Multiple Agency Fiscal Note Summary

Bill Number: 5699 SB	**Title:** Out-of-network health care

Estimated Cash Receipts

Agency Name	2019-21		2021-23		2023-25	
	GF- State	Total	GF- State	Total	GF- State	Total
University of Washington	Non-zero but indeterminate cost and/or savings. Please see discussion.					
Total $	**0**	**0**	**0**	**0**	**0**	**0**

Estimated Operating Expenditures

Agency Name	2019-21			2021-23			2023-25		
	FTEs	GF-State	Total	FTEs	GF-State	Total	FTEs	GF-State	Total
Office of Financial Management	.0	300,000	300,000	.0	240,000	240,000	.0	240,000	240,000
Washington State Health Care Authority	Non-zero but indeterminate cost and/or savings. Please see discussion.								
Office of Insurance Commissioner	2.3	0	589,584	3.5	0	768,139	2.1	0	461,920
Department of Health	Fiscal note not available								
University of Washington	Non-zero but indeterminate cost and/or savings. Please see discussion.								
Total $	**2.3**	**300,000**	**889,584**	**3.5**	**240,000**	**1,008,139**	**2.1**	**240,000**	**701,920**

Estimated Capital Budget Expenditures

Agency Name	2019-21			2021-23			2023-25		
	FTEs	Bonds	Total	FTEs	Bonds	Total	FTEs	Bonds	Total
Office of Financial Management	.0	0	0	.0	0	0	.0	0	0
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	Fiscal note not available								
University of Washington	.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

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

** See local government fiscal note

FNPID: 55611

FNS029 Multi Agency rollup

Prepared by: Robyn Williams, OFM	**Phone:** (360) 902-0575	**Date Published:** Preliminary 2/12/2019

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

** See local government fiscal note

FNPID: 55611

Individual State Agency Fiscal Note

Bill Number: 5699 SB	Title: Out-of-network health care	Agency: 105-Office of Financial Management

Part I: Estimates

☐ **No Fiscal Impact**

Estimated Cash Receipts to:

NONE

Estimated Operating Expenditures from:

	FY 2020	FY 2021	2019-21	2021-23	2023-25
Account					
General Fund-State 001-1	180,000	120,000	300,000	240,000	240,000
Total $	180,000	120,000	300,000	240,000	240,000

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:	Evan Klein	Phone: 786-7483	Date: 01/29/2019
Agency Preparation:	Jim Jenkins	Phone: 360-902-0403	Date: 02/01/2019
Agency Approval:	Aaron Butcher	Phone: 360-902-0406	Date: 02/01/2019
OFM Review:	Bryan Way	Phone: (360) 902-0650	Date: 02/01/2019

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 directs the office of financial management (OFM) with the Washington State All-Payer Health Care Claims Database (WA-APCD) lead organization established in Chapter 43.371 RCW to "establish a data set and business process to provide health carriers, health care providers, hospitals, ambulatory surgical facilities, and arbitrators with prevailing payment and billed charge amounts for the services described in section 6 of this act to assist in determining commercially reasonable payments and resolving payment disputes for out-of-network medical services rendered by health care providers." The first data and business processes must be available starting January 1, 2019.

OFM will need $180,000 in FY 2020 and $120,000 in each subsequent year to pay for the WA-APCD lead organization contract to complete this work.

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.

Part III: Expenditure Detail

III. A - Operating Budget Expenditures

Account	Account Title	Type	FY 2020	FY 2021	2019-21	2021-23	2023-25
001-1	General Fund	State	180,000	120,000	300,000	240,000	240,000
		Total $	180,000	120,000	300,000	240,000	240,000

III. B - Expenditures by Object Or Purpose

	FY 2020	FY 2021	2019-21	2021-23	2023-25
FTE Staff Years					
A-Salaries and Wages					
B-Employee Benefits					
C-Professional Service Contracts	180,000	120,000	300,000	240,000	240,000
E-Goods and Other Services					
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 $	180,000	120,000	300,000	240,000	240,000

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.

Individual State Agency Fiscal Note

Bill Number: 5699 SB	Title: Out-of-network health care	Agency: 107-Washington State Health Care Authority

Part I: Estimates

☐ **No Fiscal Impact**

Estimated Cash Receipts to:

NONE

Estimated Operating Expenditures from:

Non-zero but indeterminate cost. Please see discussion.

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:	Evan Klein	Phone: 786-7483	Date: 01/29/2019
Agency Preparation:	Kate LaBelle	Phone: 360-725-1846	Date: 02/03/2019
Agency Approval:	Rene Newkirk	Phone: 360-725-1307	Date: 02/03/2019
OFM Review:	Jane Sakson	Phone: 360-902-0549	Date: 02/04/2019

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.

