COMMITTEE ON LEGISLATIVE RESEARCH
OVERSIGHT DIVISION

FISCAL NOTE

L.R. No.: 1844-02
Bill No.: SCS for SB 445
Subject: Health Care; Insurance Department; Insurance - Medical; Health Care Professionals
Type: Original
Date: February 23, 2001

FISCAL SUMMARY

ESTIMATED NET EFFECT ON STATE FUNDS			
FUND AFFECTED	FY 2002	FY 2003	FY 2004
All Funds	(Unknown)	(Unknown)	(Unknown)
General Revenue	(More than $40,000)	(More than $40,000)	(More than $40,000)
Insurance Dedicated	$1,450	$0	$0
Total Estimated Net Effect on All State Funds	**(MORE THAN $38,550)**	**(MORE THAN $40,000)**	**(MORE THAN $40,000)**

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**

***Revenues and expenditures of more than $60,000 annually net to $0.**

ESTIMATED NET EFFECT ON LOCAL FUNDS			
FUND AFFECTED	FY 2002	FY 2003	FY 2004
Local Government	**$0**	**$0**	**$0**

Numbers within parentheses: ( ) indicate costs or losses.
This fiscal note contains 7 pages.

FISCAL ANALYSIS

ASSUMPTION

Officials from the **Department of Transportation**, and the **Department of Conservation** assume this proposal would not fiscally impact their agencies.

Missouri Consolidated Health Care Plan (**HCP**) officials state the proposal revises "prompt-pay" provisions for health carriers and places other restrictions on health carriers. HCP states the proposal would:

1. 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.

2. 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.

3. create 376.386 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.
- 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

ASSUMPTION (continued)

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 would 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.

HCP states 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, accepting electronically filed claims and allowing providers up to one year to file claims. The carriers may need to upgrade their computer systems to allow for uniformed 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.

HCP also states any health carriers with multiple benefit lines would be prohibited from requiring participating providers to participate in all lines as a condition of contracting. HCP states the proposal would also prohibit the health carrier’s contract language including mandatory use of a hospitalist. Currently, providers would be allowed to contract with a single product with our carriers. For instance, some carriers may be providers under United Health Care Select HMO and not the United Health Care Select Plus POS. Therefore, the provision should not fiscally impact HCP.

HCP states prohibiting the mandatory use of hospitalists could have an unknown fiscal impact on

ASSUMPTION (continued)

HCP. Most hospital personnel contact the member's PCP prior to treatment. The PCP usually oversees the care received and visits the member in the hospital. However, some plans do employ hospitalists and believe they are more cost effective than using the PCP or specialists. However, HCP is not aware of any studies on the cost effectiveness of hospitalists. Consequently, the plans may experience increased costs that would be recouped in premiums. However, the cost of this proposal in unknown.

Oversight assumes that the cost of a hospitalist would be between the member's PCP and hospitalist.

Officials from the **Department of Social Services - Division of Medical Services** (**DMS**) state they would be affected by this proposal because it administers a managed care program which contracts with health maintenance organizations (HMO) for the purpose of providing health care services through capitated rates. DMS states these HMOs would be subject to the regulations 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 would be incurred when managed care contracts are rebid. DMS states the fiscal impact is unknown but greater than $100,000.

Department of Insurance (**INS**) officials state HMOs would be required to amend contracts of coverage in order to comply with the proposal. INS states the amendments to contracts for coverage must be filed with INS. It is anticipated that current appropriations and staff would be able to absorb the work for implementation of this single proposal. However, if additional proposals are approved during the legislative session, INS would need to request additional staff to handle the increase in workload. INS estimates 29 HMOs would be required to file amendments to their policy form to comply with this proposal resulting in revenue of $1,450. If multiple proposals pass during the legislative session which require policy form amendments to be filed, the insurers would probably file one amendment for all required mandates. This would result in increased revenue of $1,450 for all proposals.

Officials from the **Department of Public Safety - Missouri State Highway Patrol** did not respond to our fiscal impact request.

FISCAL IMPACT - State Government	FY 2002 (10 Mo.)	FY 2003	FY 2004
ALL FUNDS			
Costs - 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 - Division of Medical Services			
Increase in managed care contracts	(More than $40,000)	(More than $40,000)	(More than $40,000)
ESTIMATED NET EFFECT ON GENERAL REVENUE FUND	**(MORE THAN $40,000)**	**(MORE THAN $40,000)**	**(MORE THAN $40,000)**
INSURANCE DEDICATED FUND			
Income - Department of Insurance			
Form filing fees	**$1,450**	**$0**	**$0**
ESTIMATED NET EFFECT ON INSURANCE DEDICATED FUND	**$1,450**	**$0**	**$0**
FEDERAL FUNDS			
Income - Department of Social Services - Division of Medical Services			
Medicaid reimbursements	More than $60,000	More than $60,000	More than $60,000

MW:LR:OD (12/00)

FISCAL IMPACT - State Government	FY 2002 (10 Mo.)	FY 2003	FY 2004
Costs - Department of Social Services - Division of Medical Services			
Increase in managed care contracts	(More than $60,000)	(More than $60,000)	(More than $60,000)
ESTIMATED NET EFFECT ON FEDERAL FUNDS	**$0**	**$0**	**$0**

FISCAL IMPACT - Local Government	FY 2002 (10 Mo.)	FY 2003	FY 2004
	$0	**$0**	**$0**

FISCAL IMPACT - Small Business

Small businesses could expect to be fiscally impacted to the extent they may incur increased health insurance premiums as a result of the requirements of this proposal.

DESCRIPTION

This proposal would provide stricter prompt pay requirements for insurance companies. Currently, provider/health carrier agreements are outlined in Section 354.606, RSMo. A new subsection 9 would be added to prohibit any contract between a provider and health carrier from mandating the use of a hospitalist. A "hospitalist" would be defined as a physician who becomes the physician of record for a patient of a participating provider. The hospitalist would return care to the participating provider when the patient is released from the hospital. Currently, Section 376.383, RSMo, requires claim reimbursement within forty-five days or a notice 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 forty-five 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, would be filed until ten days after notifying the health carrier of the intent to sue. A new Section 376.386 would 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 would accept electronically filed claims and issue prompt confirmation of receipt. Health carriers

DESCRIPTION (continued)

would accept all codes included in the physician's current procedural terminology and must provide current fee schedules. They would not request a refund more than one year 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.

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
Department of Conservation
Department of Social Services
Missouri Consolidated Health Care Plan
Department of Transportation

NOT RESPONDING: Department of Public Safety - Missouri State Highway Patrol

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Director

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