COMMITTEE ON LEGISLATIVE RESEARCH
OVERSIGHT DIVISION

FISCAL NOTE

L.R. No.: 4183-02
Bill No.: Perfected SCS for SB 1026
Subject: Insurance - Medical; Physicians; Health Care; Health Care Professionals
Type: Original
Date: April 18, 2002

FISCAL SUMMARY

ESTIMATED NET EFFECT ON STATE FUNDS			
FUND AFFECTED	FY 2003	FY 2004	FY 2005
Insurance Dedicated	$9,850	$0	$0
Total Estimated Net Effect on All State Funds	**$9,850**	**$0**	**$0**

ESTIMATED NET EFFECT ON FEDERAL FUNDS			
FUND AFFECTED	FY 2003	FY 2004	FY 2005
Total Estimated Net Effect on All Federal Funds	**$0**	**$0**	**$0**

ESTIMATED NET EFFECT ON LOCAL FUNDS			
FUND AFFECTED	FY 2003	FY 2004	FY 2005
Local Government	**$0**	**$0**	**$0**

Numbers within parentheses: ( ) indicate costs or losses.
This fiscal note contains 5 pages.

FISCAL ANALYSIS

ASSUMPTION

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

Officials from the **Department of Public Safety - Missouri State Highway Patrol (MHP)** defer their fiscal note response to the Department of Transportation.

Official from the **Department of Transportation (DHT)** state that the Highway and Patrol Medical Plan is not mentioned in the legislation but section 104.801 RSMo. 2000 would require similar coverage. Currently, the Medical Plan does cover a second opinion, whether the specialist is in the provider network or out of the provider network. The only difference is that charges with a provider in the network are paid at a 90% co-insurance with the maximum out-of-pocket for the patient at $750 and charges with an out-of-network provider are paid at an 80% co-insurance with the maximum out-of-pocket for the patient increasing to $1,500. In addition, DHT states office visit charges with an in-network provider have a $15 co-pay for the patient without being applied to their deductible and co-insurance. Out-of-network office visit charges are applied to the patients deductible and co-insurance.

DHT assumes there are two ways of looking at this legislation. One way is to assume that if a patient is seen by an in-network doctor and then referred to an out-of-network specialist that both provider's charges would have to be paid at 90% co-insurance with the maximum out-of-pocket for the patient at $750 and the office visits would have a $15 co-payment only. Likewise, DHT states if the patient is seen by an out-of-network provider and then referred to a specialist within the network the charges would have to be paid at the 80% co-insurance with the maximum out-of-pocket for the patient at $1,500 and there would be no office visit co-payment applied. This assumption would probably have a fiscal impact to the Medical Plan.

DHT states the second assumption could be, because the medical plan does not limit coverage to in-network providers only, and the Medical Plan would cover the services with an out-of-network provider, there would be no fiscal impact to the Medical Plan. The legislation states, "Such coverage shall be subject to the same deductible and co-insurance conditions applied to other referrals and all other terms and conditions applicable to other benefits". DHT assumes, based on this statement, that the Medical Plan's current provisions would be applicable, because the 80-20 co-insurance is currently applied to other referrals and other benefits when seen by an out-of-network provider. DHT assumes the first assumption if the legislation read, "Such coverage shall be subject to the same deductible, co-insurance and co-payments as coverage for an in-network provider".

Based on the current language, DHT assumes there would be no fiscal impact to DHT or the

ASSUMPTION (continued)

Highway and Patrol Medical Plan.

Officials from the **Department of Insurance (INS)** assume insurers and HMOs would be required to amend their policies to comply with this legislation. Amendments must be filed with INS. INS estimates that 171 insurers and 26 HMOs would be required to file at least one amendment to their policy form with a filing fee of $50, resulting in revenue of $9,850 in FY 2003. INS has reached capacity in policy form reviews and the additional workload created by this legislation would cause delays in policy form reviews. Additional staff are not being requested with this single proposal, but if multiple proposals pass during the legislative session which require policy form amendments, the department would need to request additional staff to handle the increase in workload.

Officials from the **Department of Social Services - Division of Medical Services (DMS)** assume the proposed legislation requires insurance companies to provide coverage for a second opinion by a specialist for a patient that has been newly diagnosed with cancer. The specialist, referred by the physician, may be within or outside of the patient's provider network.

The proposed legislation will not have a fiscal impact to the DMS. Currently, second opinions for cancer patients is already a covered service for Missouri Medicaid in the fee for service program and the managed care program.

For the fee for service program, section 1.5 (Restricted Benefits) in the Missouri Medicaid provider manual does not include second opinions; therefore, Missouri Medicaid does cover second opinions. Section 13.30 of the provider manual specifically references coverage for second opinions on surgeries. For the managed care program, the MC+ managed care contracts paragraph 2.13 provide for second opinions.

Officials from the **Missouri Consolidated Health Care Plan (HCP)** state this proposal requires the physician to refer any member newly diagnosed with cancer to a specialist within the network. If a specialist within the network is not available, the provider shall refer to a non-network specialist.

The provider contract with a health carrier requires them to refer members to participating specialists. Medical plans must meet the Department of Insurance's Network Adequacy regulations, therefore, most plans provide a vast network of primary care physicians, specialists, and hospitals. If a provider must make an occasional referral out of the network, the provider should still contact the health carrier who would then work on a reimbursement arrangement. HCP states health plans must pay a non-network claim which could cost more. Depending on the provider and which state the services are rendered, the costs are too difficult to estimate but are moderate.

ASSUMPTION (continued)

Oversight assumes since members currently may receive second opinions from in-network providers, fiscal impact would be minimal.

FISCAL IMPACT - State Government	FY 2003 (10 Mo.)	FY 2004	FY 2005
INSURANCE DEDICATED FUND			
Income - Department of Insurance Form filing fees	$9,850	$0	$0
ESTIMATED NET EFFECT ON INSURANCE DEDICATED FUND	**$9,850**	**$0**	**$0**

FISCAL IMPACT - Local Government	FY 2003 (10 Mo.)	FY 2004	FY 2005
	$0	**$0**	**$0**

FISCAL IMPACT - Small Business

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

DESCRIPTION

This proposal allows a physician to refer a patient who has been newly diagnosed with cancer to a specialist for a second opinion regarding the patient's treatment. The specialist would be within the network. If there is not an appropriate specialist within the network, then a referral shall be made to a non-network specialist. This proposal requires insurance companies to provide coverage for the second opinion rendered by the specialist, regardless if the specialist is outside the patient's provider network.

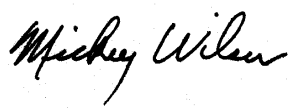
This legislation is not federally mandated, would not duplicate any other program and would not require additional capital improvements or rental space.

SOURCES OF INFORMATION

Department of Transportation
Department of Social Services

CM:LR:OD (12/01)

Missouri Consolidated Health Care Plan
Department of Insurance
Missouri Department of Conservation
Department of Public Safety -
Missouri State Highway Patrol



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CM:LR:OD (12/01)