HOUSE BILL REPORT
HB 1160

As Reported by House Committee On:
Health Care & Wellness
Appropriations

Title: An act relating to health provider contracts.

Brief Description: Concerning health provider contracts.

Sponsors: Representatives Cody, Macri and Pollet.

Brief History:
Committee Activity:
Health Care & Wellness: 1/21/21, 2/3/21 [DPS];
Appropriations: 2/16/21, 2/17/21 [DP2S(w/o sub HCW)].

Brief Summary of Second Substitute Bill

- Regulates health carrier contracts with hospitals and providers.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 11 members: Representatives Cody, Chair; Bateman, Vice Chair; Caldier, Assistant Ranking Minority Member; Bronoske, Davis, Macri, Riccelli, Rude, Simmons, Stonier and Tharinger.

Minority Report: Do not pass. Signed by 4 members: Representatives Schmick, Ranking Minority Member; Harris, Maycumber and Ybarra.

Staff: Kim Weidenaar (786-7120).

Background:

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 Contracts and Provider Compensation Agreements.
Health insurance 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 the OIC are deemed approved, except the 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. The 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, the OIC must reject the filing and notify the carrier to amend the filing in order to comply with the confidentiality instructions.

Consumer Protection Act.
Under the Consumer Protection Act (CPA), unfair or deceptive acts or practices in trade or commerce are unlawful. The CPA provides that any person injured in his or her business or property through such practices may bring a civil action to recover actual damages sustained and costs of the suit, including reasonable attorneys' fees. The Attorney General may bring an action under the CPA to restrain and prevent unfair and deceptive acts and practices.

Summary of Substitute Bill:

Beginning January 1, 2022, a contract between a hospital or affiliate hospital and a health carrier may not, directly or indirectly:

- set provider compensation agreements or other terms for nonparticipating affiliates of the hospital;
- require a health carrier to contract with the hospital's affiliates;
- require health carriers to place a hospital or affiliate in an enrollee cost-sharing tier that reflects the lowest or lower enrollee cost-sharing amounts; or
- require health carriers to keep the contracts payment rates confidential from any existing or potential payor that is or may become financially responsible for the payments, though these communications may be subject to a reasonable nondisclosure agreement.

The restriction on prohibiting a contract from requiring a health carrier to contract with one or more of the hospital's affiliates does not prohibit a provision requiring the health carrier to contract with the medical groups that the hospital's medical staff is affiliated or from the health carrier voluntarily agreeing to contract with affiliates. If the health carrier voluntarily agrees to contract with hospital affiliates, the health carrier must file an attestation with the Office of the Insurance Commissioner 30 days before the contract is used.

The prohibitions against these contractual requirements between a health carrier and hospital do not apply to the extent that the prohibitions impair the ability of a hospital, provider, or health carrier to participate in a state-sponsored, federally funded program, or grant opportunity.

Beginning January 1, 2022, health provider contracts between a health carrier and a provider may not contain a provision that prohibits disclosure of health care service claims data to employers providing the coverage. Any disclosure of claims data must comply with state and federal privacy laws.

Contracts that violate these provisions are an unfair or deceptive act in trade or commerce and an unfair method of competition for purposes of the Consumer Protection Act. The Insurance Commissioner is authorized to adopt rules necessary to implement the act.

"Provider compensation agreement" is defined as 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. "Affiliate" is a person who directly or indirectly through intermediaries, controls or is controlled by, or is under common control with, another specified person. "Control" is defined as 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.

"Provider" means:

- a health care provider that is regulated under Title 18 or by in-home care agencies to practice health or health-related services and the employees or agents of a health care provider;
- a participating provider, who is a provider, who has contracted in writing with a health care service contractor to accept payment from and to look solely to such contractor according to the terms of the subscriber contract for any health care services rendered to a person who has previously paid, or on whose behalf prepayment has been made, to such contractor for such services;
- a hospital, hospice, rural health care facility, psychiatric hospital, nursing home, community mental health center, kidney disease treatment center, ambulatory diagnostic, treatment, or surgical facilities, home health agencies, and other facilities as required by federal law; and
- intermediaries that have agreed in writing with a health carrier to provide access to

providers who render covered services to the enrollees of a health carrier.

Substitute Bill Compared to Original Bill:

The substitute bill:

- applies the protections of the Consumer Protection Act to the whole act, rather than to only the prohibition on a health provider contract from preventing disclosure of health care services claims data to employers providing the coverage;
- authorizes the Insurance Commissioner to adopt rules necessary to implement the act;
- provides that the prohibitions against certain contractual requirements between a health carrier and hospital do not apply to the extent that the prohibitions impair the ability of a hospital, provider, or health carrier to participate in a state-sponsored, federally funded program, or grant opportunity;
- requires the attestation a carrier must file if it voluntarily contracts with a hospital's affiliates to be filed 30 days before use (as currently required for health carrier contracts), rather than 30 days after the contract is effective or renewed;
- makes technical and terminology changes such as replacing "shall not" with "may not" and replacing a reference to a "health insurer" with a "health carrier"; and
- defines "tiered provider network."

Appropriation: None.

Fiscal Note: Available. New fiscal note requested on February 3, 2021.

Effective Date of Substitute Bill: The bill takes effect 90 days after adjournment of the session in which the bill is passed.

Staff Summary of Public Testimony:

(In support) The text of this bill is from the Sutter settlement in California. Sutter is a hospital system in Northern California that was successfully able to drive up the cost of health care through their contracting practices, until charges were brought against them. While the sponsor did not think that these contracting methods were an issue in Washington yet, it has come to the sponsor's attention that there have been several instances of this behavior in Washington. Accordingly, this bill is very timely and can stop these contracting practices before they become widespread in Washington.