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.

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.

See attached narrative

Part III: Expenditure Detail

Part IV: Capital Budget Impact

NONE

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

Bill Number: 5699 SB HCA Request #: 19-55

Part II: Narrative Explanation

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

Section 3(1)(a) – Requires coverage in network and out of network emergency services without prior authorization up to the point of patient stabilization.

Section 3(1)(b) – States if the plan then authorizes emergency services, the plan may not retroactively rescind the authorization or reduce payment unless the original approval was based on a material misrepresentation of the patient's condition by the provider with the knowledge and consent of the patient.

Section 3(1)(c) – States covered emergency services are only subject to the in-network copayment, coinsurance and deductibles.

Section 3(2) – States that if a health plan requires authorization post-stabilization of an emergency patient in order for additional services to be covered (e.g. Kaiser) the health plan must provide telephone access to an authorized representative. Failure of the health plan to respond to a request for authorization within thirty minutes of a request will constitute authorization of immediately required services.

Section 3(3) – States the health plan must immediately arrange alternate plan of treatment if an out of network emergency provider and the plan cannot reach agreement on which services are necessary.

Section 6 – Out of network providers and facilities may not balance bill an enrollee for:

- Emergency service, which Section 2(14) expands the definition of an emergency medical condition to include mental health, or substance use disorder conditions.
- Non-emergency services at an in-network hospital or ambulatory surgical facility if the services involve surgical or ancillary services

Section 7(1)(a) – If a patient receives emergency or non-emergency services at a network hospital or ambulatory surgical facility described in Section 6 the patient's costs are limited to the in-network cost-sharing of their health plan (deductibles, coinsurance or copays) as noted in the explanation of benefits from their health plan.

Section 7(1)(b) – States the health carrier, out of network provider or out of network facility must ensure that those costs are no greater than if the enrollee had services performed by a network provider or facility.

Section 7(1)(c) – The out of network providers and facilities may not balance bill an enrollee for more than the network cost-share, may not submit adverse credit information to consumer credit reporting agencies or take civil action against an enrollee in less than 150 days after the initial billing; may not garnish wages or apply liens on a primary residence as a means of collecting outstanding amounts from an enrollee.

Section 7(1)(d) – Explains member cost sharing is limited to the plan's in network cost sharing amounts and percentages and applies to the out of pocket limits, just as in-network care applies.

Section 7(2) – States health plans must make payment directly to an out of network provider or facility in an amount "limited to a commercially reasonable amount, based on payments for the same or similar services provided in a similar geographic area."

Section 7(3) – Requires the notice of payment to the hospital or provider from the carrier or claims administrator for an electing self-funded group must indicate in a clear manner that the payments are subject to this chapter.

Section 8 – States disputes between the carrier and the out of network provider about the amount of payment may be settled informally if communication is initiated within thirty days of payment or payment notification to the provider. If the dispute is not resolved informally either party may request arbitration through a formal request to the Office of the Insurance Commissioner (OIC). The Commissioner will provide a list of arbitrators, the parties will select one or the commissioner will provide a shortened list they can exclude two each and the remaining arbitrator will review the case, or multiple cases for the same provide and same CPT codes processed within a six month period. The arbitration process could take up to 170 days to complete.

Expenses including the arbitrator's expenses and fees (excluding attorney fees) will be paid equally by both parties.

Section 10 – Transparency OIC with health carriers, providers, facilities and consumers must develop standard template language for a notice of consumer rights notifying consumers that:

(a) Balance billing is prohibited for all insured plans and self-funded plans administered by HCA and those that opt in to the law (annually).

II. B - Cash Receipts Impact

No estimated cash receipt impact.

II. C - Expenditures

The fiscal impact for this bill is indeterminate as described below. In general, this bill may lead to increased claims costs for plans administered by the Health Care Authority (HCA), such as the Uniform Medical Plan (UMP) and the fully-insured plans. It may also impact the plans' administrative costs due to arbitration costs. These increased costs may result in higher bid rates from the plans.

Section 3(1)(c) – States covered emergency services are only subject to the in-network copayment, coinsurance and deductibles.

This bill allows out-of-networks providers to receive payment from plans administered by the HCA, but the member would pay the in-network cost-sharing or copayment amount for emergency services, thus shifting the remainder of the expense to the plan.

Section 6 – States that an out-of-network provider or facility may not balance bill an enrollee for the following health care services: 1) emergency services provided to an enrollee; and 2) nonemergency health care services provided to an enrollee at an in-network hospital or in-network ambulatory surgical facility if the services involve surgical or ancillary services and are provided by an out-of-network provider.

