

COMMITTEE ON LEGISLATIVE RESEARCH  
OVERSIGHT DIVISION

**FISCAL NOTE**

L.R. No.: 0691-07  
Bill No.: Truly Agreed To and Finally Passed SS #2 for SCS for HS for HCS for HB 328 and 88  
Subject: Insurance - Medical; Medical Procedures and Personnel; Insurance Department  
Type: Original  
Date: June 12, 2001

**FISCAL SUMMARY**

<b>ESTIMATED NET EFFECT ON STATE FUNDS</b>			
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
<b>Total Estimated Net Effect on All State Funds*</b>	<b>(UNKNOWN)</b>	<b>(UNKNOWN)</b>	<b>(UNKNOWN)</b>

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

<b>ESTIMATED NET EFFECT ON FEDERAL FUNDS</b>			
FUND AFFECTED	FY 2002	FY 2003	FY 2004
Federal*	\$0	\$0	\$0
<b>Total Estimated Net Effect on All Federal Funds*</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

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

<b>ESTIMATED NET EFFECT ON LOCAL FUNDS</b>			
FUND AFFECTED	FY 2002	FY 2003	FY 2004
<b>Local Government</b>	<b>(UNKNOWN)</b>	<b>(UNKNOWN)</b>	<b>(UNKNOWN)</b>

Numbers within parentheses: ( ) indicate costs or losses.

This fiscal note contains 9 pages.

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## FISCAL ANALYSIS

### ASSUMPTION

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

**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.

**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 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. 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.

3. Would create 376.384 RSMo which would:

· Permit providers to file confirmation numbers of certified services and claims in the same manner and format

ASSUMPTION (continued)

- 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 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 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.

4. Would amend the new born child language in 376.406 RSMo. If the health carriers require an

ASSUMPTION (continued)

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.

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.

Officials from the **Department of Social Services - Division of Legal Services** indicated that the proposal would not directly affect their Division.

Officials of the **Department of Social Services - Division of Family Services** stated that the requirement that completed applications for services described in section 208.152, RSMo, (medical services for needy people) be accepted or rejected within thirty (30) days could be accomplished with existing resources.

Officials of the **Department of Social Services - Division of Medical Services (DMS)** stated they would be affected by sections 376.383 to 376.406 of this proposal because DMS administers a managed care program which contracts with health maintenance organizations (HMOs) for the purpose of providing health care services through capitated rates. 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. The cost impact to DMS would be incurred when managed care contracts are rebid. The fiscal impact is unknown but greater than \$100,000.

DMS officials assume that the requirement that applications for medical services for needy persons be approved or rejected within thirty (30) days means within 30 days of the applicant submitting all information necessary to determine Medicaid eligibility. As long as regulations and the courts support this interpretation, there would be no cost to DMS due to this provision.

DMS officials state that the proposal would require DMS to reimburse licensed nursing home operators for newly admitted Medicaid residents in long term care facilities within forty-five (45) days of the date of admission. Officials believe that 45 days is not long enough, in all cases, to decide if residents are Medicaid eligible and meet the criteria for long term care. Any payments made for admissions of persons who are not eligible for long term care would be paid

ASSUMPTION (continued)

100% from state general revenue. The cost is unknown but expected to be less than \$100,000 in a given fiscal year. Officials also assume that they would make payments to Medicaid certified facilities, only. (If this interpretation is not correct and DMS must make payments to facilities which are not Medicaid certified then costs would be up to \$51,200,000 per year.)

<u>FISCAL IMPACT - State Government</u>	FY 2002 (10 Mo.)	FY 2003	FY 2004
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**ALL FUNDS**

Cost - All Funds

Increased state contributions*	<u>(Unknown)</u>	<u>(Unknown)</u>	<u>(Unknown)</u>
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**ESTIMATED NET EFFECT ON ALL FUNDS\***

<b><u>(UNKNOWN)</u></b>	<b><u>(UNKNOWN)</u></b>	<b><u>(UNKNOWN)</u></b>
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\*Expected to exceed \$100,000 annually.

**GENERAL REVENUE FUND**

Costs - Department of Social Services

Medical assistance payments	<u>\$0</u>	<u>(Unknown)</u>	<u>(Unknown)</u>
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**ESTIMATED NET EFFECT ON GENERAL REVENUE FUND**

<b><u>\$0</u></b>	<b><u>(UNKNOWN)</u></b>	<b><u>(UNKNOWN)</u></b>
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**INSURANCE DEDICATED FUND**

Income - Department of Insurance

Form filing fees	<u>\$0 to \$10,000</u>	<u>\$0</u>	<u>\$0</u>
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**ESTIMATED NET EFFECT ON INSURANCE DEDICATED FUND**

<b><u>\$0 TO \$10,000</u></b>	<b><u>\$0</u></b>	<b><u>\$0</u></b>
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**FEDERAL FUNDS**

<u>FISCAL IMPACT - State Government</u>	FY 2002 (10 Mo.)	FY 2003	FY 2004
<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>
<b>ESTIMATED NET EFFECT ON FEDERAL FUNDS*</b>	<b><u>\$0</u></b>	<b><u>\$0</u></b>	<b><u>\$0</u></b>

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

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

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 several changes to managed care regulations. The proposal would require employees of hospitals and ambulatory surgical centers to be informed of their right to notify the Department of Health of any information concerning alleged violations of applicable federal or state laws or administrative rules concerning patient care and safety or facility safety.

