LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 78TH LEGISLATIVE REGULAR SESSION

May 27, 2003

TO: Honorable David Dewhurst , Lieutenant Governor, Senate
Honorable Tom Craddick, Speaker of the House, House of Representatives

FROM: John Keel, Director, Legislative Budget Board

IN RE: **SB418** by Nelson (Relating to the regulation and prompt payment of health care providers; providing penalties.), **Conference Committee Report**

Estimated Two-year Net Impact to General Revenue Related Funds for SB418, Conference Committee Report: an impact of $0 through the biennium ending August 31, 2005.

The bill would make no appropriation but could provide the legal basis for an appropriation of funds to implement the provisions of the bill.

General Revenue-Related Funds, Five-Year Impact:

Fiscal Year	Probable Net Positive/(Negative) Impact to General Revenue Related Funds
2004	$0
2005	$0
2006	$0
2007	$0
2008	$0

All Funds, Five-Year Impact:

Fiscal Year	Probable Revenue Gain/ (Loss) from *DEPT INS OPERATING ACCT* 36	Probable Savings/(Cost) from *DEPT INS OPERATING ACCT* 36	Change in Number of State Employees from FY 2003
2004	$314,262	($314,262)	5.0
2005	$193,247	($193,247)	3.5
2006	$193,247	($193,247)	3.5
2007	$193,247	($193,247)	3.5
2008	$193,247	($193,247)	3.5

Fiscal Analysis

The bill would require the Department of Insurance (TDI) to adopt rules under which a Health Maintenance Organization (HMO) and a physician may extend the claims submission period by contract. The bill would provide rulemaking authority for TDI to implement the new requirements including standards for electronic claim filing. The bill would address duplicate claims submission by physicians and providers and includes rulemaking authority for TDI relative to an HMO determining whether a claim is a duplicate claim. The bill would include rulemaking authority for rules to identify a submission by a physician or provider that includes additional information requested by the HMO. The bill would address requirements related to the claims audit process and establish new

requirements that affect current rules; revisions would be necessary, including new sections that define certain terms in the bill such as "billed charges." The bill would require a Preferred Provider Benefit Plan (PPBP) issuer to disclose certain information in an Explanation of Benefits. The bill would require a carrier or HMO to use "nationally recognized, generally accepted Correct Procedural Terminology codes…" consistent with nationally recognized generally accepted clinically appropriate bundling and logic edits known as the National Correct Coding Initiative. The bill would permit a provider to request a description of coding guidelines including bundling processes but this request could not be interpreted to require an HMO to violate a copyright contract with a software company. The bill would also allow a physician or provider to collect a penalty for claims paid after the 45th day, and require PPBP issuers and HMOs to verify that services are medically necessary for an enrollee before the physician or provider renders covered services.

The bill would require TDI to consult with the Health and Human Services Commission to determine waivers of application of certain insurance code provisions for certain federal plans if application of the provisions would cause a negative fiscal impact to the state.

The bill would take effect on June 1, 2003 if it receives two-thirds vote from each House. Otherwise, the bill would take effect September 1, 2003.

Methodology

In order to implement the provisions of the bill, the Department of Insurance (TDI) would require 0.5 Manager IV FTE, 1.0 Program Specialist V FTE, 0.25 Insurance Specialist III FTE, and 0.25 Insurance Specialist V FTE for the development of rules, to handle additional complaints, and for related responsibilities. Costs associated with these responsibilities would be $170,244 in 2004 and $91,711 each year thereafter.

TDI would also require 2.0 Attorney IV FTEs in 2004 and 1.5 Attorney IV FTEs each year thereafter to perform rulemaking functions, respond to inquiries, provide support, and to handle additional contested case hearings. Costs associated with these responsibilities would be $144,018 in 2004 and $101,536 each year thereafter.

It is assumed TDI would adjust the insurance maintenance tax to offset costs associated with implementation of the bill.

The bill would have no significant fiscal impact on the Health and Human Services Commission (HHSC) Medicaid or CHIP HMO providers. The bill would allow TDI, in consultation with HHSC, to waive the application of the provisions of this act to certain federal plans, if they would cause a negative fiscal impact on the state. These federal plans include Title XIX, Social Security Act (Medicaid) and Title XXI, Social Security Act (Children’s Health Insurance Program).

According to the Employees Retirement System (ERS), the bill would impact HealthSelect and HMO’s in the Uniform Group Insurance Program (UGIP).

The bill would provide requirements for the payment of claims if an insurer makes an error by declining medical service and then corrects the error at a later date. It also provides requirements for the payment of claims for which medical service is not declined.

ERS administrative costs during the fiscal year 2006 could be expected to add an additional increase of approximately 1% from the fiscal year 2005 level. Any increase in administrative costs would be paid for out of ERS trust accounts.

Technology

The Department of Insurance would require $8,910 for computers and related equipment for new employees.

Local Government Impact

No fiscal implication to units of local government is anticipated.

Source Agencies: 327 Employees Retirement System, 454 Department of Insurance, 529 Health and Human Services Commission, 302 Office of the Attorney General

LBB Staff: JK, JRO, RT, RB, PP, ZS