COMMITTEE ON LEGISLATIVE RESEARCH
OVERSIGHT DIVISION

FISCAL NOTE

L.R. NO.: 3821-15
BILL NO.: CCS for HS for HCS for SB 856
SUBJECT: Elderly; Nursing and Boarding Homes; Insurance Department
TYPE: Original
DATE: May 10, 2000

FISCAL SUMMARY

ESTIMATED NET EFFECT ON STATE FUNDS			
FUND AFFECTED	FY 2001	FY 2002	FY 2003
All funds	(Unknown)	(Unknown)	(Unknown)
General Revenue*	(Unknown)	(Unknown)	(Unknown)
Total Estimated Net Effect on All State Funds*	**(UNKNOWN)**	**(UNKNOWN)**	**(UNKNOWN)**

***Expected to exceed $100,000 annually.**

ESTIMATED NET EFFECT ON FEDERAL FUNDS			
FUND AFFECTED	FY 2001	FY 2002	FY 2003
Federal	$0	$0	$0
Total Estimated Net Effect on All Federal Funds*	**$0**	**$0**	**$0**

***Unknown revenues and expenditures net to $0.**

ESTIMATED NET EFFECT ON LOCAL FUNDS			
FUND AFFECTED	FY 2001	FY 2002	FY 2003
Local Government	**$0**	**$0**	**$0**

Numbers within parentheses: ( ) indicate costs or losses.
This fiscal note contains 6 pages.

FISCAL ANALYSIS

ASSUMPTION

Officials from the **Department of Transportation**, the **Department of Public Safety - Missouri State Highway Patrol**, the **Department of Insurance**, the **Missouri Consolidated Health Care Plan**, and the **Department of Conservation** assume this proposal would not fiscally impact their agencies.

Department of Health (**DOH**) officials assume the proposal would not fiscally impact the department. DOH states the proposal transfers the responsibility from DOH to the Department of Insurance. DOH states they are not currently performing this function and it would not result in a workload savings to the department.

Officials from the **Missouri Consolidated Health Care Plan** (**HCP**) state it is likely that there would be additional cost incurred by HMOs as a result of increased litigation and removal of the "hold harmless" clause. HCP states it is likely that this cost would be passed through to members in the form of increased premiums. The direct fiscal impact is unknown but could be extremely significant depending upon the nature of the cases. HCP states that most carriers currently allow providers thirty to sixty days to file a claim. Allowing providers one year to file a claim could affect the plans cost projections and utilization data and the reports they have to provide to HCP. Projections may become skewed if additional data is received and processed one year after occurring. The data is also provided in the report card providing members with a valuable tool to measure the health plans. HCP states the newborn coverage provision states that if an application or form would be required to continue coverage, the member would have an additional thirty-one days from the date the forms are provided in which to enroll the newborn child. Since the plan is currently required by law to allow thirty-one days to enroll a new born, the plan would not be absorbing any additional claims if the newborn child is added. The provision allows an extension of up to thirty-one days to add the newborn. However, additional administrative costs would be incurred. These additional costs may be passed along in premiums. However, the fiscal impact of this proposal would probably be minimal.

HCP states the requirements that plans must confirm receipt of a claim within twenty-four hours, post information on the internet, notify both parents of a child's coverage, provide standardized explanation of benefits and referrals, notify the pharmacist, primary care physician, and the enrollee of an approved non-formulary drug in cases of medically necessity appeals, and removes the requirement that providers have to participate in all health plans offered by a carrier in order to participate. HCP states these requirements would cause the plans to incur additional administrative costs. HCP assumes these costs would be passed on in increased premiums. However, HCP states it is difficult to estimate the actual amount.

ASSUMPTION (continued)

HCP officials also state the proposal would allow members to access participating obstetricians or gynecologists without a referral from a primary care physician (PCP). HCP states the more "open" the access to providers the higher the premium associated with the product. As evident in the HCP plans the open access plans are considerably more costly than those requiring a PCP referral to a specialist. HCP states that it is very difficult to accurately predict the cost associated with this proposal. However, even if HCP would predict a one to two percent impact, the state may experience an increase of $1,563,975 to $3,127,950 for the first year. The Public Entities may experience an increase of $998,265 to $1,996,530 for the first year.

Oversight notes that the proposal is a self-referral for a covered person to seek the services of a participating obstetrician or gynecologist without obtaining a referral from a primary care physician. **Oversight** assumes the proposal would have an unknown fiscal impact to all funds. **Oversight** does not have available information concerning health plans for local governments and has not estimated a fiscal impact for them.

Department of Social Services (**DOS**) - **Division of Medical Services** (**DMS**) officials state they would be affected by this proposal because they administer a managed care program which contracts with health maintenance organizations for the purpose of providing health care services through capitated rates. These health maintenance organizations would be subject to the requirements in this proposal. DMS assumes that any additional costs incurred by managed care contractors because of mandated federal or state laws would have an effect on the administrative costs included in future bids with the Medicaid program. DMS states the cost impact to DMS would be incurred when MC+ contracts are rebid. Currently the Medicaid managed care plans average a nine percent administrative cost built in to the capitation payments. Although it is not possible to predict capitation payment amounts that would be bid in future contracts, for the sake of perspective DMS has conservatively estimated a one percent increase in capitation payments due to increased administrative costs. DMS estimates the fiscal impact could range from $0 to over $5 million.

