Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Health Care & Wellness Committee

HB 1589

Brief Description: Concerning the relationships between health carriers and contracting providers.

Sponsors: Representatives Bronoske, Macri, Shavers, Pollet and Reed.

Brief Summary of Bill

- Requires the Office of the Insurance Commissioner to determine whether providers included in a health carrier's provider network are actually providing services to enrollees.
- Requires health carriers to negotiate in good faith with providers.
- Prohibits certain provisions from provider contracts.

Hearing Date: 2/4/25

Staff: Jim Morishima (786-7191).

Background:

Provider Networks.
A health carrier is required under federal and state law to maintain adequate provider networks, which must be sufficient in numbers and types of providers to assure, to the extent feasible, that all covered services are accessible in a timely and appropriate manner. To effectuate this requirement, a health carrier's provider networks are subject to approval by the Office of the Insurance Commissioner (OIC), which evaluates both proposed networks and the ongoing adequacy of existing networks. A health carrier is required to maintain and monitor its provider network on an ongoing basis and report any changes affecting the network's ability to furnish covered services to enrollees.

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.

Provider Contracting.
To build their provider networks, health carriers enter into contracts with health care providers. A health carrier may not require a provider to extend the carrier's Medicaid rates, or some percentage above the health carrier's Medicaid rates, to a commercial plan or line of business without express agreement from the provider. Additionally, the health carrier must provide at least 60 days' notice to a provider of any proposed material changes to the provider's contract. During the 60-day period, the provider may reject the material amendment without affecting the existing contract.

Summary of Bill:

Provider Networks.
When determining the ongoing adequacy of an in-force provider network, the Office of the Insurance Commissioner (OIC) must determine whether providers included in the network are actually providing services to the health carrier's enrollees. The OIC must adopt, by rule, a uniform data request form and may adopt additional requirements consistent with this requirement. When adopting the form, the OIC must consider the model data request form developed by the Bowman Family Foundation's Mental Health Treatment and Research Institute.

Provider Contracting.
A health carrier must offer providers a meaningful opportunity to negotiate the terms of a provider contract. Such negotiations must be conducted in good faith. The following conduct violates this requirement:

- failure to furnish the provider with the name and contact information of the primary contact for negotiations;
- failure to furnish a provider with a copy of the proposed contract that clearly indicates the differences from the previous contract;
- refusal to negotiate with a group of providers with the same employer or the same federal tax identification number;
- failure to provide a fee schedule in a manner that does not require access to a secure website or other portal; or
- any other conduct that the OIC determines, in rule, violates the requirement.

Provider contracts entered into or renewed on or after January 1, 2027, may not include an all-or-nothing clause or a requirement to accept a discounted rate under any other contract to which the provider is a party. "All-or-nothing clause" is defined as a requirement that the provider contract with multiple health plans or other insurance products offered by, or associated with, the health carrier.

These requirements apply to health carriers offering comprehensive plans or dental-only coverage and health care benefit managers acting on behalf of such health carriers. The requirements do not apply to negotiations between a health carrier and a provider who is an employee of the health carrier or a provider who is an employee of a hospital.

Any trade secrets or other confidential information disclosed to the OIC for purposes of implementing these requirements are confidential and exempt from public disclosure.

Appropriation: None.

Fiscal Note: Requested on January 30, 2025.

Effective Date: The bill contains multiple effective dates. Please see the bill.