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**HOUSE BILL 1741**

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**State of Washington 67th Legislature 2022 Regular Session**

**By** Representatives Cody, Macri, Bateman, Chopp, Tharinger, Pollet, Riccelli, and Harris-Talley

AN ACT Relating to addressing affordability through health care provider contracting; amending RCW 48.43.730; adding new sections to chapter 48.43 RCW; creating new sections; and providing an effective date.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. **Sec.**  (1) The legislature finds that:

(a) The health care system is a comprehensive and interconnected entity;

(b) Health care costs and spending continue to rise and significantly outgrow inflation and the United States gross domestic product per capita;

(c) According to the health care cost institute, from 2015 to 2019 the average health care spending per person reached $6,000, an increase of 21 percent. Health care prices accounted for nearly two-thirds of this increase in spending after adjusting for inflation;

(d) According to a Milbank memorial fund issue brief, mitigating the price impacts of health care provider consolidation, consolidation of health care providers into health systems with market power is a primary driver of the high health care prices. Further, the issue brief explains, competition in the health care market exists in three areas: (i) Competition between health care providers for inclusion in health plan networks; (ii) competition between health carriers in health plan enrollment; and (iii) competition between health care providers for in-network patients;

(e) A 2020 report to congress on medicare payment policy from the medicare payment advisory commission found "the preponderance of evidence suggests that hospital consolidation leads to higher prices. These findings imply that hospitals seek higher prices from insurers and will get them when they have greater bargaining power." Further, the review noted that "a recent study found that hospital and insurer concentration both increase premiums in the affordable care act marketplace;" and

(f) Significant vertical and horizontal consolidation has already occurred in the health care market. In 2010, the five largest hospital systems in Washington state had 30 hospitals, which grew to 49 hospitals by 2021. According to a 2020 American medical association survey, nearly 40 percent of patient care physicians were employed directly by a hospital or a practice owned a least partially by a hospital or health system, an increase from just 23.5 percent in 2012. According to a 2020 study published in health affairs, 72 percent of hospitals were affiliated with a hospital system in 2018.

(2) Therefore, the legislature intends to prohibit the use of certain contractual provisions often used by providers, hospitals, health systems, and carriers with significant market power and provide oversight to the insurance commissioner to implement affordability standards in provider compensation agreements with the goal of increasing health care competition, lowering health care prices, and increasing affordability for consumers.

NEW SECTION. **Sec.**  A new section is added to chapter 48.43 RCW to read as follows:

(1) Except as provided in subsections (2), (3), and (4) of this section, for health plans issued or renewed on or after January 1, 2023, a provider contract between a hospital or any affiliate of a hospital and a health carrier may not, directly or indirectly, include any of the following provisions:

(a) An all-or-nothing clause;

(b) An antisteering clause;

(c) An antitiering clause; or

(d) Any clause that sets provider compensation agreements or other terms for affiliates of the hospital that have not contracted with a carrier or a carrier's contractor or subcontractor to provide health care services to enrollees.

(2) Subsection (1)(a) of this section does not prohibit a health carrier from voluntarily agreeing to contract with other hospitals owned or controlled by the same single entity. If a health carrier voluntarily agrees to contract with other hospitals owned or controlled by the same single entity under subsection (1)(a) of this section, the health carrier must file an attestation with the office of the insurance commissioner that complies with the filing requirements of RCW 48.43.730.

(3) Subsection (1)(a) and (d) of this section does not apply to the limited extent that it impairs the ability of a hospital, provider, or health carrier to participate in a state-sponsored health care program, federally funded health care program, or state or federal grant opportunity.

(4) This section does not prohibit a hospital certified as a critical access hospital by the centers for medicare and medicaid services or an independent hospital certified as a sole community hospital by the centers for medicare and medicaid services from negotiating payment rates and methodologies on behalf of an individual health care practitioner or a medical group that the hospital is affiliated with.

(5) The attorney general may enforce this section under the consumer protection act, chapter 19.86 RCW. For actions brought by the attorney general to enforce this section, the legislature finds that the practices covered by this section are matters vitally affecting the public interest for the purpose of applying the consumer protection act, chapter 19.86 RCW, and that a violation of this section is not reasonable in relation to the development and preservation of business and is an unfair or deceptive act in trade or commerce and an unfair method of competition for the purpose of applying the consumer protection act, chapter 19.86 RCW.

(6) For the purposes of this section:

(a) An "all-or-nothing clause" means a provision of a provider contract that requires a health carrier to contract with multiple hospitals owned or controlled by the same single entity.

(b) "Antisteering clause" means a provision of a provider contract that restricts the ability of a health carrier to encourage an enrollee to obtain a health care service from a competitor of the hospital, including offering incentives to encourage enrollees to utilize specific health care providers.

(c) "Antitiering clause" means a provision in a provider contract that requires a health carrier to place a hospital or any affiliate of the hospital in a tier or a tiered provider network reflecting the lowest or lower enrollee cost-sharing amounts.

