COMMITTEE ON LEGISLATIVE RESEARCH
OVERSIGHT DIVISION

FISCAL NOTE

L.R. No.: 1414-01
Bill No.: SB 395
Subject: Consumer Protection; Health Care; Health Care Professionals; Hospitals; Insurance - Medical; Insurance Department; Medical Procedures and Personnel; Nursing and Boarding Homes
Type: Original
Date: February 13, 2001

FISCAL SUMMARY

ESTIMATED NET EFFECT ON STATE FUNDS			
FUND AFFECTED	FY 2002	FY 2003	FY 2004
All Funds*	(Unknown)	(Unknown)	(Unknown)
General Revenue	(Unknown)	(Unknown)	(Unknown)
Insurance Dedicated	$0 to $10,000	$0	$0
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 2002	FY 2003	FY 2004
Federal*	$0	$0	$0
Total Estimated Net Effect on All Federal Funds*	**$0**	**$0**	**$0**

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

ESTIMATED NET EFFECT ON LOCAL FUNDS			
FUND AFFECTED	FY 2002	FY 2003	FY 2004
Local Government	**(UNKNOWN)**	**(UNKNOWN)**	**(UNKNOWN)**

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

FISCAL ANALYSIS

ASSUMPTION

Officials from the **Department of Conservation** assume this proposal would not fiscally impact their agency.

Department of Transportation (**DHT**) officials state the Highway and Patrol Medical Plan is not included in the definition used for managed health care or health carrier in the statutes; therefore, there would be no fiscal impact to DHT or the Medical Plan.

Officials from the **Missouri Consolidated Health Care Plan** (**HCP**) state this proposal would provide for the following:

1. Would add "insurance company and health service corporation to the definition of managed care organizations under 198.530 RSMo. This provision does not have a fiscal impact on HCP.

2. Would amend 354.603 1(3) RSMo. Health carriers would not be allowed to request the provider's tax returns as a means of monitoring the provider's financial stability. The health carrier may request audited financial statements under certain conditions. Since this only modifies the plan's current ability to continue monitoring providers, this provision does not have a fiscal impact on HCP.

3. Would amend 354.618 RSMo to allow open access to participating obstetricians and gynecologist at all times. Allowing obstetricians and gynecologist to participate as PCPs should have little fiscal impact. However, having direct access to specialty services provided by obstetricians and gynecologist could have an unknown fiscal impact.

4. Would amend 376.383 RSMo. After April 1, 2002, health carriers would be required to process a claim or part of the claim if the necessary information is available for processing. If a portion of the claim requires additional information, the health carrier can request specific information. This revision would also allow health carriers to combine interest payments and make payments once the aggregate amount reaches five dollars. The fiscal impact is hard to evaluate. Health carriers may now use the "claim holding time" as an investing period for their funds. Requiring the health carrier to process any payable portion of the claim may reduce the time available to invest their funds thus reducing their investment income. On the other hand, the health carriers may save money (lower printing cost, mailing costs, etc) if they are able to hold any interest payments until the aggregate amount reaches five dollars. However, it is difficult to determine if these two impacts would offset each other.

ASSUMPTION (continued)

5. Would amend 376.383 RSMo by allowing enrollees the right to file civil action. The court may award damages of $50 per day beginning the 10th day following the date interest becomes due. As with any other product or service, the right to file civil suit increases costs. The health carriers may try to recoup the litigation costs by increasing premiums. However, the fiscal impact is unknown.