MANAGED CARE REGULATION

Health carriers are currently required to monitor the ability, clinical and financial capacity, and legal authority of their providers to furnish contracted benefits to enrollees. The proposal would

DESCRIPTION (continued)

remove the requirement to monitor financial capacity and would allow a health carrier to require a health care provider to obtain audited financial statements if the provider received at least 10% of total medical expenditures made by the health carrier.

The proposal would establish procedures for submission of claims, time frames within which claims would be paid, and penalties for failure to act on a claim in the required fashion; these provisions would become effective on January 1, 2002. Health carriers would, within 10 days of receipt of a claim, either send an acknowledgment of the date of receipt or send a status notice requesting additional information. Within 15 days of receipt of additional information, the health carrier would pay the claim or the undisputed portion of the claim or send notice of receipt and claim status denying all or part of the claim, specifying each reason for denial or making a final request for more information.

If the health carrier has not paid the claimant by the 45th day from the date of receipt of the claim, the health carrier would pay the claimant 1% interest per month on the unpaid balance of the claim. If the health carrier would fail to pay, deny, or suspend the claim within 40 processing days and has received notice from the health care provider by the 40th day that the claim has not

been paid, denied, or suspended, the health carrier would also pay 50% of the claim (up to \$20) per day for failure to pay the claim or interest. This penalty would not accrue beyond 30 days unless the claimant provides a second written or electronic notice on or after 30 days to the health carrier that the claim remains unpaid and that penalties are due. If a court finds that the health carrier failed to meet the claim payment requirements, the court would award reasonable attorney fees. If the court finds that the health care provider filed suit without reasonable grounds to recover a claim, the court would award the health carrier reasonable attorney fees.

The proposal would require health carriers to allow nonparticipating health care providers to file claims for up to one year from the date of service and participating health care providers to file claims for up to 6 months from the date of service, unless a contract between the carrier and provider specifies otherwise. Refunds or offsets against paid claims cannot be requested after 12 months, except in cases of fraud or misrepresentation by the health care provider. These provisions would become effective on January 1, 2002.

Health carriers would issue confirmations of receipt of electronically-filed claims within one working day. After January 1, 2003, all claims for reimbursement for health care services would be submitted in an electronic format consistent with standards required by the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996. All electronically-filed claims would be submitted in a uniform format using standard medical code sets. The Department of Insurance would issue rules pertaining to the format and medical code sets which are consistent and no more stringent than simplification standards in HIPAA. These provisions would become

DESCRIPTION (continued)

effective on January 1, 2002.

The Department of Insurance would be authorized to conduct examinations to determine compliance with claim processing requirements. Compliance would be defined as paying 95% of claims received in a given calendar year within the bill's guidelines. The director would be authorized to levy administrative penalties up to \$25 per claim for the percentage of non-compliant claims, up to \$250,000 annually. If the director would determine that health carriers are not paying interest due, he or she may order the health carriers to pay the interest; and the director may assess a monetary penalty of up to 25% of unpaid interest payments. The department would develop a method for health care providers to file complaints of violations of the proposal's provisions, and the director would consider any complaints when determining whether to examine a health carrier's compliance. The proposal would specify information to be included in complaints. These provisions would become effective January 1, 2002.

The proposal would require health carriers, upon notification, to provide an enrollee with the necessary forms, instructions, and an additional 10 days to enroll a newly-born child if an application is required in order to continue coverage beyond the 31-day period after the child's birth.

OTHER PROVISIONS

No contract between providers and health carriers could require the mandatory use of a hospitalist, which is defined in the proposal. A completed application for medical assistance benefits would be approved or denied within 30 days from submission to the Division of Family Services or its successor. The proposal would require the Division of Medical Services to remit to a licensed nursing home operator the Medicaid payment for a newly-admitted Medicaid resident in a licensed, long-term care facility within 45 days of the admission date.

The proposal would also prohibit any insurer or its agent from requiring an applicant or policyholder to disclose whether or not any insurer has denied any of that person's claims.

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  
Missouri Consolidated Health Care Plan  
Department of Insurance

MW:LR:OD (12/00)

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SOURCES OF INFORMATION (continued)

Department of Public Safety  
Missouri State Highway Patrol  
Department of Social Services

**NOT RESPONDING: Cooper County Memorial Hospital**

A handwritten signature in black ink, appearing to read "Jeanne Jarrett". The signature is cursive and somewhat stylized, with the first name "Jeanne" being more prominent than the last name "Jarrett".

Jeanne Jarrett, CPA  
Director  
June 12, 2001