Multiple Agency Fiscal Note Summary

Bill Number: 1018 HB	**Title:** Dental insurance practices

Estimated Cash Receipts

NONE

Estimated Operating Expenditures

Agency Name	2019-21			2021-23			2023-25		
	FTEs	GF-State	Total	FTEs	GF-State	Total	FTEs	GF-State	Total
Washington State Health Care Authority	Non-zero but indeterminate cost and/or savings. Please see discussion.								
Office of Insurance Commissioner	.8	0	228,002	.1	0	16,916	.1	0	16,916
Department of Health	.0	0	0	.0	0	0	.0	0	0
Total $	**0.8**	**0**	**228,002**	**0.1**	**0**	**16,916**	**0.1**	**0**	**16,916**

Estimated Capital Budget Expenditures

Agency Name	2019-21			2021-23			2023-25		
	FTEs	Bonds	Total	FTEs	Bonds	Total	FTEs	Bonds	Total
Washington State Health Care Authority	.0	0	0	.0	0	0	.0	0	0
Office of Insurance Commissioner	.0	0	0	.0	0	0	.0	0	0
Department of Health	.0	0	0	.0	0	0	.0	0	0
Total $	**0.0**	**0**	**0**	**0.0**	**0**	**0**	**0.0**	**0**	**0**

Estimated Capital Budget Breakout

NONE

Prepared by: Jane Sakson, OFM	**Phone:** 360-902-0549	**Date Published:** Final 1/28/2019

* See Office of the Administrator for the Courts judicial fiscal note

** See local government fiscal note

FNPID: 53660

Individual State Agency Fiscal Note

Bill Number: 1018 HB	Title: Dental insurance practices	Agency: 107-Washington State Health Care Authority

Part I: Estimates

☐ **No Fiscal Impact**

Estimated Cash Receipts to:

NONE

Estimated Expenditures from:

Non-zero but indeterminate cost. Please see discussion.

Estimated Capital Budget Impact:

NONE

The cash receipts and expenditure estimates on this page represent the most likely fiscal impact. Factors impacting the precision of these estimates, and alternate ranges (if appropriate), are explained in Part II.

Check applicable boxes and follow corresponding instructions:

☒ If fiscal impact is greater than $50,000 per fiscal year in the current biennium or in subsequent biennia, complete entire fiscal note form Parts I-V.

☐ If fiscal impact is less than $50,000 per fiscal year in the current biennium or in subsequent biennia, complete this page only (Part I).

☐ Capital budget impact, complete Part IV.

☐ Requires new rule making, complete Part V.

Legislative Contact:	Kim Weidenaar	Phone: 360-786-7120	Date: 01/15/2019
Agency Preparation:	Crystal Lester	Phone: 360-725-1447	Date: 01/24/2019
Agency Approval:	Carl Yanagida	Phone: 360-725-1033	Date: 01/24/2019
OFM Review:	Jane Sakson	Phone: 360-902-0549	Date: 01/28/2019

Part II: Narrative Explanation

II. A - Brief Description Of What The Measure Does That Has Fiscal Impact

Briefly describe by section number, the significant provisions of the bill, and any related workload or policy assumptions, that have revenue or expenditure impact on the responding agency.

Please see attached narrative.

II. B - Cash receipts Impact

Briefly describe and quantify the cash receipts impact of the legislation on the responding agency, identifying the cash receipts provisions by section number and when appropriate the detail of the revenue sources. Briefly describe the factual basis of the assumptions and the method by which the cash receipts impact is derived. Explain how workload assumptions translate into estimates. Distinguish between one time and ongoing functions.

Please see attached narrative.

II. C - Expenditures

Briefly describe the agency expenditures necessary to implement this legislation (or savings resulting from this legislation), identifying by section number the provisions of the legislation that result in the expenditures (or savings). Briefly describe the factual basis of the assumptions and the method by which the expenditure impact is derived. Explain how workload assumptions translate into cost estimates. Distinguish between one time and ongoing functions.

Please see attached narrative.

Part III: Expenditure Detail

Part IV: Capital Budget Impact

Please see attached narrative.

Part V: New Rule Making Required

Identify provisions of the measure that require the agency to adopt new administrative rules or repeal/revise existing rules.

Please see attached narrative.