For emergency services, UMP currently pays both in- and out-of-network (1) providers, (2) ancillary services, and (3) facilities at the in-network rate. Thus, there is some anticipated increased claims cost under this version of the bill related to emergency services.

For non-emergency services, the UMP plan design creates an opportunity for out-of-network care. Covering higher allowed amounts and limiting cost sharing for members lowers the incentive for members to seek treatment within the contracted provider network. Use of network providers holds down costs and provides some quality measurement that ensures quality of care.

Section 7(2) – Requires health plans must make payment directly to an out of network provider or facility in an amount "limited to a commercially reasonable amount, based on payments for the same or similar services provided in a similar geographic area."

Initial cost estimates are based on a review of January 2018 to December 2018 claims data. The HCA anticipates paying up to the total cost of care, less the member cost-sharing, of out-of-network providers that billed in this period. The total out-of-network claims in this period totaled $7.4 million. Based on the plan year 2018 data, the HCA could expect to pay at least $7 million for these claims because this bill requires member cost-sharing amounts to be limited to the in-network cost which is 15% of a negotiated (reduced) fee. The HCA is not able to determine what would be negotiated as reasonable between the plan and any out-of-network provider, thus anticipates the possibility of paying all claimed expenses, less the member cost-share. However, if member annual out-of-pocket limits were met, the increased UMP cost would have been even higher, as the 15 percent member cost-share expenses would also shift to the plan.

Section 8 – States disputes between the carrier and the out of network provider about the amount of payment may be settled informally. However, if an agreement cannot be reached, either party can request arbitration.

Expenses including the arbitrator's expenses and fees (excluding attorney fees) will be split by the two parties. There is a potential for increased expenses to the HCA for arbitration expenses. The volume of arbitrations may be significant even though aggregation of claims may occur in some instances. The addition of annual arbitration costs may be passed on as administrative costs and when a provider wins an arbitration there are increased claims costs for UMP.

Part IV: Capital Budget Impact

None

Part V: New Rule Making Required

None

Individual State Agency Fiscal Note

Bill Number: 5699 SB	Title: Out-of-network health care	Agency: 160-Office of Insurance Commissioner

Part I: Estimates

☐ **No Fiscal Impact**

Estimated Cash Receipts to:

NONE

Estimated Operating Expenditures from:

	FY 2020	FY 2021	2019-21	2021-23	2023-25
FTE Staff Years	0.3	4.3	2.3	3.5	2.1
Account					
Insurance Commissioners Regulatory Account-State 138-1	49,949	539,635	589,584	768,139	461,920
Total $	49,949	539,635	589,584	768,139	461,920

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:

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☐ 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:	Evan Klein	Phone: 786-7483	Date: 01/29/2019
Agency Preparation:	Jane Beyer	Phone: 360-725-7043	Date: 02/08/2019
Agency Approval:	Candice Myrum	Phone: 360-725-7042	Date: 02/08/2019
OFM Review:	Robyn Williams	Phone: (360) 902-0575	Date: 02/08/2019

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 1 provides that the Insurance Commissioner is responsible for ensuring that provider networks include sufficient numbers and types of contracted providers to reasonably ensure consumers have in-network access for covered benefits.

Section 3 removes current standards required to be in benefit contracts for emergency medical services and implements new standards.

Section 7(a) and (d) add a new standard for enrollee cost-sharing and out of pocket maximum (OOPM) calculations that will need to be described in the enrollee contract.

Section 8(1)(a) required the health carrier, provider or facility to notify the Insurance Commissioner in writing when initiating arbitration.

Section 8(2) requires the Insurance Commissioner to provide the parties with a list of approved arbitrators upon receipt of notice of initiation of arbitration, to provide the parties with the names of give arbitrators from the list if the parties do not agree on an arbitrator and to choose the final arbitrator from the remaining arbitrators if the parties can't get it down to one arbitrator on their own.

Section 8(3)(a) requires the arbitrator, within 30 calendar days after receipt of the parties' written submissions, to provide the decision and the information described in section 9 of this act regarding the decision to the Commissioner.

Section 9(1) requires the Commissioner to prepare an annual report summarizing the dispute resolution information provided by the arbitrators under section 8 of this act. The report must include summary information related to the matters decided through arbitration, as well as the name of the carrier, name of the health care provider, the health care provider's employer or business entity in with the provider has an ownership interest; the health care facility where the services were provided and the type of health care services at issue.

Section 9(2) requires the Commissioner to post the report on the OIC web site and submit it to the appropriate committees of the legislature by July 1st.

Section 9(3) provides that the required annual report expires in 2024.

