SENATE BILL REPORT
SB 5393

As of February 21, 2023

Title: An act relating to addressing affordability through health care provider contracting.

Brief Description: Addressing affordability through health care provider contracting.

Sponsors: Senators Robinson, Dhingra, Hasegawa, Keiser, Randall, Valdez and Wilson, C..

Brief History:
Committee Activity: Health & Long Term Care: 1/27/23, 2/17/23 [DPS-WM, w/oRec]. Ways & Means: 2/21/23.

Brief Summary of First Substitute Bill

- Prohibits the use of certain contractual provisions in contracts between health carriers and hospitals or hospital affiliates under certain circumstances.

SENATE COMMITTEE ON HEALTH & LONG TERM CARE

Majority Report: That Substitute Senate Bill No. 5393 be substituted therefor, and the substitute bill do pass and be referred to Committee on Ways & Means.

Signed by Senators Cleveland, Chair; Robinson, Vice Chair; Conway, Dhingra, Randall and Van De Wege.

Minority Report: That it be referred without recommendation.

Signed by Senators Rivers, Ranking Member; Muzzall, Assistant Ranking Member; Holy and Padden.

Staff: Greg Attanasio (786-7410)

SENATE COMMITTEE ON WAYS & MEANS

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not part of the legislation nor does it constitute a statement of legislative intent.

Staff: Sandy Stith (786-7710)

Background: Health carriers must file all provider contracts and provider compensation agreements with the Office of the Insurance Commissioner (OIC) 30 calendar days before use. When a carrier and provider negotiate an agreement that deviates from a filed agreement, the specific contract must be filed 30 days prior to use. Any provider compensation agreements not affirmatively disapproved by OIC are deemed approved, except OIC may extend the approval date an additional 15 days with notice before the initial 30-day period expires. Changes to the previously filed agreements that modify the compensation or related terms must be filed and are deemed approved upon filing if no other changes are made to the previously approved agreement.

OIC may not base a disapproval of the agreement on the amount of the compensation or other financial arrangements between the carrier and provider, unless the compensation amount causes the underlying health benefit plan to be in violation of state or federal law.

Provider compensation agreements are confidential and not subject to public inspection or public disclosure if they are filed following the procedures for submitting confidential filings in the electronic rate and form filings. If the filing instructions are not followed and the carrier indicates that the compensation agreement will be withheld from public inspection, OIC must reject the filing and notify the carrier to amend the filing to comply with the confidentiality instructions.

Summary of Bill (First Substitute): For health plans, including plans offered to public employees, issued on or after January 1, 2024, a provider contract between a hospital or any affiliate of a hospital and a health carrier may not directly include an all-or-nothing clause, an anti-steering clause, an anti-tiering clause, or any clause that sets provider compensation agreements or other terms for an affiliate of a hospital that will not be included as participating providers in the agreement.

For the purposes of this act:

- an "all-or-nothing clause" means a contract provision that requires a health carrier to contract with multiple hospitals or affiliates of a hospital owned or controlled by the same single entity. All-or-nothing clause also means a provision of a provider contract that requires a hospital or provider to accept multiple product lines offered by a health carrier;
- an "anti-steering clause" means a contract provision that restricts the ability of a health carrier to encourage an enrollee to obtain a health care service from a competitor of the hospital or an affiliate of the hospital, including offering incentives to encourage enrollees to utilize specific health care providers; and
- an "anti-tiering clause" means a contract provision 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.

The prohibition on anti-steering and anti-tiering clauses applies only to carrier networks where tiering is based on quality metrics.

The prohibition on all-or-nothing clauses and clauses that set provider compensation agreements for affiliates outside the network do not:

- apply if they prevent a hospital, provider, or carrier from participating in state or federally sponsored health care program or grant opportunity;
- apply if they prevent a hospital, provider or carrier from participating in a value-based purchasing agreement, including agreements involving integrated networks, accountable care organizations, managed care or bundled payment agreements;
- apply to specialized services that are centralized in one hospital;
- allow carriers to exclude hospital or affiliates when 50 percent or more of the total charges from those facilities are for Medicaid and Medicare patients; and
- allow carriers to refuse to credential providers who become an employee of a hospital or physician group which has an existing compensation agreement.

This act does not prohibit a critical access hospital or sole community hospital from negotiating payment rates and methodologies on behalf of an individual health care practitioner or a medical group the hospital is affiliated with.

The provision of this act do not apply to independent health care provider groups, including but not limited to emergency physicians, anesthesiologists, radiologists, pathologists and hospitalists, that contract with hospitals to provide facility-based services, and are not otherwise affiliated with a hospital.