6. Would create 376.384 RSMo which would:

· Permit providers to file confirmation numbers of certified services and claims in the same manner and format
· Allow providers up to one year after service has been rendered to file a claim.
· Be effective January 1, 2003, health carriers would be required to accept claims electronically in a format specified by the Department of Insurance.
· Health carriers, within 24 hours of receiving an electronic claim, would provide a confirmation number.
· Health carriers would accept all codes used in submitting the claims. The Department of Insurance is to promulgate rules establishing and approving the codes.
· Any contract negotiations effective after this proposal would provide a current fee schedule for provider reimbursement and provide a 30-day notice of any modifications to the fee schedule.
· Health carriers could not request a refund from providers on a claim after twelve months of payment unless it is found to be a fraudulent or misrepresented claim.
· Health carriers would be required to provide an electronic provider directory through the internet.
· Health carriers wold inform enrollees of any denials for health services request.
· Effective July 1, 2002, health carriers would provide to the enrollees an insurance card with the telephone number for the plan, prescription drug information and a brief description of the plan type. Cards would be reissued upon any change to the benefits or coverage that is listed on the card.

HCP states that most of these provisions are already available through their plans. Most health carriers are capable of accepting and processing electronically filed claims. HCP's current carriers have internet sites available providing provider and formulary information. The carriers may need to modify the information on the health insurance cards slightly, but, again, most of the information listed is currently available on our member's cards. The cards indicate what the office, specialist, and pharmacy copayments are for HMO members.

Where the carriers may see an increase in cost would be the areas of uniformed procedures for confirmation numbers, accepting any coding approved by the Department of insurance, notifying the enrollee of any denied request for health services and allowing providers up to one year to file claims. The carriers may need to upgrade their computer systems to allow for uniformed

ASSUMPTION (continued)

confirmation numbers and to accept any medical code submitted by the provider as approved by the Department of Insurance. Allowing providers up to one year to file claims may prohibit the plans from accurately establishing their rates for the next year. The plans rely on timely claims data to establish the rates necessary to remain profitable. If providers would be allowed up to one year to file claims, the carriers may artificially inflate the premiums to absorb any late or unexpected expense. All of these expenses combined may exceed $100,000.

7. Would amend the new born child language in 376.406 RSMo. If the health carriers require an application to add a new born and the enrollee has notified the health carrier either orally or in writing, the health carrier would provide all forms and instructions necessary to enroll the new born. The health carrier would allow an additional 10 days from the date the forms and instructions were provided in which to enroll the new born child. Currently carriers are required to automatically cover a newbom child from the moment of birth. Carriers may request application and premium for coverage to extend beyond the 31 days after the date of birth. Since carriers are required to cover all newborns at birth, the extension of an additional 10 days to enroll is not anticipated to dramatically increase costs.

8. Would create 376.419 RSMo addressing the harmless agreements. The first provision states the provider assumes sole liability in the provision of health care. Also, any contract between the provider and health carrier would include a clause that states each party "shall be responsible for any and all claims, liabilities, damages or judgements which may arise as a result of its own negligence or intentional wrongdoing." Each party would hold harmless and indemnify the other party of the above-mentioned liability that results because of their negligence. Health carriers are currently liable for their own actions. Therefore, this provision would not impact HCP.

9. Would amend 376.893 and 376.895 to require health carrier to issue cards to both parents in cases of divorced or legally separated parents. Issuing a duplicate card would increase the plan's cost, but the cost should be minimal.

10. Would add "or prescription medications" to the definition of health care services in 376.1350 RSMo. No fiscal impact is anticipated.

11. Would add language under 376.1361 that would require a health carrier to notify the provider, pharmacist and enrollee when a non-formulary drug is approved under certain conditions. This provision may increase the carrier's mailing and printing costs. However, the cost should not be too substantial.

12. Would add another criteria for health carriers to retract authorization of a service under 376.1361 RSMo. Plans would not be allowed to retract authorization of services after the services have been provided unless, in addition to the current provisions, the covered person's

ASSUMPTION (continued)

coverage has exceeded such person's lifetime maximum. Since the member is not eligible for benefits after exceeding their lifetime maximum, there is no fiscal impact.

13. Would create 376.1405 RSMo, which standardizes the explanation of benefits and requires the carriers to have their formulary list on the internet by January 1, 2004. This provision may create additional administrative costs for the plans, which may be passed along in the premiums. However, any impact should be minimal.