Bill Number: HB 1018 HCA Request #: 19-05

Part II: Narrative Explanation

II. A - Brief Description Of What The Measure Does That Has Fiscal Impact

The bill requires that a portion of the patient bill of rights extend to dental only health plans.

Section 2 amends RCW 48.43.005 section 2 (the definitions), specifically subsection (26) “health plan” or “health benefit plan” by inserting language that requires a “dental only plan offered after December 31, 2019” to comply with portions of the patient bill of rights.

Section 3 adds two subsections to RCW 48.43.740:

(1)(b) which prevents health carriers from taking or threatening to take punitive action against a provider if the provider disputes the carrier's determination of coverage or payment for a dental service; and prevents carriers from denying any claim for a covered dental service provided by a treating dentist to a covered person.

(1)(c) which prevents health carriers that deny a claim for a covered dental service provided by a treating dentist to advertise in promotional materials or an explanation of benefits sent to a prospective or current members that the carrier covers the dental service.

Section 4 adds a new section to RCW 48.43 that requires that dental only plans submit their summary of benefits and benefit forms to the insurance commissioner for their approval beginning October 1, 2019 and annually thereafter. Included in the submission are definitions of all terms used. Dental only plans may not use terms and forms disapproved by the insurance commissioner.

Section 5 states that health care service contractors or health carriers who offer dental benefits may not deny or limit coverage base on preexisting oral health conditions.

II. B - Cash Receipts Impact

None

II. C - Expenditures

Indeterminate

The Public Employment Benefits (PEB) fully-insured dental plans, DeltaCare Dental Plan and Willamette Dental Plan, would be impacted by the new requirements. This bill does not apply to the self-insured group, Uniform Dental Plan. This would not affect PEB policy, or operations, but the fiscal impact would be significant as rates would be increased to cover the increased utilization and costs of paying non-participating dentists.

DeltaCare Dental Plan and Willamette Dental Plan are both fully-capitated dental plans, meaning the providers are paid by head count for each patient enrolled, whether the patient seeks care or not. DeltaCare providers are contracted providers, and Willamette providers are direct employees of the dental plan. DeltaCare has a current enrollment of 29,577 and Willamette Dental Plan has an enrollment of 32,048 as of December 2018.

This bill could increase the costs of dental insurance because it severely limits the ability to apply utilization management to dental procedures. The price of individual dental procedures would be unregulated, and therefore likely to rise. With the unregulated cost, and an inability to determine how

many members will utilize these changes, there is an indeterminate fiscal impact. Any increase in premiums for employees would be costs paid by the state because dental coverage is a mandatory employee benefit and the premium is fully paid for by the state.

This bill does not alter statutes that govern how the HCA administers its existing Medicaid dental coverage. In addition, HCA does not anticipate any changes under the upcoming Medicaid managed care dental policy, which is anticipated to start July 1, 2019, since Medicaid managed care contracts are regulated by HCA, and therefore RCW 48.42.020 indicates they are not subject to regulation by the Office of the Insurance Commissioner.

Part IV: Capital Budget Impact

None.

Part V: New Rule Making Required

None.

Individual State Agency Fiscal Note

Bill Number: 1018 HB	Title: Dental insurance practices	Agency: 160-Office of Insurance Commissioner

Part I: Estimates

☐ **No Fiscal Impact**

Estimated Cash Receipts to:

NONE

Estimated Expenditures from:

	FY 2020	FY 2021	2019-21	2021-23	2023-25
FTE Staff Years	1.5	0.1	0.8	0.1	0.1
Account					
Insurance Commissioners Regulatory Account-State 138-1	219,544	8,458	228,002	16,916	16,916
Total $	219,544	8,458	228,002	16,916	16,916

Estimated Capital Budget Impact:

NONE

The cash receipts and expenditure estimates on this page represent the most likely fiscal impact. Factors impacting the precision of these estimates, and alternate ranges (if appropriate), are explained in Part II.

Check applicable boxes and follow corresponding instructions:

☒ If fiscal impact is greater than $50,000 per fiscal year in the current biennium or in subsequent biennia, complete entire fiscal note form Parts I-V.

☐ If fiscal impact is less than $50,000 per fiscal year in the current biennium or in subsequent biennia, complete this page only (Part I).

☐ Capital budget impact, complete Part IV.

☒ Requires new rule making, complete Part V.

