

# Multiple Agency Fiscal Note Summary

<b>Bill Number:</b> 1065 2S HB	<b>Title:</b> Out-of-network health care
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## 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.					
<b>Total \$</b>	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	0	0	.0	0	0	.0	0	0
Washington State Health Care Authority	Non-zero but indeterminate cost and/or savings. Please see discussion.								
Office of Insurance Commissioner	2.7	0	1,014,928	3.5	0	1,008,139	2.1	0	701,920
Department of Health	.0	0	0	.0	0	0	.0	0	0
University of Washington	Non-zero but indeterminate cost and/or savings. Please see discussion.								
<b>Total \$</b>	2.7	0	1,014,928	3.5	0	1,008,139	2.1	0	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	.0	0	0	.0	0	0	.0	0	0
University of Washington	.0	0	0	.0	0	0	.0	0	0
<b>Total \$</b>	0.0	0	0	0.0	0	0	0.0	0	0

## Estimated Capital Budget Breakout

NONE

<b>Prepared by:</b> Robyn Williams, OFM	<b>Phone:</b> (360) 902-0575	<b>Date Published:</b> Final 3/13/2019
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# Individual State Agency Fiscal Note

<b>Bill Number:</b> 1065 2S HB	<b>Title:</b> Out-of-network health care	<b>Agency:</b> 105-Office of Financial Management
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## Part I: Estimates

☒ 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.

<b>Legislative Contact:</b> Catrina Lucero	<b>Phone:</b> 360-786-7192	<b>Date:</b> 03/06/2019
<b>Agency Preparation:</b> Jim Jenkins	<b>Phone:</b> 360-902-0403	<b>Date:</b> 03/08/2019
<b>Agency Approval:</b> Aaron Butcher	<b>Phone:</b> 360-902-0406	<b>Date:</b> 03/08/2019
<b>OFM Review:</b> Bryan Way	<b>Phone:</b> (360) 902-0650	<b>Date:</b> 03/11/2019

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.*

For Section 26 of this substitute version of the bill, the Office of the Insurance Commissioner (OIC) shall contract with the Office of Financial Management (OFM) and the WA-APCD lead organization to complete the work requirements of Section 26. OFM assumes the necessary funding requirements would be included in the OIC fiscal note.

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

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

<b>Bill Number:</b> 1065 2S HB	<b>Title:</b> Out-of-network health care	<b>Agency:</b> 107-Washington State Health Care Authority
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## 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: Catrina Lucero	Phone: 360-786-7192	Date: 03/06/2019
Agency Preparation: Kate LaBelle	Phone: 360-725-1846	Date: 03/11/2019
Agency Approval: Rene Newkirk	Phone: 360-725-1307	Date: 03/11/2019
OFM Review: Robyn Williams	Phone: (360) 902-0575	Date: 03/11/2019

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

# HCA Fiscal Note

Bill Number: 1065 2SHB

HCA Request #: 19-165

## Part II: Narrative Explanation

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

This version of the bill varies from the HB 1065 in the following ways:

Section 6(4) - Requires health plans and payers to hold a member harmless for out of network costs in excess of in-network cost-sharing at facilities in a state that borders Washington State.

Section 32 – States that if funding is not provided by June 30, 2019, this bill is null and void.

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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.

# HCA Fiscal Note

Bill Number: 1065 2SHB

HCA Request #: 19-165

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 an 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 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) must be paid by the losing party, or if one party failed to submit material timely without good cause the arbitrator may close the case and charge the untimely party for all arbitration fees.

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.



## HCA Fiscal Note

Bill Number: 1065 2SHB

HCA Request #: 19-165

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 6(4) - Requires health plans and payers to hold a member harmless for out of network costs in excess of in-network cost-sharing at facilities in a state that borders Washington State. Costs associated with this change are indeterminate and the HCA anticipates the impacts to be significant.

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 percent 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) must be paid by the losing party, or if one party failed to submit material timely without good cause the arbitrator may close the case and charge the untimely party for all arbitration fees. 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 increase in annual arbitration costs may be passed on as administrative costs and when a provider wins an arbitration there are increased claims costs for UMP.

Section 32 – States that if funding is not provided by June 30, 2019, this bill is null and void.