EFFECT OF CHANGES MADE BY HEALTH & LONG TERM CARE COMMITTEE (First Substitute):

- Removes the provision requiring carriers to file a declaration with OIC if they choose to contract with multiple hospitals owned by a single entity.
- Limits the prohibition on anti-steering and anti-tiering clauses to carrier networks where tiering is based on quality metrics.
- Specifies that the prohibition on all-or-nothing clauses and clauses that set provider compensation agreements for affiliates outside the network do not:
    1. apply if they prevent a hospital, provider, or carrier from participating in state or federally sponsored health care program or grant opportunity;
    2. apply if they prevent a hospital, provider or carrier from participating in a value-based purchasing agreement, including agreements involving integrated networks, accountable care organizations, managed care or bundled payment agreements;
    3. apply to specialized services that centralized in one hospital;
    4. allow carriers to exclude hospital or affiliates when 50 percent or more of the total charges from those facilities are for Medicaid and Medicare patients; and
    5. allow carriers to refuse to credential providers who become an employee of a

hospital or physician group which has an existing compensation agreement.

- Removes the requirement for an attestation stating that terms prohibited in the bill were not part of the negotiations for a carrier contract.
- Removes the provision prohibiting a contract clause in a contract between a health plan and a hospital, physician or physician group, or ancillary provider requiring the health carrier to reimburse a hospital, physician or physician group, or ancillary provider at the acquirer's contract rate when acquired by that entity.
- Exempts independent provider groups from the provisions of the bill.
- Modifies the definition of all-or-nothing clause.
- Removes "indirectly" from several provision in the bill.
- Removes the provision requiring OIC to conduct a study on the impact of anticompetitive behavior on affordability.
- Removes the self-funded plan opt-in.

Appropriation: None.

Fiscal Note: Available.

Creates Committee/Commission/Task Force that includes Legislative members: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony on Original Bill (Health & Long Term Care): *The committee recommended a different version of the bill than what was heard.* PRO: One key driver of health care prices is consolidation of health systems. Consolidation does not lead to lower costs or better care. Carriers need sufficient networks, and with health system consolidation network participation is controlled by a single entity that can leverage that power for higher rates. Contract negotiations are not level and this bill helps to level the playing field and puts sideboards on consolidation. Increased health care costs reduces the ability of small businesses to provide health care to employees. This bill prohibits anticompetitive practices.

CON: Consolidation allows needed facilities to remain open and it is not done for market leverage. This bill gives disproportionate power to health carriers. This bill will negatively affect the ability to negotiate value based contracts. This bill would fracture integrated care models. Increased payment rates have been below inflation. The bill only applies in one direction and carriers use all or nothing provision as well. This bill is unnecessary and could harm competition. This would affect those groups without market power.

OTHER: There is a concern that value-based care will be negatively affected by this bill. To provide value-based care, hospitals need partnerships.

Persons Testifying (Health & Long Term Care): PRO: Senator June Robinson, Prime Sponsor; Jennifer Ziegler, Association of Washington Health Care Plans; Jane Beyer,

Office of the Insurance Commissioner; Gary Strannigan, Premera Blue Cross; Chris Bandoli, AHIP; Denise Corcoran, Regence; Bill Kramer, Purchaser Business Group on Health; Emily Brice, Northwest Health Law Advocates; Sam Hatzenbeler, Economic Opportunity Institute; Sybill Hyppolite, WA State Labor Council; Jim Freeburg, Patient Coalition of Washington.

CON: Bill Robertson, MultiCare Health System; Suzanne Daly, MultiCare Health System; Dhyan Lal, Virginia Mason Franciscan Health; Douglas Ross; Sean Graham, Washington State Medical Association; Lisa Thatcher, Washington State Hospital Association.

OTHER: Nari Heshmati, The Everett Clinic.

Persons Signed In To Testify But Not Testifying (Health & Long Term Care): No one.

Staff Summary of Public Testimony (Ways & Means): PRO: We all share a goal in trying to figure out how to decrease healthcare costs. If you pull apart healthcare costs, there are two drivers that stick out. One is the cost of hospitals and the other is the cost of pharmaceuticals. Balance between health plans and healthcare providers is important. Healthcare coverage has little value unless consumers can access the care they need. This bill is a work in progress to find the right balance. Network adequacy matters. Healthcare consolidation has gone unchecked in Washington and has left us with a tightly limited number of hospital systems with tremendous bargaining power.

OTHER: This bill's substitute is an improvement on the original bill. It is unclear that there is an actual problem that this bill addresses. Studies are needed before the bill should move forward.

Persons Testifying (Ways & Means): PRO: Senator June Robinson, Prime Sponsor; Jane Beyer, Office of the Insurance Commissioner; Erin Dziedzic, Patient Coalition of Washington; Christine Brewer, Premera Blue Cross.

OTHER: Zosia Stanley, Washington State Hospital Association.

Persons Signed In To Testify But Not Testifying (Ways & Means): No one.