FISCAL IMPACT - State Government	FY 2001 (10 Mo.)	FY 2002	FY 2003
ALL FUNDS			
Costs - All Funds			
Increased state contributions	(Unknown)	(Unknown)	(Unknown)
ESTIMATED NET EFFECT ON ALL FUNDS	**(UNKNOWN)**	**(UNKNOWN)**	**(UNKNOWN)**

FISCAL IMPACT - State Government	FY 2001 (10 Mo.)	FY 2002	FY 2003
GENERAL REVENUE FUND			
Cost - Department of Social Services			
Program specific expenditures*	(Unknown)	(Unknown)	(Unknown)
ESTIMATED NET EFFECT ON GENERAL REVENUE FUND*	**(UNKNOWN)**	**(UNKNOWN)**	**(UNKNOWN)**
FEDERAL FUNDS			
Income - Department of Social Services			
Medicaid reimbursements	Unknown	Unknown	Unknown
Costs - Department of Social Services			
Program specific expenditures	(Unknown)	(Unknown)	(Unknown)
ESTIMATED NET EFFECT ON FEDERAL FUNDS*	**(UNKNOWN)**	**(UNKNOWN)**	**(UNKNOWN)**

***Expected to exceed $100,000 annually.**

***Unknown revenues and expenditures net to $0.**

FISCAL IMPACT - Local Government	FY 2001 (10 Mo.)	FY 2002	FY 2003
	$0	**$0**	**$0**

FISCAL IMPACT - Small Business

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

DESCRIPTION

This proposal would change provisions of law relating to managed care. In its major provisions, the proposal would: (1) clarify that Section 354.603, RSMo, would not require providers to submit copies of their income tax returns to a health carrier. The entity may require a provider to

obtain audited financial statements if the provider receives 10% or more of the total medical expenditures made by the health carrier; (2) specify that the "prompt pay" provisions of Section 376.383 would apply after a health carrier receives a claim for a health care service. The current statute applies when a carrier receives a claim from a person entitled to reimbursement. The carrier would also be required to provide, within 45 days of receiving the claim, a complete description of all additional information that would be necessary to process the entire claim; (3) allow a person who has filed a claim for reimbursement for a health care service to file a civil action against a carrier for violations of the "prompt pay" provisions of Section 376.383. The court may award attorney fees and costs to a prevailing plaintiff unless the court finds that the carrier's position was substantially justified; (4) require health carriers, when processing claims, to permit providers to file confirmation numbers of authorized services and claims for reimbursement in the same format, to allow providers to file claims for reimbursement for a period of at least one year following the provision of a health care service, to issue within 24 hours an electronic confirmation of receiving a claim for reimbursement, and to accept all medical codes and modifiers used by the Health Care Financing Administration; (5) require health carriers to furnish providers with a current fee schedule for reimbursement amounts of covered services; (6) prohibit carriers from requesting a refund against a claim more than 6 months after the provider has filed the claim except in cases of fraud or misrepresentation by the provider; (7) require health carriers to provide Internet access to a current provider directory; (8) require health carriers to inform enrollees of any denial of health care coverage. The explanation would be in plain language that is easy for a layperson to understand; (9) prohibit "hold harmless" clauses that require a health care provider to assume the sole liability of the provision of health care services; (10) prohibit health carriers from requiring a health care provider to agree to participate in all health care plans operated by the health carrier as a condition for participating in one plan; (11) prohibit health carriers from requiring health care providers to participate in lease business if the health carrier leases its provider network to another health carrier without the provider's consent; (12) require group insurers to issue to enrollees a card that includes a telephone number for the plan and a brief description of the enrollee's type of health care plan; (13) require insurers to provide both parents of a covered child with coverage information regardless of whether the parent is the primary policyholder; (14) require health carriers to notify the pharmacist, primary care physician, and enrollee when a nonformulary drug is authorized for a limited period of time; (15) allow a health carrier to retract a prior authorization of a health care service if the enrollee's coverage under the plan has exceeded the enrollee's lifetime or annual benefits limit. Certification of a health care service would be deemed to be an authorization of a health care service; and (16) require health carriers to use, after January 1, 2002, standardized

DESCRIPTION (continued)

forms for referrals and the explanation of benefits. The Department of Insurance would establish a task force to develop the standardized forms.

The proposal would also clarify that managed care organizations licensed by the Department of Insurance must allow enrollees the option of receiving covered services in the long-term care

facility which serves as the enrollee's primary residence and must allow the enrollee, if certain conditions are met, to select a long-term care facility with the enrollee's religious affiliation. In addition, health carriers would also be required to notify enrollees of the proper procedures to enroll a newly born child if the carrier is notified of the birth within 31 days of the date of birth.

This proposal would also prohibit health carriers from requiring a covered person to obtain a referral from a primary care physician before seeking the services of a participating obstetrician or gynecologist. Services would be limited to those defined by the published recommendations of the accreditation council for graduate medical education for training an obstetrician or gynecologist. Health carriers could not charge additional fees for a covered person's direct access to a participating obstetrician or gynecologist unless those fees would be charged for other types of health care services within the carrier's network of providers.

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 Health
Department of Insurance
Department of Social Services
Missouri Consolidated Health Care Plan
Department of Transportation
Department of Conservation
Department of Public Safety
Missouri State Highway Patrol

Jeanne Jarrett, CPA
Director
May 10, 2000

MPW:LR:OD:005 (9-94)