Section 10(1)(a) through (c) requires the Commissioner, in consultation with health carriers, health care providers, health care facilities and consumers to develop standard template language for a notice of consumer rights notifying consumers that actions are prohibited, and what can or can't be balance billed.

Section 10(2) requires the standard template include contact information for the OIC so a consumer can contact OIC if they believe they have received a balanced bill in violation of this chapter.

Section 10(3) requires the Commissioner to determine by rule when and in what format health carriers, health care providers, and health care facilities must provide consumers with the notice developed under this section.

Section 11(1) and (2) requires all hospitals and ambulatory surgical facilities to post, or provide to consumers orally or in writing upon request, the notice of the consumer rights developed under this act.

Section 11(3) requires hospitals and ambulatory surgical facilities to provide carriers with a list of the nonemployed provider groups providing surgical or ancillary services at the hospital or ambulatory surgical facility prior to executing a contract with the carrier. Notice of changes to the list must be provided to the carrier within 30 days of the change. The hospital or ambulatory surgical facility must provide an updated list of the nonemployed providers upon request of the carrier.

Section 12(3) requires in-network provides to submit accurate information to a health carrier regarding the provider's network status in a timely manner, consistent with the terms of the contract between the provider and the carrier.

Section 14(1) allows the Commissioner to submit information to the Department of Health or the appropriate disciplinary authority if the Commissioner has cause to believe that a provider or facility has engaged a pattern of unresolved violations of sections 6 or 7 of this act. Prior to submitting information to the appropriate disciplinary authority, the Commissioner may provide the health care provider, hospital or ambulatory surgical facility an opportunity to cure the alleged violations or explain why the actions in question did not violate section 6 or 7 of this act.

Section 14(2) requires the department of health or disciplining authority to notify the Commissioner of the results of the review, including whether the violation was substantiated and any enforcement action taken as a result of a finding of a substantiated violation.

Section 14(3) allows the Commissioner to levy a fine or apply remedies authorized in chapter 48.02 RCW against a health carrier who violates or has violated any provision of this chapter.

Section 15 allows the Commissioner to adopt rules to implement and administer this chapter, including rules governing the dispute resolution process established in section 8 of this act.

Section 17, 18, 19 and 20 provide authority for other agencies to take action on the referrals made by the OIC.

Section 23 allows self-funded group health plans to elect to participate in these provision. If a self-funded health plan elects to participate, the self-funded group health plan shall provide notice on an annual basis to the Commissioner in a manner prescribed by the Commissioner, attesting to the plan's participation and agreeing to be bound by sections 6 through 8 of this action. The entity administering the self-funded health benefits plan shall comply with the provisions of section 6 through 8 of this act.

Section 25 states that when determining the adequacy of the proposed provider network or the ongoing adequacy of an in-force provider network, the Commissioner must consider whether the network includes a sufficient number of contracted providers practicing at the same facilities with which the health carrier has contracted tor reasonably ensure enrollees have in-network access for covered benefits delivered at the facility.

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.

The following assumptions, used throughout the fiscal note, are based upon information received from CA, FL, and NY, all states that have had balance billing prohibition in place for at least 2 years:

1. The balanced billing act applies to small group, large group, individual plans, and all self-insured plans that elect to participate. This translates into 1,775,500 plan enrollees which converts into around 15,359 balanced billings per year (2016 estimates).
2. We anticipate 75% compliance in FY2020; 80% compliance in FY 2021 and 90% compliance in FY2022 and thereafter.
3. After compliance adjustments, we anticipate consumers will contact OIC about balance billing complaints as follows: FY2020 = 960; FY2021 = 1,536; FY2022 and thereafter = 768
4. We anticipate complaints will result in provider referrals to the appropriate disciplinary authority on the following scale, 3%, 2%, 2% and 1% as follows: FY2020 = 29; FY2021 = 31; FY2022 = 15; FY 2023 and thereafter = 8
5. We anticipate complaints will result in carrier disciplinary referrals on the following scale, 8%, 8%, 5% as follows: FY2020 = 77; FY2021= 123; FY2022 and thereafter = 38
6. We anticipate carrier legal enforcements as follows: FY2020 = 8; FY2021= 12; FY2022 and thereafter = 4
7. We anticipate OIC related administrative hearings as follows: FY2020 =1; FY2021 = 0; FY2022 and thereafter = 0
8. We anticipate carriers or providers will utilize arbitration as follows: FY2020 = 384; FY2021=614; FY2020 and thereafter = 307
9. We anticipates carriers/providers will need OIC to provide list of 5 arbitrators as follows: FY2020 =77; FY2021 = 123; FY2022 and thereafter = 61
10. OIC anticipate carriers/providers will need OIC to choose final arbitrator as follows: FY2020 =15; FY2021 = 25; FY2022 and thereafter = 12

Section 3 removes current standards required to be in benefit contracts for emergency medical services and implements new bill standards. Section 7(d) adds new standards for cost and out of pocket maximum (OOPM) calculations that will need to be describe in the enrollee contract. This would require the removal of elements of the Rates and Forms Analyst Checklist and add one to two new elements to the Analyst Checklist for all individual, small group and large group checklists, which is estimated to require a one-time task of 24 hours at the Functional Program Analyst 4 (FPA4) level. It would also add new elements to review on each health benefit plan which is estimated to add 15 minutes per review of 150 health plans each year.