Legislative Contact:	Kim Weidenaar	Phone: 360-786-7120	Date: 01/15/2019
Agency Preparation:	Mandy Weeks-Green	Phone: 360-725-7052	Date: 01/21/2019
Agency Approval:	AnnaLisa Gellermann	Phone: 360-725-7106	Date: 01/21/2019
OFM Review:	Robyn Williams	Phone: (360) 902-0575	Date: 01/21/2019

Part II: Narrative Explanation

II. A - Brief Description Of What The Measure Does That Has Fiscal Impact

Briefly describe by section number, the significant provisions of the bill, and any related workload or policy assumptions, that have revenue or expenditure impact on the responding agency.

Section 2(26)(b) of the bill would extend some of the protections of the Patient Bill of Rights from RCW 48.43 to dental-only plans offered after December 31, 2019. The protections come from RCW 48.43.520 (utilization review), RCW 48.43.525 (prohibition against retrospective denial), RCW 48.43.530 (grievance and appeal processes) and RCW 48.43.535 (the right to appeal a dispute to an independent review organization (IRO)).

Section 3(1)(b) restricts a health carrier offering dental only plans from taking or threatening to take punitive action against a provider who is advocating on behalf of an enrollee because the provider disputes the carrier's determination of coverage or payment for a dental service.

Beginning October 1, 2019, section 4(1) requires health carriers to submit to the Office of Insurance Commissioner (OIC) the explanation of benefit (EOB) forms the carrier intends to use for dental only plans for the subsequent plan year. The submission must include a standardized list of definitions and terms the carrier will use and include an example of a completed form.

Section 4(2) requires the OIC to adopt rules, no later than July 1, 2020, setting the minimum standards for EOBs and including a model EOB form. The rule must include a standardized list of definitions and terms.

Section 4(3), beginning for plan year 2021, authorizes the OIC to disapprove EOB's if the OIC finds the forms confusing, inconsistent, or misleading. The OIC cannot disapprove a form if it is substantially identical to the model form. A form that has been disapproved by the OIC may not be used by a health carrier.

Section 5 prohibits a health benefit plan, health care service contractor (HCSC), or health carrier from denying or limiting coverage based on an individual's oral health condition, including situations in which a tooth is missing at the time coverage starts with the carrier. Definitions for health benefit plan, HCSC, and health carrier are those in RCW 48.43.005.

II. B - Cash receipts Impact

Briefly describe and quantify the cash receipts impact of the legislation on the responding agency, identifying the cash receipts provisions by section number and when appropriate the detail of the revenue sources. Briefly describe the factual basis of the assumptions and the method by which the cash receipts impact is derived. Explain how workload assumptions translate into estimates. Distinguish between one time and ongoing functions.

II. C - Expenditures

Briefly describe the agency expenditures necessary to implement this legislation (or savings resulting from this legislation), identifying by section number the provisions of the legislation that result in the expenditures (or savings). Briefly describe the factual basis of the assumptions and the method by which the expenditure impact is derived. Explain how workload assumptions translate into cost estimates. Distinguish between one time and ongoing functions.

Section 2(26)(b) of the bill would extend some of the protections of the Patient Bill of Rights from RCW 48.43 to dental-only plans offered after December 31, 2019. The protections come from RCW 48.43.520 (utilization review), RCW 48.43.525 (prohibition against retrospective denial), 48.43.530 (grievance and appeal processes) and RCW 48.43.535 (the right to appeal a dispute to an independent review organization (IRO)).

The OIC will need to enhance and modify several programs within its existing information technology (IT) system. The estimated workload is estimated at 671 hours utilizing seven IT resources and is based on similar enhancement/modification projects that the OIC has completed.
(a) Consumer Toolkit (IRO) – Add review type (health, dental) to screens, reports, and search criteria; add dental

specific procedure and diagnosis codes to all screens and reports.
(b) IRO registration process – Add review type (health, dental) to registration page to indicate which types of reviews the organization can do.
(c) Insurer & IRO portal for request and reporting – Add flag to denote which type of review the carrier is asking for (dental or health); add dental specific procedure and diagnosis codes; add new logic to assign appropriate review organization type based on type of review being requested and based on rotation logic as required by RCW 48.43.535.
(d) Case Management (SIMBA Core) – Add type of review indicator (dental or health) to database, screens, search, and reports; add dental specific procedure and diagnosis codes to screens and reports.

