# SENATE BILL REPORT
# E2SHB 1589

As of March 24, 2025

**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:** House Committee on Appropriations (originally sponsored by Representatives Bronoske, Macri, Shavers, Pollet and Reed).

**Brief History:** Passed House: 3/8/25, 73-23.
**Committee Activity:** Health & Long-Term Care: 3/25/25.

**Brief Summary of Bill**

- 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.

## SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

**Staff:** Greg Attanasio (786-7410)

**Background:** To build their provider networks, health carriers enter into contracts with health care providers. 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

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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.

**Summary of Bill:** 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. Only 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;
- requiring a group of providers with the same employer or the same federal tax identification number to negotiate contracts individually, if the group of providers prefers to negotiate as a group; or
- 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.

OIC may submit to the Legislature recommended statutory changes to address additional conduct that may violate the good-faith negotiation requirements. 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. OIC must, by rule, develop a standard form for the attestation. The good-faith negotiation requirements do not prohibit a health carrier from negotiating with groups of providers. The good-faith negotiation requirements apply to a provider who elects to terminate a contract in place on January 1, 2027.

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. Contract provisions that are contrary to these requirements are against the public policy of the state and are unenforceable.

A health carrier must provide contract and payment policy updates in a manner that does not require access to a secure website or other portal, such as by emailing an electronic copy to the provider.

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, 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 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, 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. OIC must report the aggregated 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.

**Appropriation:** None.

**Fiscal Note:** Requested on March 19, 2025.

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

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