(d) "Control" means the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of a person, whether through ownership of voting securities, membership rights, by contract, or otherwise.

(e) "Provider" has the same meaning as in RCW 48.43.730.

(f) "Provider compensation agreement" has the same meaning as in RCW 48.43.730.

(g) "Provider contract" has the same meaning as in RCW 48.43.730.

(h) "Tiered provider network" means a network that identifies and groups providers and facilities into specific groups to which different provider reimbursement, enrollee cost sharing, or provider access requirements, or any combination thereof, apply as a means to manage cost, utilization, quality, or to otherwise incentivize enrollee or provider behavior.

NEW SECTION. **Sec.**  A new section is added to chapter 48.43 RCW to read as follows:

When determining whether to approve, disapprove, or take any other action authorized under RCW 48.43.730 with respect to provider compensation agreements, the insurance commissioner may consider whether the health carrier's provider compensation agreements are affordable and whether the carrier has implemented effective strategies to enhance the affordability of its health plans.

NEW SECTION. **Sec.**  A new section is added to chapter 48.43 RCW to read as follows:

When determining whether a provider compensation agreement is affordable under section 3 of this act, the insurance commissioner shall consider whether the provider compensation agreement:

(1) Protects the public interest and the interests of consumers;

(2) Encourages the fair treatment of providers;

(3) Considers the health care system as a comprehensive entity;

(4) Advances the welfare of the public through overall efficiency, affordability, improved health care quality, and appropriate access; and

(5) Meets or aims to meet the health care cost transparency board's health care cost growth benchmarks established pursuant to RCW 70.390.020.

**Sec.**  RCW 48.43.730 and 2019 c 427 s 30 are each amended to read as follows:

(1) For the purposes of this section:

(a) "Carrier" means a:

(i) Health carrier as defined in RCW 48.43.005; and

(ii) Limited health care service contractor that offers limited health care service as defined in RCW 48.44.035.

(b) "Provider" means:

(i) A health care provider as defined in RCW 48.43.005;

(ii) A participating provider as defined in RCW 48.44.010;

(iii) A health care facility, as defined in RCW 48.43.005; and

(iv) Intermediaries that have agreed in writing with a carrier to provide access to providers under this subsection (1)(b) who render covered services to enrollees of a carrier.

(c) "Provider compensation agreement" means any written agreement that includes specific information about payment methodology, payment rates, and other terms that determine the remuneration a carrier will pay to a provider.

(d) "Provider contract" means a written contract between a carrier and a provider for any health care services rendered to an enrollee.

(2) A carrier must file all provider contracts and provider compensation agreements with the commissioner thirty calendar days before use. When a carrier and provider negotiate a provider contract or provider compensation agreement that deviates from a filed agreement, the carrier must also file that specific contract or agreement with the commissioner thirty calendar days before use.

(a) Any provider contract and related provider compensation agreements not affirmatively disapproved by the commissioner are deemed approved, except the commissioner may extend the approval date an additional fifteen calendar days upon giving notice before the expiration of the initial thirty‑day period.

(b) Changes to previously filed and approved provider compensation agreements modifying the compensation amount or related terms that help determine the compensation amount must be filed and are deemed approved upon filing if no other changes are made to the previously approved provider contract or compensation agreement.

(3) ((~~The~~)) Except as provided in sections 3 and 4 of this act, the commissioner may not base a disapproval of a provider compensation agreement on the amount of compensation or other financial arrangements between the carrier and the provider, unless that compensation amount causes the underlying health benefit plan to otherwise be in violation of state or federal law. This subsection does not grant the commissioner the authority to regulate provider reimbursement amounts.

(4) The commissioner may withdraw approval of a provider contract or provider compensation agreement at any time for cause.

(5) Provider compensation agreements are confidential and not subject to public inspection under RCW 48.02.120(2), or public disclosure under chapter 42.56 RCW, if filed in accordance with the procedures for submitting confidential filings through the system for electronic rate and form filings and the general filing instructions as set forth by the commissioner. In the event the referenced filing fails to comply with the filing instructions setting forth the process to withhold the compensation agreement from public inspection, and the carrier indicates that the compensation agreement is to be withheld from public inspection, the commissioner shall reject the filing and notify the carrier through the system for electronic rate and form filings to amend its filing to comply with the confidentiality filing instructions.

(6) In the event a provider contract or provider compensation agreement is disapproved or withdrawn from use by the commissioner, the carrier has the right to demand and receive a hearing under chapters 48.04 and 34.05 RCW.

(7) Provider contracts filed pursuant to subsection (2) of this section shall identify the network or networks to which the contract applies.

(8) The commissioner may adopt rules to implement this section.

NEW SECTION. **Sec.**  The insurance commissioner may adopt rules necessary to implement this act.

NEW SECTION. **Sec.**  Sections 3 and 4 of this act take effect January 1, 2024.

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