Section 3(1)(b) restricts a health carrier offering dental only plans from taking or threatening to take punitive action against a provider who is advocating on behalf of an enrollee because the provider disputes the carrier's determination of coverage or payment for a dental service. This will require a one-time modification of provider contracts. Based on a three year trend, 125 dental provider contracts are filed annually. To address those 125 contracts, we assume carriers will submit 60 contract amendments and 100 new contract templates requiring 187 hours of a Functional Program Analyst 3 (FPA3) and 13 hours of an Insurance Technician 3 in FY2020.

Beginning October 1, 2019, section 4(1) requires health carriers to submit to the OIC the explanation of benefit (EOB) forms the carrier intends to use for dental only plans for the subsequent plan year. The submission must include a standardized list of definitions and terms the carrier will use and include an example of a completed form.

Section 4(2) requires the OIC to adopt rules, no later than July 1, 2020, setting the minimum standards for EOBs and including a model EOB form. The EOB must include a standardized list of definitions and terms. This is expected to take a 'complex' rulemaking process.

Section 4(3), beginning for plan year 2021, authorizes the OIC to disapprove EOB's if the OIC finds the forms confusing, inconsistent, or misleading. The OIC cannot disapprove a form if it is substantially identical to the model form. A form that has been disapproved by the OIC may not be used by a health carrier.

Section 4, for the first year, will require the incorporation of the new EOB requirements into the review process as well as staff training. Additionally, it is assumed 54 unique EOBs filed by 27 different carriers will be submitted in the first year requiring an addition 60 minutes each to review. This work will require 40 hours of a FPA3, 39 hours of a FPA4, 11 hours of a WMS Manager and 4.5 hours of an Insurance Technician 3. Each year thereafter, it will take much less time to review each unique EOB requiring only 8 hours of a FPA3, 4 hours of a FPA4, 2 hours of a WMS3, and 4 hours of an Insurance Technician 3. It is further estimated that section 4 will create one new case for enforcement per year. The estimate is based on previous actions taken regarding dental plans as well as similar enforcement action percentages for failing to use filed and approved forms. Each enforcement action requires approximately 11 hours of an Insurance Enforcement Specialist and 15.5 hours of a Paralegal 2.

Section 5 prohibits a health benefit plan, Health Care Service Contractor (HCSC), or health carrier from denying or limiting coverage based on an individual's oral health condition, including situations in which a tooth is missing at the time coverage starts with the carrier. Definitions for health benefit plan, HCSC, and health carrier are those in RCW 48.43.005. Rates for dental only plans will most likely increase due to the removal of pre-existing condition and anti-selection. It is assumed that all plans that include dental coverage will have to have its forms reviewed. For the first year, the incorporation of the new review standards into the review process

as well as staff training will be required. Additionally, it is assumed that all plans that include dental coverage (760 filings) will be required to be reviewed requiring an addition 10 minutes of review each in the first year. This work will require 78 hours of a FPA3, 68 hours of a FPA4, and 6.5 hours of a WMS Manager. Each year thereafter, it will take much less time for filing reviews requiring only 42 hours of a FPA3, 21 hours of a FPA4, and 2 hours of a WMS3.

Ongoing Costs:
Salary, benefits and associated costs for .03 FTE Functional Program Analyst 3, .02 FTE Functional Program Analyst 4, .01 FTE Insurance Enforcement Specialist and .01 FTE Paralegal 2.

Part III: Expenditure Detail

III. A - Operating Budget Expenditures

Account	Account Title	Type	FY 2020	FY 2021	2019-21	2021-23	2023-25
138-1	Insurance Commissioners Regulatory Account	State	219,544	8,458	228,002	16,916	16,916
		Total $	219,544	8,458	228,002	16,916	16,916

III. B - Expenditures by Object Or Purpose

	FY 2020	FY 2021	2019-21	2021-23	2023-25
FTE Staff Years	1.5	0.1	0.8	0.1	0.1
A-Salaries and Wages	131,577	4,959	136,536	9,918	9,918
B-Employee Benefits	44,058	1,807	45,865	3,614	3,614
C-Professional Service Contracts					
E-Goods and Other Services	43,909	1,692	45,601	3,384	3,384
G-Travel					
J-Capital Outlays					
M-Inter Agency/Fund Transfers					
N-Grants, Benefits & Client Services					
P-Debt Service					
S-Interagency Reimbursements					
T-Intra-Agency Reimbursements					
9-					
Total $	219,544	8,458	228,002	16,916	16,916