The consolidation of hospitals and hospital systems in Washington is a very important issue and is not good for consumers, costs, or quality of health care. This bill is a tool in the toolbox to extract more competitive contracts and increase affordability of healthcare. While some health plans may be concerned that the bill requires some additional administrative procedures, its benefits outweigh any additional administrative duties. There is some question as to the last section of the bill related to claims data and the plans just

want to ensure that any data shared with employers is protected.

(Opposed) The hospitals are generally supportive of the transparency provisions in this bill, but there are some concerns about section 1 (1)(a) and (b). This bill came out of a settlement in California to address a specific problem in that state and so there may be unintended consequences in applying these provisions to Washington hospitals. There is some concern that rural hospitals will not be able to contract for their provider groups in their rural communities under this bill. Additionally, there is concern that this bill may prohibit or negatively impact the Health Care Authority's primary care and value-based arrangements that are unique to Washington.

Providers have a lot of concerns about this bill, but there are also a number of questions about how common these practices are in Washington. This bill came out of a case in California where there were some pretty egregious practices. Additionally, there is already an existing mechanism to address anti-competitive practices through the Attorney General, who is not shy about pursuing anti-trust issues. The providers prefer that this bill does not move forward, but if it does, they request that the anti-competitive provisions apply both ways so that health carriers cannot require providers to contract with all of the carrier's health plans.

(Other) Health plans agree and support the intention of this bill. The contract negotiating process needs to be fair and balanced. However, there is some concern that how this bill tries to achieve this goal is a little backwards, since it regulates health plan conduct in order to prevent hospitals from doing something. Accordingly, this process needs to be deliberate and there should be careful consideration to ensure that the regulatory process does not create any unintended consequences.

Persons Testifying: (In support) Representative Cody, prime sponsor; and Sarah Kwiatkowski, Premera Blue Cross.

(Opposed) Lisa Thatcher, Washington State Hospital Association; and Sean Graham, Washington State Medical Association.

(Other) Chris Bandoli, Association of Washington Healthcare Plans.

Persons Signed In To Testify But Not Testifying: None.

HOUSE COMMITTEE ON APPROPRIATIONS

Majority Report: The second substitute bill be substituted therefor and the second substitute bill do pass and do not pass the substitute bill by Committee on Health Care & Wellness. Signed by 18 members: Representatives Ormsby, Chair; Gregerson, Vice Chair; Macri, Vice Chair; Caldier, Chopp, Cody, Dolan, Fitzgibbon, Frame, Hansen, Johnson, J., Lekanoff, Pollet, Ryu, Senn, Stonier, Sullivan and Tharinger.

Minority Report: Do not pass. Signed by 12 members: Representatives Stokesbary, Ranking Minority Member; Chambers, Assistant Ranking Minority Member; Corry, Assistant Ranking Minority Member; MacEwen, Assistant Ranking Minority Member; Boehnke, Chandler, Dye, Hoff, Jacobsen, Rude, Schmick and Steele.

Minority Report: Without recommendation. Signed by 3 members: Representatives Bergquist, Vice Chair; Harris and Springer.

Staff: Meghan Morris (786-7119).

Summary of Recommendation of Committee On Appropriations Compared to Recommendation of Committee On Health Care & Wellness:

The second substitute bill specifies that:

- only for purposes of actions brought by the Office of the Attorney General is a violation of the bill an unfair or deceptive practice in trade or commerce that is an unfair method of competition; and
- a certified critical access hospital is not prohibited from negotiating on behalf of a provider or medical group affiliated with the hospital.

Appropriation: None.

Fiscal Note: Preliminary fiscal note available.

Effective Date of Second Substitute Bill: The bill takes effect 90 days after adjournment of the session in which the bill is passed.

Staff Summary of Public Testimony:

(In support) The intent of the bill is to make sure consumers do not pay increased rates secondary to mergers and acquisitions. This bill addresses unfair contracting practices between hospitals and health insurers. The fiscal note identifies the need for new staff within the Office of the Insurance Commissioner (OIC) for contract review and rulemaking. The financial resources to support this important work come from the regulatory surcharge that health insurance companies pay and not the State General Fund.

(Opposed) This bill is based solely on a legal settlement in Northern California. There is no documentation of the issues identified in the California case happening in Washington. There are concerns about the unintended consequences of this bill as it directs the conditions of business-to-business negotiations between private parties. Hospitals merge for financial reasons when one system can no longer remain independent. Tipping the balance of commercial market negotiations towards health carriers does not lead to more financial stability for hospitals or lower overall costs. The financial viability of hospitals is a real concern during the COVID-19 pandemic, especially when hospitals are underpaid by

Medicare and Medicaid. This bill allows insurers to choose which hospital affiliate they want to contract with, potentially leading to less integrated care with more balanced billing and out-of-network costs.

The biggest issue of this bill is the current financial status of physician organizations and the contracting dynamics between physician practices and health carriers. Many physician groups are struggling through the COVID-19 pandemic as they experience decreased patient volumes and revenue. Many are reducing hours and physician compensation or implementing furloughs and layoffs. The recovery of physician groups has been uneven as smaller independent groups lag. This bill increases pressure on these smaller groups, potentially leading to more consolidations. The timing is also difficult with other recently passed legislation, primarily the balanced billing prohibition that shifted more contracting leverage to health carriers. This will shift even more leverage towards health carriers when many physicians are struggling to secure reasonable contract terms. This bill runs in one direction by imposing restrictions on providers.

Persons Testifying: (In support) Representative Cody, prime sponsor; and Sarah Kwiatkowski, Premera Blue Cross.

(Opposed) Lisa Thatcher, Washington State Hospital Association; and Sean Graham, Washington State Medical Association.

Persons Signed In To Testify But Not Testifying: None.