## HCA Fiscal Note

Bill Number: 1065 2SHB

HCA Request #: 19-165

### **Part IV: Capital Budget Impact**

None

### **Part V: New Rule Making Required**

None

# Individual State Agency Fiscal Note

<b>Bill Number:</b> 1065 2S HB	<b>Title:</b> Out-of-network health care	<b>Agency:</b> 160-Office of Insurance Commissioner
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## 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	1.1	4.3	2.7	3.5	2.1
<b>Account</b>					
Insurance Commissioners Regulatory Account-State 138-1	355,293	659,635	1,014,928	1,008,139	701,920
<b>Total \$</b>	355,293	659,635	1,014,928	1,008,139	701,920

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- ☐ Capital budget impact, complete Part IV.
- ☒ Requires new rule making, complete Part V.

Legislative Contact: Catrina Lucero	Phone: 360-786-7192	Date: 03/06/2019
Agency Preparation: Jane Beyer	Phone: 360-725-7043	Date: 03/08/2019
Agency Approval: Gynger Steele	Phone: 360-725-7056	Date: 03/08/2019
OFM Review: Robyn Williams	Phone: (360) 902-0575	Date: 03/11/2019

## 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 Office of Insurance Commissioner (OIC) 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 6(b) requires the OIC, in consultation with health carriers, health care providers, health care facilities and customers to develop a standard template language for the state required in (a) of this subsection. The standard template language must include contact information for the OIC. The OIC shall determine by rule how execution of the statement must be documented.

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 describe in the enrollee contract.

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

Section 8(2) requires the OIC 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 OIC.

Section 9(1) requires the OIC 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 OIC to post the report on its 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 OIC, in consultation with health carriers, health care providers, health care facilities and consumers, develop a 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 OIC 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, a list of the in-network carrier health plans and a notice of the consumer rights developed under this act not less than 30 days prior to executing a contract.

Section 11(3) requires a hospital or ambulatory surgical facility to provide a carrier with a list of the nonemployed providers or provider groups within 30 days 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 providers 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 OIC to submit information to the Department of Health or the appropriate disciplinary authority if the OIC 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 OIC 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 to reasonably ensure enrollees have in-network access for covered benefits delivered at the facility.

Section 26 requires the Commissioner to contract with the Office of Financial Management and the lead organization to establish a data set and business process to provide health carriers, health care providers,

hospitals, ambulatory surgical facilities and arbitrators with data to assist in determining commercially reasonable payments and resolving payment disputes for out-of-network medical services rendered by health care facilities or providers. The data set and business process must be developed in collaboration with health carriers, health care providers, hospitals and ambulatory surgical facilities and provide the amounts references in section 8(3)(b) for the services described in section 6. This data set must be available beginning November 1, 2019 and must be reviewed by an advisory committee, established under chapter 43.371 RCW, prior to use.

Section 30 indicates this act will take effect on January 1, 2020, except section 26.

## **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 elects 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 all 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 6(b) requires the Commissioner, in consultation with health carriers, health care providers, health care facilities and customers to develop a standard template language for the state required in (a) of this subsection. The standard template language must include contact information for the Office of the Insurance Commissioner. The Commissioner shall determine by rule how execution of the statement must be documented. The work required for this section is equivalent to a complex rulemaking.

Section 8(1)(a) required 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 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. 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 within 30 days 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 providers 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 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 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.

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 contract. 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.

Section 26 requires the Commissioner to contract with the Office of Financial Management (OFM) and the lead organization to establish a data set and business process to provide health carriers, health care providers, hospitals, ambulatory surgical facilities and arbitrators with data to assist in determining commercially reasonable payments and resolving payment disputes for out-of-network medical services rendered by health care facilities or providers. The data set and business process must be developed in collaboration with health carriers, health care providers, hospitals and ambulatory surgical faculties and provide the amounts references in section 8(3)(b) for the services described in section 6. This data set must be available beginning November 1, 2019 and must be reviewed by an advisory committee, established under chapter 43.371 RCW, for validation before use. OIC will require \$180,000 in FY2020 and \$120,000 in each subsequent year to contract with OFM in order to provide health carriers, health care providers, hospitals, ambulatory surgical facilities and arbitrators with data to assist in determining commercially reasonable payments and resolving payment disputes for out-of-network medical services.