14. Would create 376.1406 RSMo, which standardizes the referral forms used by the providers. This provision may create additional administrative costs for the plans, which may be passed along in the premiums. However, any impact should be minimal.

15. Would create 376.1408 RSMo, which would instruct the Department of Insurance to develop a task force to develop the standardized forms and procedures mentioned in 376.1405 and 376.1406 RSMo. This provision does not fiscally impact HCP.

The unknown costs, such as litigation, limit our ability to determine the exact impact. Overall, the fiscal impact of this entire bill would exceed $100,000.

Department of Insurance (**INS**) officials state there may be some form filings and contract amendments as a result of this proposal. INS states increased revenue would be unknown but is expected to be less than $10,000. INS anticipates that current appropriations would be able to absorb the expense of task force meetings, rulemaking, and filing reviews but depending on actual expenses and workload INS may need to request an increase in appropriations.

Officials from the **Department of Social Services** (**DOS**) state there would be no fiscal impact to the Division of Medical Services because of the language regarding open access to OB/GYM's. DOS states that section 354.618.3 specifically states that "Any health benefit plan provided pursuant to the Medicaid program shall be exempt from the requirements of this section."

DOS assumes that written notice can be in electronic format. However, if the assumption is incorrect and DOS would be required to send written notice for denied claims there would be an increase in administrative costs.

DOS states section 376.1408 section 1 would require managed care organizations to allow enrollees the right to select a long-term facility with same religious orientation as demonstrated by the enrollees. If there is not a long-term care facility in the network, the managed care organization must provide the enrollee the option to receive care from an out-of-network provider with conditions. The reimbursement would be mandated to be at the rate of

ASSUMPTION (continued)

reimbursement consistent with the carrier's contract with HCFA for long-term care. Currently, the health plans use long-term care facilities as step down care from hospital care. DOS assumes that there would be a decrease in long-term care usage because of the mandatory reimbursement rate. Therefore, hospital care usage would increase. DOS states this would have a fiscal impact on the contract rates with the managed care organizations.

DOS assumes there would be no fiscal impact in FY 2002 and the fiscal impact for FY 2003 and FY 2004 would be unknown.

FISCAL IMPACT - State Government	FY 2002 (10 Mo.)	FY 2003	FY 2004
ALL FUNDS			
Cost - All Funds			
Increased state contributions*	(Unknown)	(Unknown)	(Unknown)
ESTIMATED NET EFFECT ON ALL FUNDS*	**(UNKNOWN)**	**(UNKNOWN)**	**(UNKNOWN)**
GENERAL REVENUE FUND			
Costs - Department of Social Services			
Medical assistance payments	$0	(Unknown)	(Unknown)
ESTIMATED NET EFFECT ON GENERAL REVENUE FUND	**$0**	**(UNKNOWN)**	**(UNKNOWN)**
INSURANCE DEDICATED FUND			
Income - Department of Insurance			
Form filing fees	$0 to $10,000	$0	$0
ESTIMATED NET EFFECT ON INSURANCE DEDICATED FUND	**$0 TO $10,000**	**$0**	**$0**

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

MW:LR:OD (12/00)

FISCAL IMPACT - State Government	FY 2002 (10 Mo.)	FY 2003	FY 2004
FEDERAL FUNDS			
Income - Department of Social Services			
Medicaid reimbursements	Unknown	Unknown	Unknown
Costs - Department of Social Services			
Medical assistance payments	(Unknown)	(Unknown)	(Unknown)
ESTIMATED NET EFFECT ON FEDERAL FUNDS*	**$0**	**$0**	**$0**

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

FISCAL IMPACT - Local Government	FY 2002 (10 Mo.)	FY 2003	FY 2004
LOCAL POLITICAL SUBDIVISIONS			
Costs - Local Political Subdivision			
Increased insurance contributions	(Unknown)	(Unknown)	(Unknown)
ESTIMATED NET EFFECT ON LOCAL POLITICAL SUBDIVISIONS	**(UNKNOWN)**	**(UNKNOWN)**	**(UNKNOWN)**

FISCAL IMPACT - Small Business

Small businesses would expect to be fiscally impacted to the extent they may incur increased health insurance costs due to the requirements of this proposal.