Section 8(1)(a) requires the health carrier, provider or facility to notify the Office of Insurance Commissioner (OIC) in writing when initiating arbitration. OIC assumes the arbitration initiation document will come to OIC via mail or email. OIC's Legal Affairs division will create an electronic case file, put the arbitration initiation into AX and associate the case to the AX document in the case file. This process will take a Legal Assistant 1 an estimated 15 minutes per arbitration.

Section 8(2) requires the Insurance Commissioner to provide the parties with a list of approved arbitrators upon receipt of notice of initiation of arbitration, to provide the parties with the names of give arbitrators from the list if the parties do not agree on an arbitrator and to choose the final arbitrator from the remaining arbitrators if the parties can't get it down to one arbitrator on their own. OIC will keep a copy of the arbitration list on its website for reference by both parties. Legal Affairs will provide a list of 5 arbitrator's names. This will also be a manual process. Request and response will be stored in AX to be associated with the case file. This will take a Legal

Assistant 1 about 15 minutes per request. When requested, Legal Affairs will provide the final arbitrator. This will also be a manual process. Requests and response will be stored in AX to be associated with the case file. This will take a Legal Assistant 1 about 15 minutes per request.

Section 8(3)(a) requires the arbitrator, within 30 calendar days after receipt of the parties' written submissions, to provide the decision and the information described in section 9 of this act regarding the decision to the commissioner. Legal Affairs will put the arbitration decisions and any other documentation received from the arbitrator into AX to be associated with the case file. This will take a Legal Assistant 1 an estimated 15 minutes per arbitration decision.

Section 9(1) requires the Commissioner to prepare an annual report summarizing the dispute resolution information provided by the arbitrators under section 8 of this act. The report must include summary information related to the matters decided through arbitration, as well as the name of the carrier, name of the health care provider, the health care provider's employer or business entity in with the provider has an ownership interest; the health care facility where the services were provided and the type of health care services at issue. Legal Affairs will pull all the necessary data and create the initial draft report for the Legislature. This will take a Legal Assistant 1 an estimated 8 hours annually through 2024. A Policy Analyst will then review, edit and modify the report as necessary to prepare it for final viewing by the public. This will take a Policy Analyst 6 hours total annually through 2024.

Section 9(2) requires the Commissioner to post the report on the OIC web site and submit it to the appropriate committees of the legislature by July 1st. Section 9(3) provides that the required annual report expires in 2024. Policy will post the Legislative report on the web and the Legislative Director will provide the report to the appropriate committees on behalf of OIC. This process is expected to take 2 hours for an Administrative Assistant 2 to complete annually, beginning in FY2021.

Section 10(1)(a) through (c) requires the Commissioner, in consultation with health carriers, health care providers, health care facilities and consumers, to develop standard template language for a notice of consumer rights notifying consumers that actions are prohibited, and what can or can't be balance billed. Section 10(2) requires the standard template include contact information for the OIC so a consumer can contact OIC if they believe they have received a balance bill in violation of this chapter. Section 10(3) requires the Commissioner to determine, by rule, when and in what format health carriers, health care providers, and health care facilities must provide consumers with the notice developed under this section. This process is equivalent to a complex rule making given the volume of stakeholders involved in developing standard language. The rulemaking is expected to take place in FY2020 and FY 2021. Additionally, a Functional Program Analyst 4 will require 40 hours of time to update the Consumer Advocacy webpages, create educational materials and conduct outreach.

Section 11(3) requires a hospital or ambulatory surgical facility to provide a carrier with a list of the nonemployed providers or provider groups prior to executing a contract with a carrier. The hospital or ambulatory surgical facility must also notify the carrier within 30 days of a removal from or addition to the nonemployed provider list. Section 12(3) requires in-network provides to submit accurate information to a health carrier regarding the provider's network status in a timely manner, consistent with the terms of the contract between the provider and the carrier. All provider contracts in the marketplace will need to be updated to address this new requirement. The addition of this element to the Analyst Checklist is estimated to require a Functional Program Analysts 3 a one-time task of 8 hours. Additionally, a new review element adds an estimated 15 minutes per review. OIC currently reviews around 150 plans resulting in 38 hours of additional work per year beginning in FY2020.

