Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Health Care & Wellness Committee

HB 1741

Brief Description: Addressing affordability through health care provider contracting.

Sponsors: Representatives Cody, Macri, Bateman, Chopp, Tharinger, Pollet, Riccelli and Harris-Talley.

Brief Summary of Bill

- Prohibits the use of certain contractual provisions in contracts between health carriers and hospitals or hospital affiliates.
- Authorizes the Insurance Commissioner (Commissioner) to consider affordability when approving provider compensation agreements and establishes standards the Commissioner must consider when determining affordability.

Hearing Date:

Staff: Kim Weidenaar (786-7120).

Background:

Provider Contracts and Provider Compensation Agreements.
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 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

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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.

Critical Access Hospitals.
There are 39 hospitals in Washington that are federally certified by the Centers for Medicare or Medicaid Services as Critical Access Hospitals. These are hospitals with 25 beds or less that are generally located in rural areas. The Critical Access Hospital program allows hospitals under Washington's medical assistance programs to receive payment for hospital services based on allowable costs and to have more flexibility in staffing.

Sole Community Hospitals.
Sole Community Hospital is a federal hospital classification for hospitals that meet certain criteria based on location, size, or distance, such as being located a certain distance from other hospitals or being located in areas with severe weather so as to make other like hospitals inaccessible for prolonged periods.

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.

Health Care Cost Transparency Board.
The Health Care Cost Transparency Board (Transparency Board) was established in 2020 to calculate and analyze information and trends related to health care costs in Washington. The Transparency Board's activities relate to annually calculating total health care expenditures. The Transparency Board must also annually calculate health care cost growth and establish the health care cost growth benchmark for increases in total health expenditures.

Summary of Bill:

Prohibited provider contract provisions.
For 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 or indirectly, include

the following provisions:

- an all-or-nothing clause, which is a provision that requires a health carrier to contract with multiple hospitals owned or controlled by the same single entity;
- an anti-steering clause, which is a provision 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;
- an anti-tiering clause, which is a provision 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; or
- any clause that sets provider compensation agreements or other terms for affiliates of the hospital that have not contracted with a carrier or a carrier's contractor or subcontractor to provide health care services to an enrollee.

The prohibition on the use of an all-or-nothing clause does not prohibit a health carrier from voluntarily agreeing to contract with other hospitals owned or controlled by the same single entity. If the health carrier voluntarily agrees, the health carrier must file an attestation with the Office of the Insurance Commissioner 30 days before the contract is used.

The prohibitions on the use of an all-or-nothing clause and the use of clauses that set provider compensation agreements or other terms for affiliates that have not contracted with the carrier do not apply to the limited extent that the prohibitions impair the ability of a hospital, provider, or health carrier to participate in a state-sponsored or federally funded health care program or state or federal grant opportunity.

A certified critical access hospital or an independent certified sole community hospital is not prohibited from negotiating payment rates and methodologies on behalf of an individual health care practitioner or medical group that the hospital is affiliated with.

The Attorney General is authorized to enforce these provisions under the Consumer Protection Act (CPA). For purposes of CPA actions that are brought by the Attorney General, contracts that violate these provisions are considered an unfair or deceptive act in trade or commerce and an unfair method of competition.

Definitions.
A "provider compensation agreement" is 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. A "provider contract" is a written contract between a carrier and a provider for any health care services rendered to an enrollee. "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. "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.

For purposes of these requirements, "provider" means:

- a health care provider that is regulated under Title 18 RCW 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, drug and alcohol treatment 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.

Affordability Standards.
When determining whether to approve, disapprove, or take any other authorized action with respect to provider compensation agreements (agreements), the Insurance Commissioner (Commissioner) may consider whether the agreements are affordable and whether the health carrier has implemented effective strategies to enhance the affordability of its health plans. When determining whether an agreement is affordable, the Commissioner must consider whether the agreement:

- protects the public interest and the interests of consumers;
- encourages the fair treatment of providers;
- considers the health care system as a comprehensive entity;
- advances the welfare of the public through overall efficiency, affordability, improved health care quality, and appropriate access; and
- meets or aims to meet the Health Care Cost Transparency Board's Health Care Cost Growth Benchmarks.

The Commissioner is authorized to adopt rules necessary to implement the prohibitions on the use of certain provider contract provisions and the use of affordability standards.

Appropriation: None.

Fiscal Note: Requested on January 4, 2022.

Effective Date: This bill takes effect 90 days after adjournment of the session in which the bill is passed, except for sections 3 and 4, relating to the affordability standards, which take effect January 1, 2024.