III. C - Operating FTE Detail: *List FTEs by classification and corresponding annual compensation. Totals need to agree with total FTEs in Part I and Part IIIA*

Job Classification	Salary	FY 2020	FY 2021	2019-21	2021-23	2023-25
Functional Program Analyst 3	66,888	0.2	0.0	0.1	0.0	0.0
Functional Program Analyst 4	73,908	0.2	0.0	0.1	0.0	0.0
Information Technology Specialist 4	79,548	0.1		0.1		
Information Technology Specialist 5	87,792	0.1		0.0		
Information Technology Specialist 6	96,912	0.2		0.1		
Insurance Enforcement Specialist	82,092		0.0	0.0	0.0	0.0
Insurance Technician 3	42,900	0.0		0.0		
Paralegal 2	65,292		0.0	0.0	0.0	0.0
Senior Policy Analyst	96,504	0.7		0.3		
WMS Manager	95,700	0.0		0.0		
Total FTEs		1.5	0.1	0.8	0.1	0.1

Part IV: Capital Budget Impact

Part V: New Rule Making Required

Identify provisions of the measure that require the agency to adopt new administrative rules or repeal/revise existing rules.

Section 4(2) requires the OIC to adopt rules, no later than July 1, 2020, setting the minimum standards for explanation of benefits (EOB) and including a model EOB form. The EOB must include a standardized list of definitions and terms. This is expected to be a long process involving many stakeholder; therefore it is assumed to take a 'complex' rulemaking process.

Individual State Agency Fiscal Note

Bill Number: 1018 HB	Title: Dental insurance practices	Agency: 303-Department of Health

Part I: Estimates

[X] **No Fiscal Impact**

The cash receipts and expenditure estimates on this page represent the most likely fiscal impact. Factors impacting the precision of these estimates, and alternate ranges (if appropriate), are explained in Part II.

Check applicable boxes and follow corresponding instructions:

[ ] If fiscal impact is greater than $50,000 per fiscal year in the current biennium or in subsequent biennia, complete entire fiscal note form Parts I-V.

[ ] If fiscal impact is less than $50,000 per fiscal year in the current biennium or in subsequent biennia, complete this page only (Part I).

[ ] Capital budget impact, complete Part IV.

[ ] Requires new rule making, complete Part V.

Legislative Contact:	Kim Weidenaar	Phone: 360-786-7120	Date: 01/15/2019
Agency Preparation:	Donna Compton	Phone: (360) 236-4538	Date: 01/18/2019
Agency Approval:	Stacy May	Phone: (360) 236-4532	Date: 01/18/2019
OFM Review:	Bryce Andersen	Phone: (360) 902-0580	Date: 01/21/2019

Part II: Narrative Explanation

II. A - Brief Description Of What The Measure Does That Has Fiscal Impact

Briefly describe by section number, the significant provisions of the bill, and any related workload or policy assumptions, that have revenue or expenditure impact on the responding agency.

This bill adds dental insurance to the Patient Bill of Rights law, it also outlines dental insurance companies reporting requirements to the Office of the Insurance Commission. However, this bill does not direct the Department of Health to do anything, therefore no fiscal impact.

II. B - Cash receipts Impact

Briefly describe and quantify the cash receipts impact of the legislation on the responding agency, identifying the cash receipts provisions by section number and when appropriate the detail of the revenue sources. Briefly describe the factual basis of the assumptions and the method by which the cash receipts impact is derived. Explain how workload assumptions translate into estimates. Distinguish between one time and ongoing functions.

NONE

II. C - Expenditures

Briefly describe the agency expenditures necessary to implement this legislation (or savings resulting from this legislation), identifying by section number the provisions of the legislation that result in the expenditures (or savings). Briefly describe the factual basis of the assumptions and the method by which the expenditure impact is derived. Explain how workload assumptions translate into cost estimates. Distinguish between one time and ongoing functions.

NONE

Part III: Expenditure Detail

Part IV: Capital Budget Impact

NONE

Part V: New Rule Making Required

Identify provisions of the measure that require the agency to adopt new administrative rules or repeal/revise existing rules.

NONE