Section 14(1) allows the Commissioner to submit information to the Department of Health or the appropriate disciplinary authority for engaging in patterns of unresolved violations of sections 6 or 7 of this act. Prior to submitting information to the appropriate disciplinary authority, the Commissioner may provide the health care provider, hospital or ambulatory surgical facility an opportunity to cure the alleged violations or explain why the actions in question did not violate section 6 or 7 of this act. Section 14(2) requires the Department of Health or disciplining authority to notify the Commissioner of the results of the review, including whether the violation was substantiated and any enforcement action taken as a result of a finding of a substantiated violation. Complaints are normally handled by Consumer Advocacy. It is estimated it will take an Insurance Technician 3 1.5 hours per complaint for initial intake and scanning of documents into AX. It will additionally take a Functional Program Analyst 3 up to 4 hours of time and a Functional Program Analyst 4 up to 2 hours of time for complaint review, information gathering, handling (which includes an opportunity to cure the alleged violation(s) or explanation why the actions did not violate section 6 or 7 of this act). We anticipate referrals to the appropriate disciplinary authority will be minimal.

To make direct referrals to the Department of Health (DOH) and the Health Care Authority (HCA), OIC will create new IT modules (similar to our current link with HBE). These modules will allow the other agencies to see what referrals we send them and provide us with outcomes when they are done with their agency action. OIC estimates the creation of the new module will take 204 hours of an IT project group consisting of 5 staff in FY 2020.

Section 14(3) allows the Commissioner to levy a fine or apply remedies authorized in chapter 48.02 RCW against a health carrier who violates or has violated any provision of this chapter. Legal Affairs expects it will take a Paralegal 2 1.5 hours for review and processing of each referral. Additionally, if an administrative hearing is needed it will take a Paralegal 2 an additional 28 hours of time and an Insurance Enforcement Specialist 8 hours of time per hearing.

Section 15 allows the Commissioner to adopt rules to implement and administer this chapter, including rules governing the dispute resolution process established in section 8 of this act. Policy expects this rulemaking to be complex given that it is a new process and involves a large stakeholder group. This rulemaking will span over FY 2020 and FY 2021.

Section 17, 18, 19 and 20 provide authority for other agencies to take action on the referrals made by the OIC. OIC will need to define referral procedures from Legal Affairs and Consumer Advocacy in conjunction with HCA, DOH and any other identified disciplinary authority. This would be done via an ad hoc work group with each of the following contributing 5 hours of time: WMS 3 Program Manager, Management Analyst 3, Functional Program Analyst 4, Functional Program Analyst 3 and Insurance Technician 3. Additional time beyond the 25 hours identified above will be absorbed into OIC normal business process.

Section 23 allows self-funded group health plans to elect to participate in these provision. If they elect to participate, the self-funded health plan shall provide notice on an annual basis to the Commissioner in a manner prescribed by the Commissioner, attesting to the plan's participation and agreeing to be bound by sections 6 through 8 of this action. The entity administering the self-funded health benefits plan shall comply with the provisions of section 6 through 8 of this act. This section expands the reach of the balanced billing act from small group, large group and individual's plans to also include self-insured plans that choose to opt in.

Section 25 states that when determining the adequacy of the proposed provider network or the ongoing adequacy of an in-force provider network, the Commissioner must consider whether the network includes a sufficient number of contracted providers practicing at the same facilities with which the health carrier has contracted tor

reasonably ensure enrollees have in-network access for covered benefits delivered at the facility. This bill requires a change in how OIC reviews health benefit plan networks and adds a new element to review provider and facility contracts. OIC estimates the total number of contracts to be reviewed under this section will be 300 annually. OIC currently collects data in the Provider Network Form A report that could be utilized to meet the review standard in this section in addition to our current review of provider contracts. To complete the detailed review work contemplated in this section without delaying speed to market of products, it is anticipated to take a Management Analyst 3 7.5 hours to complete 150 standard contract reviews and 24 hours per review for a Management Analyst 4 to review the remaining 50 complex contracts.

Ongoing Costs:
Salary, benefits and associated costs for .24 FTE Functional Program Analyst 3, .12 FTE Functional Program Analyst 4, .98 FTE Management Analyst 3, .56 FTE Management Analyst 4, .09 FTE Insurance Technician 3, and .09 FTE Legal Assistant 1.