#### Ongoing Costs:

\$120,000 per year for an interagency agreement with OFM; and 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	355,293	659,635	1,014,928	1,008,139	701,920
<b>Total \$</b>			355,293	659,635	1,014,928	1,008,139	701,920

### III. B - Expenditures by Object Or Purpose

	FY 2020	FY 2021	2019-21	2021-23	2023-25
FTE Staff Years	1.1	4.3	2.7	3.5	2.1
A-Salaries and Wages	105,611	313,772	419,383	443,650	267,590
B-Employee Benefits	34,623	113,136	147,759	170,861	101,946
C-Professional Service Contracts					
E-Goods and Other Services	215,059	226,727	441,786	393,628	332,384
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-					
<b>Total \$</b>	355,293	659,635	1,014,928	1,008,139	701,920

### 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	0.2	0.6	0.4	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	0.9	1.1	1.0		
<b>Total FTEs</b>		1.1	4.3	2.8	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. The development of a standard template and execution of how the statement must be documented per section 6(b) is equivalent to a complex rulemaking.
2. Rules governing the dispute resolution process established in section 8 of this act. This is expected to be a normal rulemaking.
3. 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.
4. 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

<b>Bill Number:</b> 1065 2S HB	<b>Title:</b> Out-of-network health care	<b>Agency:</b> 303-Department of Health
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## Part I: Estimates

☒ 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.

<b>Legislative Contact:</b> Catrina Lucero	<b>Phone:</b> 360-786-7192	<b>Date:</b> 03/06/2019
<b>Agency Preparation:</b> Donna Compton	<b>Phone:</b> (360) 236-4538	<b>Date:</b> 03/08/2019
<b>Agency Approval:</b> Stacy May	<b>Phone:</b> (360) 236-4532	<b>Date:</b> 03/08/2019
<b>OFM Review:</b> Bryce Andersen	<b>Phone:</b> (360) 902-0580	<b>Date:</b> 03/11/2019

## 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.*

The fiscal impact to the Department of Health (department) has not changed as a result of this substitute bill.

Section 14(1): Allows the Office of the Insurance Commissioner (OIC) to submit information to the Department of Health (department) or appropriate disciplining authority for action if they have cause to believe that any health care provider, hospital, or ambulatory surgical facility, has engaged in a pattern of unresolved violations of section 6 or 7 of this act.

Section 17(21): Amends RCW18.130.180, Uniform Disciplinary Act, to add language regarding a pattern of violations in regards to section 6 or 7 of this act.

Section 18: Adds a new section to chapter 70.41 RCW, Hospital Licensing and Regulation, stating the department may levy a fine upon a hospital in an amount not to exceed one thousand dollars per violation and may take other formal or informal disciplinary action as permitted if an OIC report regarding pattern of violations is substantiated.

Section 19: Adds a new section to chapter 70.230 RCW, Ambulatory Surgical Facilities, stating the department may levy a fine upon an Ambulatory Surgical Facility in an amount not to exceed one thousand dollars per violation and may take other formal or informal disciplinary action as permitted if an OIC report regarding pattern of violations is substantiated.

Section 20: Adds a new section to chapter 70.42 RCW, Medical Test Sites, stating the department may levy a fine upon an Medical Test Site in an amount not to exceed one thousand dollars per violation and may take other formal or informal disciplinary action as permitted if an OIC report regarding pattern of violations is substantiated.

Based on complaint data from New York and California who currently have similar regulations, as well as assumptions from OIC the department anticipates no complaints to be received from OIC. The department also assumes that no additional complaints from private entities will be received if this bill is passed.

This bill does not give the department investigative authority, therefore rules would not be needed. If the OIC did submit a complaint the information would be reviewed and issued a civil penalty in accordance with existing process, therefore the department assumes 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

# Individual State Agency Fiscal Note

<b>Bill Number:</b> 1065 2S HB	<b>Title:</b> Out-of-network health care	<b>Agency:</b> 360-University of Washington
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## 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: Catrina Lucero	Phone: 360-786-7192	Date: 03/06/2019
Agency Preparation: Kelsey Rote	Phone: 2065437466	Date: 03/11/2019
Agency Approval: Becka Johnson Poppe	Phone: 206-616-7203	Date: 03/11/2019
OFM Review: Breann Boggs	Phone: (360) 902-0659	Date: 03/13/2019

## 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.*

The changes from the original bill to the second substitute are as follows:

- Section 6(2) adds language regarding enrollees who have knowingly, voluntarily, and specifically selected out-of-network health services.
- Section 6(4) adds language regarding holding enrollees harmless from balance billing when their emergency service is provided by an out-of-network hospital in a state that borders Washington.

None of the language changes from the original to the second substitute impact the fiscal note for the University of Washington.

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 provide 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.

## **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.*