

COMMITTEE ON LEGISLATIVE RESEARCH
OVERSIGHT DIVISION

FISCAL NOTE

L.R. No.: 0691-01
Bill No.: HB 328
Subject: Insurance - Medical; Medical Procedures and Personnel; Insurance Department
Type: Original
Date: February 3, 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 <u>All</u> 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 <u>All</u> 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 10 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.
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

ASSUMPTION (continued)

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 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.

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 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

ASSUMPTION (continued)

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 newborn 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 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.

ASSUMPTION (continued)

13. Would reduce the time the health carrier has to approve emergency services if they require post-approval to 45 minutes from 60 minutes under 376.1367 RSMo. The carriers already have the staff available to perform this duty so no additional cost should be incurred as a result of this provision.

14. 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.

15. 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.

16. 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.

17. Would create Section 1, which would require all managed care organizations to allow enrollees the right to select a long-term care facility with the same religious orientation as the enrollee. If one is not available in the managed care organization's network, they would provide the option to receive care at an out-of-network long-term care facility if certain criteria are met. The managed care organization would base their reimbursement on their contract with HCFA for long-term care services. Carriers are currently required to pay for long-term care at participating facilities. One would assume that most members take advantage of their benefits by using participating providers. Therefore, allowing members to use out-of-network facilities should not have a fiscal impact if the carrier's payment is restricted to HCFA's contracted amount for long-term services.

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

ASSUMPTION (continued)

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 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.

| <u>FISCAL IMPACT - State Government</u> | FY 2002 (10 Mo.) | FY 2003 | FY 2004 |
|---|-------------------------|-------------------------|-------------------------|
| ALL FUNDS | | | |
| <u>Cost - All Funds</u> | | | |
| Increased state contributions* | <u>(Unknown)</u> | <u>(Unknown)</u> | <u>(Unknown)</u> |
| ESTIMATED NET EFFECT ON ALL FUNDS* | <u>(UNKNOWN)</u> | <u>(UNKNOWN)</u> | <u>(UNKNOWN)</u> |

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

| <u>FISCAL IMPACT - State Government</u> | FY 2002 (10 Mo.) | FY 2003 | FY 2004 |
|---|-------------------------------|-------------------------|-------------------------|
| GENERAL REVENUE FUND | | | |
| <u>Costs - Department of Social Services</u> | | | |
| Medical assistance payments | <u>\$0</u> | <u>(Unknown)</u> | <u>(Unknown)</u> |
| ESTIMATED NET EFFECT ON GENERAL REVENUE FUND | <u>\$0</u> | <u>(UNKNOWN)</u> | <u>(UNKNOWN)</u> |
| INSURANCE DEDICATED FUND | | | |
| <u>Income - Department of Insurance</u> | | | |
| Form filing fees | <u>\$0 to \$10,000</u> | <u>\$0</u> | <u>\$0</u> |
| ESTIMATED NET EFFECT ON INSURANCE DEDICATED FUND | <u>\$0 TO \$10,000</u> | <u>\$0</u> | <u>\$0</u> |
| FEDERAL FUNDS | | | |
| <u>Income - Department of Social Services</u> | | | |
| Medicaid reimbursements | Unknown | Unknown | Unknown |
| <u>Costs - Department of Social Services</u> | | | |
| Medical assistance payments | <u>(Unknown)</u> | <u>(Unknown)</u> | <u>(Unknown)</u> |
| ESTIMATED NET EFFECT ON FEDERAL FUNDS* | <u>\$0</u> | <u>\$0</u> | <u>\$0</u> |

***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 make numerous changes to the managed care statutes. In its main provisions, the proposal would: (1) require that a managed care organization be licensed by the Department of Insurance rather than certified by the Department of Health; (2) clarify that providers would not be required to submit copies of their income tax returns to a health carrier. The health carrier 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; (3) allow direct access to a participating obstetrician or gynecologist in the provider network. A health carrier would be prohibited from imposing surcharges, additional copayments, or deductibles for accessing the obstetrician or gynecologist unless the same are imposed on other types of health care services received in the network; (4) specify that the "prompt pay" provisions of Section 376.383, RSMo, apply after a health carrier receives a claim for health care services provided in the state. Current law 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 necessary to process the entire claim; (5) 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. If the court would find a violation, it would award the plaintiff \$50 per day beginning 10 days following the date interest began to accrue in addition to the claimed reimbursement and interest; (6) 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 an electronic confirmation within 24 hours of receipt of an electronically filed claim for

DESCRIPTION (continued)

reimbursement, and to accept all medical codes and modifiers specified in the proposal; (7) require carriers to accept electronically filed reimbursement claims starting January 1, 2003, and would require the Department of Insurance to promulgate rules regarding the format of such forms; (8) require health carriers to furnish providers with a current fee schedule for reimbursement amounts of covered services for which the health carrier is contracted to provide and prohibits carriers from requesting a refund against a claim more than 12 months after a carrier has paid the claim, except in cases of fraud or misrepresentation by the provider; (9) require health carriers to provide Internet access to a current provider directory; (10) require health carriers to inform enrollees of any denial of health care coverage. The explanation must be in plain language that is easy for a layperson to understand; (11) effective July 1, 2002, require health carriers to issue each enrollee a card which includes a telephone number for the plan, prescription drug information, and a brief description of the enrollee's plan; (12) require health carriers to provide, upon notification, an enrollee with the forms and instructions necessary to enroll a newly born child if an application would be required in order to continue coverage beyond the 31-day period after the child's birth; (13) prohibit "hold harmless" clauses that would require a health care provider to assume the sole liability of the provision of health care services. Any contract between a health care provider and a health carrier would include a clause which states that each party would be responsible for its own negligence or intentional wrongdoing; (14) require insurers, upon request, to provide both parents of a covered child with coverage information regardless of whether the parent is the primary policyholder; (15) add prescription medication to the definition of the term "health care service" and would modify the definition of the term "certification" to include a determination that the health care service is a covered benefit under the plan; (16) require health carriers to notify the dispensing pharmacist, prescribing physician, and enrollee when a nonformulary drug is authorized with conditions; (17) allow a health carrier to retract a prior certification of a health care service if the enrollee's coverage under the plan has exceeded the enrollee's lifetime or annual benefits limit; (18) require a health carrier to provide authorization for emergency services within 45 minutes instead of 60 minutes; (19) require health carriers to use, after January 1, 2004, standardized forms for referrals and explanations of benefits. The Department of Insurance would establish a task force by January 1, 2003, to develop the standardized forms. These provisions would be preempted if the federal government develops standardized forms; (20) require health carriers to make available formulary information to participating pharmacists via the Internet or other electronic means after January 1, 2004; (21) require all managed care organizations to allow enrollees the right to select long-term care facilities which have the same religious orientation as the enrollee. If a religiously appropriate facility is not in the managed care organization's provider network, it would provide the enrollee the option to receive care from an out-of-network, long-term care facility that meets specific qualifications; and (22) repeals two sections prescribing standardized forms for explanation of benefits and referrals.

DESCRIPTION (continued)

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



Jeanne Jarrett, CPA
Director

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