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	49,949	539,635	589,584	768,139	461,920
		Total $	49,949	539,635	589,584	768,139	461,920

III. B - Expenditures by Object Or Purpose

	FY 2020	FY 2021	2019-21	2021-23	2023-25
FTE Staff Years	0.3	4.3	2.3	3.5	2.1
A-Salaries and Wages	30,094	313,772	343,866	443,650	267,590
B-Employee Benefits	9,865	113,136	123,001	170,861	101,946
C-Professional Service Contracts					
E-Goods and Other Services	9,990	106,727	116,717	153,628	92,384
G-Travel					
J-Capital Outlays		6,000	6,000		
M-Inter Agency/Fund Transfers					
N-Grants, Benefits & Client Services					
P-Debt Service					
S-Interagency Reimbursements					
T-Intra-Agency Reimbursements					
9-					
Total $	49,949	539,635	589,584	768,139	461,920

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		0.6	0.3	0.9	0.2
Functional Program Analyst 4	73,908	0.1	0.6	0.3	0.5	0.1
Information Technology Specialist 4	79,548		0.1	0.0		
Information Technology Specialist 5	87,792		0.0	0.0		
Information Technology Specialist 6	96,912		0.0	0.0		
Insurance Technician 3	42,900		0.2	0.1	0.3	0.1
Legal Assistant 1	41,856		0.2	0.1	0.3	0.1
Management Analyst 3	62,148		1.0	0.5	1.0	1.0
Management Analyst 4	72,036		0.6	0.3	0.6	0.6
Senior Policy Analyst	96,504	0.3	1.1	0.7		
Total FTEs		0.3	4.3	2.3	3.5	2.1

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.

Section 15 allows the Commissioner to adopt rules to implement and administer this chapter, including:
1. Rules governing the dispute resolution process established in section 8 of this act. This is expected to be a normal rulemaking.
2. Rules governing the adequacy of the proposed provider network or the ongoing adequacy of an in-force provider network established in section 25 of this act. This is expected to be a complex rulemaking given the significant change to the network adequacy reviews.
3. Rules to determine when and in what format health carriers, health care providers and health care facilities must provide consumers with the notice developed in section 10 of this act. This rulemaking would be complex given that it is a new process and involved a large stakeholder group.

Individual State Agency Fiscal Note

Bill Number: 5699 SB	Title: Out-of-network health care	Agency: 360-University of Washington

Part I: Estimates

☐ **No Fiscal Impact**

Estimated Cash Receipts to:

Non-zero but indeterminate cost. Please see discussion.

Estimated Operating Expenditures from:

Non-zero but indeterminate cost. Please see discussion.

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:	Evan Klein	Phone: 786-7483	Date: 01/29/2019
Agency Preparation:	Kelsey Rote	Phone: 2065437466	Date: 02/01/2019
Agency Approval:	Kelsey Rote	Phone: 2065437466	Date: 02/01/2019
OFM Review:	Breann Boggs	Phone: (360) 902-0659	Date: 02/03/2019

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 (13) amends the definition of emergency medical condition; section 2(38-43) adds definitions for allowed amount, balance bill, in-network or participating, out-of-network or nonparticipating, out-of-pocket maximum, and surgical or ancillary services.

Section 3 modifies requirements related to coverage of emergency services provided at an out-of-network emergency department.

Section 6 stipulates that an out-of-network provider may not balance bill for emergency services or nonemergency services provided at an in-network hospital or in-network ambulatory surgical facility.

Section 7 states that an enrollee's obligation is satisfied once they have paid the in-network cost-sharing amount specific in their plan. The out-of-network provider may not balance bill or otherwise attempt to collect an amount greater than the in-network cost-sharing amount. The provider may not take action against the enrollee (report adverse information, commence a civil action) or use wage garnishments or liens to collect unpaid bills. Any cost-sharing amounts paid by the enrollee must be treated the same as cost-sharing for health care services provided by an in-network provider, with those amounts applied toward the in-network out-of-pocket maximum. Any payments made by the enrollee exceeding the in-network cost-sharing amount specified in the explanation of benefits must be refunded within thirty business days; refunds made after thirty business days are subject to interest. The allowed amount paid to an out-of-network provider for health care services shall be limited to a commercially reasonable, geographically relevant amount. Disputes between the carrier and the out-of-network provider shall be resolved through arbitration if no agreement is reached within thirty days.

Section 8 creates a dispute resolution process for good faith negotiations described in section 7 that do not result in resolution of the dispute.

Section 10 states that the commissioner, in consultation with health carriers, health care providers, health care facilities, and consumers, must develop standard template language for a notice of consumer rights regarding the prohibition of balance billing.

Section 11 requires a hospital or ambulatory surgical facility to post online a list of the carrier health plans with which it is an in-network provider. For each non-employed provider groups which have contracts to provider surgical or ancillary services, the hospital must post whether the provider group contracts with the same carrier health plans as the hospital or facility.

