SHB 1741 - H AMD **958**
By Representative Cody

Strike everything after the enacting clause and insert the following:

"NEW SECTION. **Sec. 1.** (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 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 at 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 to direct the insurance commissioner to study other states' regulatory approaches to address affordability of health plan rates with the goal of increasing health care competition, lowering health care prices, and increasing affordability for consumers.

NEW SECTION. **Sec. 2.** 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 private 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 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 will not be included as participating providers in the agreement.

(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. The office of the insurance commissioner shall provide the attestations to the attorney general's office every six months. The attestations filed pursuant to this subsection are not confidential.

(3) Subsection (1)(a) and (d) of this section does not apply to the limited extent that it would prevent a hospital, provider, or health carrier from participating 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)(a) 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.

(b) For purposes of monitoring and enforcing this section, the attorney general may request proof of good faith contracting negotiations and other information determined to be relevant by the attorney general from health carriers and hospitals for provider contracts covered by attestations filed under subsection (2) of this section, and the health carriers and hospitals shall provide the requested information within 30 calendar days of the request. Information provided to the attorney general pursuant to this subsection is confidential and not subject to public inspection under RCW 48.02.120(2) or public disclosure under chapter 42.56 RCW.

(6) For the purposes of this section:

(a) "Affiliate" means a person who directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, another specified person.

(b) 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.

(c) "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.

(d) "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.

(e) "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.

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

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

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

(i) "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. 3.** A new section is added to chapter 70.41 RCW to read as follows:

If requested by the attorney general, a hospital licensed under this chapter shall provide proof of good faith contracting negotiations and other information determined to be relevant by the attorney general for provider contracts covered by attestations filed pursuant to section 2 of this act within 30 calendar days of a request by the attorney general.

Sec. 4. 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. The attestation filed pursuant to section 2 of this act is not a provider compensation agreement or included in a provider compensation agreement for purposes of this section.

(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 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. 5.** (1) The insurance commissioner shall study regulatory approaches used by other states' insurance regulators to address affordability of health plan rates. The study should focus on approaches outside of the traditional health plan rate review such as that required by the affordable care act, and shall include, for each state reported on:

(a) The statutory and regulatory authority for the state's affordability activities;

(b) A description of the activities and processes developed by the state; and

(c) Any available research or other findings related to the impact or outcomes of the state's affordability activities.

(2) The insurance commissioner may contract with a third party to conduct all or any portion of the study.

(3) The insurance commissioner shall submit a report and any recommendations to the relevant policy and fiscal committees of the legislature by December 1, 2022.

(4) This section expires July 1, 2023.

NEW SECTION. **Sec. 6.** The insurance commissioner may adopt rules necessary to implement this act."

Correct the title.

EFFECT: Requires the Office of the Insurance Commissioner (OIC) to provide the attestations filed by carriers that voluntarily agree to contract with other hospitals owned or controlled by the same, single entity to the Attorney General's Office every six months.

Specifies that the attestations are not confidential or part of a provider compensation agreement.

Removes the value-based purchasing exemption from the prohibition on the use of all-or-nothing clauses or setting terms for nonparticipating providers.

Authorizes the Attorney General to request and receive proof of good faith contracting negotiations and other relevant information from health carriers and hospitals for provider contracts covered by an attestation filed with the OIC for purposes of monitoring and enforcing the prohibitions on certain contractual provisions.

Specifies that proof of good faith contracting negotiations and other information provided to the Attorney General is confidential and not subject to public inspection or disclosure.

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