screen and stabilize a patient shall be determined by the treating health care provider.

Before a health carrier denies payment for an emergency service based on the lack of an emergency medical condition, it shall review the enrollee's medical records regarding the emergency condition at issue. If a health carrier requests records for a potential denial, the provider shall submit the record to the carrier within 45 processing days or the claim shall be subject to the prompt payment insurance law. The carrier's review of the records shall be completed by a board certified physician licensed to practice in the state.

The act increases, from 30 minutes to 60 minutes, the amount of time health carriers have to provide authorization decisions for immediate post evaluation or post stabilization services before the services are deemed approved.

When a patient's health benefit plan does not provide for payment to out-of-network healthcare providers for emergency services, including but not limited to HMO and EPO plans, payment for all emergency services necessary to screen and stabilize the enrollee shall be paid directly to the health care provider by the health carrier. Any service authorized by the health carrier for the enrollee once the enrollee is stabilized shall also be paid by the health carrier directly to the provider.

This act specifies that agreements to receive notice and correspondence regarding portable electronics insurance shall be determined in accordance with the Uniform Electronic Transactions Act.

This legislation is not federally mandated, would not duplicate any other program and would not require additional capital improvements or rental space.

SOURCES OF INFORMATION

Department of Insurance, Financial Institutions and Professional Registration
Department of Health and Senior Services
Department of Social Services
Missouri Consolidated Health Care Plan
Office of Administration
Administrative Hearing Commission

Ross Strope

Acting Director
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KC:LR:OD