DESCRIPTION

This proposal would provide additional protections for health care consumers. Currently a person may receive managed care coverage in a long term care facility. New language would revise the definition of "managed care organization" to include "insurance company and health services corporation" and removes "preferred provider organization" (Section 198.530). A health carrier must currently maintain an adequate network of providers and monitor their ability to provide benefits. New language would prohibit requiring providers to submit income tax

DESCRIPTION (continued)

returns, however, a health carrier may request a financial statement if the provider received ten percent or more of the carrier's total medical expenditures (Section 354.603). In certain circumstances, health carriers must currently offer an open referral health plan. New language would allow members to receive direct access to OB/GYNs within the provider network. No additional copayments should be charged for such services unless they charged for all services in the network (Section 354.618). Currently, claim reimbursement by insurers are required within 45 days or a notice must be sent stating reasons for refusal. After April 1, 2002, new language would require a specific description of the additional information required in order to process a claim. Currently, a carrier must pay interest if a claim is not paid within 45 days. New language would allow the carrier to combine interest payments into one payment when it reaches five dollars. Finally, new language would allow any person who files a claim for a service to also file a civil action against the health carrier for violations of this section. No action, however, may be filed until ten days after notifying the health carrier of the intent to sue (Section 376.383). A new section is created to provide additional duties for health carriers, including permitting providers to file uniform confirmation numbers and to file reimbursement claims for up to one year. As of January 1, 2003, providers may accept electronically filed claims and issue prompt confirmation of receipt. Health carriers would accept all codes included in the physician's current procedural terminology and must provide current reimbursement schedules. They may not request a refund more than twelve months after paying a claim. Internet access to current provider directories would be provided. Enrollees would be informed of coverage denials and would receive an enrollee card with all pertinent information(Section 376.384). Currently, coverage would be provided for newborns up to thirty-one days after birth. New language would require the health carrier to provide an enrollee with the forms necessary to continue coverage of the child after thirty-one days, if necessary. Ten additional days would be allowed for the completion of such forms. This section would apply to plans current as of August 28, 2001 (Section 376.406. A new section would be created to define a "hold harmless clause" as an agreement by a health care provider to assume sole liability for services provided. Any contract between a provider and carrier would include a clause stating their liability for negligence or intentional wrongdoing. Each party would hold the other party harmless against such claims (Section 376.419). Currently, separated, divorced, or widowed spouses may continue coverage of the other spouse's insurance through COBRA. Notice must be provided by the plan to the spouse. New language would require the notice to include a statement that the insurer would provide both parents with coverage information on any child covered by the policy (Sections 376.893 - 376.895. A new section would require a managed care organization to allow an enrollee to receive coverage in a religious long term care facility, if possible, even if the facility would be out-of-network. Certain conditions would apply and, if satisfied, the facility would be reimbursed consistent with the carrier's HCFA contract for long term care services (Section 376.1258). Current utilization review sections would be revised to include prescription drugs in the term "health care service". New language would require every health carrier to notify the pharmacist, physician, and enrollee when a non-formulary drug is authorized for use with

DESCRIPTION (continued)

conditions. New language would also shorten the time during which an authorization decision for post-emergency services from 60 to 45 minutes of receiving the request (Sections 376.1350 - 376.1387). After January 1, 2004, every insurer would use a standardized form for explanation of benefits and for referrals. Health carriers would also provide formulary information to pharmacists over the internet or otherwise electronically. This mandate would be preempted if federal standardized forms are developed. The Department of Insurance would establish a task force by January 1, 2003 to develop the above forms (Sections 376.1405 - 376.14080.

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

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Director

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