HOUSE BILL REPORT
HB 1589

As Reported by House Committee On:
Health Care & Wellness

Title: An act relating to the relationships between health carriers and contracting providers.

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

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

Brief History:
Committee Activity:
Health Care & Wellness: 2/4/25, 2/21/25 [DPS].

Brief Summary of Substitute 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.
- Requires the Office of the Insurance Commissioner to study allowed amounts over time for certain services.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 16 members: Representatives Bronoske, Chair; Lekanoff, Vice Chair; Caldier, Assistant Ranking Minority Member; Marshall, Assistant Ranking Minority Member; Davis, Low, Macri, Manjarrez, Obras, Parshley, Shavers, Simmons, Stonier, Stuebe, Thai and Tharinger.

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.

Minority Report: Without recommendation. Signed by 2 members: Representatives Schmick, Ranking Minority Member; Engell.

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, 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.

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 Substitute 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. The OIC must publish, on its website, the results of these evaluations.

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 new contract with all changes indicated with strikeouts for deletions and underlining for new material along with a clean copy of the revised contract;
- providing a stand-alone amendatory exhibit or addendum that requires the provider to conduct the provider's own analysis to produce a revised contract or agreement;
- refusal to negotiate with providers with separate Type One National Provider Identifiers issued by the Centers for Medicare and Medicaid Services (CMS) who are part of the same group practice or a group of providers who are employed or affiliated with an organization that has a Type Two National Provider Identifier issued by CMS;
- failure to provide a fee schedule within 60 days of contract execution 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.

The OIC must reject a health carrier's provider contracts unless the contracts are accompanied by an attestation signed by both the health carrier and the provider that the contract negotiation requirements were met. The OIC must, by rule, develop a standard form for the attestation. The health carrier must annually report to the OIC the number of provider negotiations that failed to result in a signed attestation.

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 for services provided to enrollees under any other health plan or insurance product. "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.

A health carrier may not penalize a provider for pursuing an appeal in any way, including by imposing a fee for an appeal or an external review.

In addition to its existing enforcement authority, the OIC may impose a fine of up to $5,000 per violation of these requirements, issue an order of corrective action, or both.

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 its affiliate, an employee of a hospital or a health system, or an employee of an entity that owns or operates multistate provider clinics.

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

Office of the Insurance Commissioner Study.
Using data from the statewide All Payer Claims Database, the OIC must analyze trends in allowed amounts for a representative sample of the most commonly billed current

procedural technology codes for a representative sample of affected health professions. The OIC must report the results of the analysis to the Legislature annually, beginning on January 1, 2027. The report must include an analysis of allowed amounts compared to data in previous years' reports. The reporting requirement expires January 31, 2031.

Substitute Bill Compared to Original Bill:

The substitute bill:

- requires the Office of the Insurance Commissioner (OIC) to publish, on its website, the results of its analysis of a carrier's network to determine whether providers are actually providing services to enrollees;
- provides more specificity on how changes in a new contract must be delineated by requiring the changes to be marked with strikeouts and underlining;
- requires a clean copy of the contracted to be furnished to the provider and prohibits stand-alone amendatory exhibits or addenda;
- uses the National Provider Identifier to identify groups of providers with which a carrier must negotiate, instead of the federal tax identification number;
- requires fee schedules to be provided at least 60 days in advance, instead of upon request;
- requires the OIC to reject provider contracts unless they are accompanied by an attestation signed by the provider and the carrier indicating that the good faith negotiation requirements were met;
- requires carriers to report to the OIC on the number of negotiations that did not result in a signed attestation;
- prohibits carriers from requiring a provider to accept a discounted rate for services provided to enrollees under any other health plan or insurance product, instead of under any other contract to which the provider is a party;
- prohibits carriers from penalizing providers for pursuing an appeal in any way, including by imposing a fee for appeals or external reviews;
- allows the OIC to impose fines of up to $5,000, orders of corrective action, or both;
- expands the exemptions to the negotiation requirements to include employees of health carrier affiliates, hospital affiliates, health system affiliates, and multistate provider clinics;
- requires the OIC to use data from the All Payer Claims Database to analyze trends in allowed amounts for a representative sample of the most commonly billed current procedural technology codes for a representative sample of impacted health professions; and
- requires the OIC to report the results of its analysis to the Legislature every year beginning January 1, 2027.

Appropriation: None.

Fiscal Note: Available.

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

Staff Summary of Public Testimony:

(In support) Provider payment rates have not increased for many years, despite increasing insurance premiums. This leads to providers having trouble keeping their doors open because of rising costs. Many providers are facing burnout or leaving the profession. This is leading to provider shortages. There are fewer independent providers because of consolidation, and ensuring negotiations are fair and transparent will help these providers. Copays are exceeding the allowed amount, which means patients are paying more. Health carriers claim to negotiate, but they do not. Fee schedules are not being provided upon request, and providers are unilaterally dropped from provider panels because of all-or-nothing clauses. Providers do not even know what they are agreeing to. Providers want the opportunity to meaningfully negotiate. Health carriers are having similar problems with hospitals. The state cannot keep calling mental health a priority while allowing health carriers to dictate terms that make care unavailable. Insurers are limiting the ability of providers to collectively bargain. Many in-network providers are not actually accepting new patients. Patients should get the care they are assured when they purchase insurance. Language should be added to this bill about monitoring compliance. This bill will level the playing field and the ultimate winner will be the patients.

(Opposed) None.

(Other) Rising costs are due to consolidated systems, which is not good for anyone. Independent providers are a valuable resource, but this bill is not specific to those providers. There are administrative burdens on both sides. Distributing material by mail is not practical.

Persons Testifying: (In support) Representative Dan Bronoske, prime sponsor; Jane Beyer, Office of the Insurance Commissioner; Lori Grassi, WA State Chiropractic Association; Ben Boyle, APTA Washington; London Breedlove, WA State Psychological Association; Kendra Holloway, WA Speech - Language - Hearing Association; Melissa Johnson, APTA-WA and WA Speech, Language, Hearing; Ben Packard, Washington State Society for Clinical Social Work; Sharon Shadwell, Washington Mental Health Counselor Association; Meg Curtin Rey-Bear, Washington Mental Health Counselor Association; and Jim Freeburg, Patient Coalition of Washington.

(Other) Jennifer Ziegler, Association of Washington Health Care Plans.

Persons Signed In To Testify But Not Testifying: None.