Section 12 requires health care providers to post online the carrier health plan provider networks with which it contracts and the notice of consumer rights developed in section 10.

Sections 14, 18, and 19 allow for the Department of Health (DOH) or appropriate disciplinary authority to levy fines upon health care providers, hospitals, and ambulatory surgical facilities violating sections 6 or 7 of the act. DOH may levy a fine or cost recovery upon those in violation of this act.

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.

This bill would likely result in negative cash receipts (forgone revenue) of well over $50,000.

Section 6 prohibits balance billing under certain circumstances outlined above. With regard to emergency services, the negative cash receipts could be significant. We are unable to accurately estimate negative cash receipts associated with emergency services because it is unknown how many patients would be entitled to in-network care based on the criteria, what the cost of services would be for those patients, and what the difference in cost-sharing amounts would be. Based on preliminary data, we have determined that the lost cash receipts associated with the balance billing difference could be as high as $7.5 million per year in our academic facilities alone, but we are unable to separate emergency care from the non-emergency services as outlined in this bill. That said, it is likely that the majority of this figure is associated with emergency care. There could also be negative cash receipts associated with patients seeking out-of-network services on shorter timelines than in-network services if, for example, the patient is given a two-month wait at an in-network service but seeks emergency treatment at an out-of-network provider. This could result in further forgone cash receipts.

UW Medicine would possibly recover a partial amount of the billed charges in the arbitration process with insurance carriers, however that amount is indeterminate.

Section 7 states that out-of-network providers may not balance bill or attempt to collect any amount greater than the in-network cost-sharing amounts specified in the enrollee's health plan. Any payment in excess of the in-network cost-sharing amount must be refunded. This would very likely result in negative cash receipts, though the amount is indeterminate and difficult to predict. Section 7(3) differs in this bill from HB 1065/SB 5031 in that it does not use the Medicare rate as the guide for the arbitration process. Cash receipts may increase due to the arbitration process not being locked to a set fee schedule for purposes of reimbursement.

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.

The overall expenditure impact of this bill is well over $50,000, but is ultimately indeterminate as it is unknown how many covered persons would be eligible for in-network cost-sharing, what services would be provided to those persons, how many cases and to what extent dispute resolution will be necessary, as well as how much effort will be required to update websites and provide notices to patients required by the bill. Overall, the effort required by this bill is difficult to estimate but would likely require the addition of several FTE staff across the UW's medical facilities. Please see below for a breakdown of potential cost drivers in each section:

SECTION 6

Section 6 prohibits balance billing for emergency and nonemergency services. The impact is indeterminate as the volume of patients is unknown. Section 6 also states that the out-of-network provider may not attempt to collect from the person any amount greater than the covered person's in network cost-sharing amount. If a covered person pays the out-of-network provider an amount that exceeds the in-network cost-sharing amount, the provider must refund any amount in excess of the in-network cost-sharing amount within thirty business days of receipt, with the addition of interest after thirty business days.

The cost of this section is indeterminate, but would likely require several additional FTE to calculate and refund any amounts billed in error for out-of-network emergency services. Thus, the cost of this section is likely well

over $50,000 per year.

SECTION 7
Section 7 creates a dispute resolution process for carriers and out-of-network providers to use for any dispute involving payment for services. The impact of this section is indeterminate as it is unknown how many matters would be arbitrated under the provisions of the section. The costs to represent the University in these matters could be significant, and would likely be well over $50,000 per year.

SECTION 10
Section 10 requires the Insurance Commissioner to work with providers and facilities to develop standard template language for notifying patients that they may not be balance billed for certain services. The extent to which the UW would be asked to contribute is unknown, but it is likely that the effort associated would be minimal and absorbed within existing resources.

SECTIONS 11 & 12
These sections require hospitals, health care providers, and ambulatory facilities to post in-network health care providers online. This effort would likely be minimal and absorbed within existing resources.

SECTIONS 14, 18, & 19
These sections allow for the Department of Health (DOH) or appropriate disciplinary authority to levy fines upon persons violating provisions of the act. The impact of these sections is indeterminate as the number of violations and the amount of the fines are unknown. That said, the UW would make every effort to avoid violation of this act, and would expect the cost of these sections to be minimal.

SECTION 28
Section 28 stipulates that the act takes effect January 1, 2020. It is unknown if the UW would be able to be in compliance with this bill in the timeframe specified, due to possibly significant changes in patient notifications, staff training at all entry points, website information, and hiring of several additional employees to complete this work. Costs associated with non-compliance are indeterminate but would likely be well over $50,000.

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.