HOUSE BILL REPORT
HB 1741

As Reported by House Committee On:
Health Care & Wellness

Title: An act relating to addressing affordability through health care provider contracting.

Brief Description: Addressing affordability through health care provider contracting.

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

Brief History:
Committee Activity:
Health Care & Wellness: 1/12/22, 1/26/22 [DPS].

Brief Summary of Substitute Bill

- Prohibits the use of certain contractual provisions in contracts between health carriers and hospitals or hospital affiliates.
- Requires the Insurance Commissioner to study regulatory approaches used by other states' insurance regulators to address affordability of health plan rates.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 9 members: Representatives Cody, Chair; Bateman, Vice Chair; Bronoske, Davis, Macri, Riccelli, Simmons, Stonier and Tharinger.

Minority Report: Do not pass. Signed by 6 members: Representatives Schmick, Ranking Minority Member; Caldier, Assistant Ranking Minority Member; Harris, Maycumber, Rude and Ybarra.

Staff: Kim Weidenaar (786-7120).

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.

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 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.

Summary of Substitute 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, 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 will not be included as participating providers in the agreement.

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 prevent a hospital, provider, or health carrier from participating in:

- a state-sponsored or federally funded health care program or state or federal grant opportunity; or
- a value-based purchasing arrangement structured to reduce unnecessary utilization, improve health outcomes, and contain health care costs.

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. "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.

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 Study.
The Insurance Commissioner (Commissioner) must 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, and must include, for each state reported on:

- the statutory and regulatory authority for the state's affordability activities;
- description of the activities and processes developed by the state; and
- any available research or other findings related to the impact or outcomes of the state's affordability activities.

The Commissioner must submit a report and any recommendations to the relevant policy and fiscal committees of the legislature by December 1, 2022.

The Commissioner is authorized to adopt rules necessary to implement the act.

Substitute Bill Compared to Original Bill:

The substitute bill:

- removes provisions authorizing the Insurance Commissioner (Commissioner) to consider affordability when approving provider compensation agreements;
- requires the Commissioner to study regulatory approaches used by other states to address affordability of health plan rates;
- modifies the prohibition on including a clause in a provider contract that sets terms for hospital affiliates that have not contracted with the carrier or carrier's subcontractor to instead apply to hospital affiliates that will not be included as participating providers in the agreement;
- modifies the exemption from the prohibition on the use of all-or-nothing clauses and setting terms for nonparticipating providers so that the prohibitions must prevent a hospital, provider, or health carrier from participating, rather than impair the ability, and adds a new provision including value-based purchasing arrangements that are structured to reduce unnecessary utilization, improve health outcomes, and contain health care costs;
- specifies that the bill applies to private health plans;
- removes the provision prohibiting contracts from indirectly including the prohibited provisions;
- modifies intent language to reflect changes to the bill; and
- defines "affiliate."

Appropriation: None.

Fiscal Note: Preliminary fiscal note available.

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) This bill may look familiar; it is a continuation of House Bill 1160, which passed out of committee last year. Through the past year, the National Academy for State Health Policy (commonly known as NASHP) completed a model bill on the Sutter settlement, and this bill incorporates a lot of their language. The whole reason for the bill is to hold down the cost of health care.

Contracting between hospitals and insurance carriers has been unregulated for too long and consumers have paid the price. As hospitals merge and increase market power, hospitals are able to set prices to maximize profits and are not based on actual costs. This leads to higher prices and wild price variation. The pandemic has further concentrated wealth among large hospital systems through federal aid.

This bill brings transparency and guard rails to an otherwise opaque contracting system.

Increasing transparency and regulating provider contracting will advance equity, improve health outcomes, and make care more affordable and accessible to Washingtonians.

Washington has some of the strongest network adequacy rules in the nation and affordability and network access can sometimes be at odds. Prohibiting or limiting the use of the contractual provisions targeted in the bill can prevent providers from taking advantage of these requirements. There should be some limited exemptions for value-based purchasing. The affordability standards need to be more concrete, which would streamline the review and provide more clarity for carriers.

(Opposed) The provider contracting provisions shift leverage away from providers and towards carriers. While these dynamics are fluid, the physicians are not advantaged in these negotiations and carriers do not need the help that is proposed in this bill.

Providers were encouraged to integrate in the Affordable Care Act. This bill allows carriers to game the negotiation process. Physicians sometimes leave an area because reimbursement is too low, and this bill does not distinguish between situations in which carriers have the market power. If we had no other tools to use against providers with market power, this bill might be necessary, but we have state and federal antitrust laws, which is the better approach and has been used in other states.

One of Washington's stated goals is to shift the health care system from volume to value. This bill negatively impacts the ability of health care systems to achieve this goal and the triple aim. Adjusting this bill to exclude risk contracts, contracts in which the provider has significant responsibilities for health outcomes, would significantly address these concerns. Hospitals merge because of economic instability, and mergers have allowed these previously unsustainable hospitals to remain open in their communities.

The motivation to ensure competitive markets and control costs for consumers are understood, but this bill may have unintended consequences. Where possible, hospital systems try to avoid having certain specialties in multiple hospitals for efficiency and cost savings. This bill may allow carriers to exclude hospitals, which would require hospitals to duplicate services across a hospital system to ensure patient care.

The affordability provisions grant the Insurance Commissioner (Commissioner) broad authority, which is at odds with the current role of the Commissioner in approving the contracts and is a departure from the historical role of the Office of the Insurance Commissioner (OIC). The review of compensation agreements for affordability is a drastic change and is something the OIC is specifically prohibited from doing now.

Not-for-profit health systems invest heavily in addressing health equity. The financial ecosystem for health care is fragile. Large systems are able to provide free or discounted care to larger populations. This bill does not distinguish between the size of the system, hospital, or provider. This bill may result in unintended consequences, threatening health

care for those who need it most.

Policy decisions have consequences, and this bill will have significant unintended consequences. The premise of this bill is that it would grant health carriers more leverage in contracting and reduce health care cost. However, the trend of Medicare and Medicaid payment has resulted in an increased cost in the gap between the cost of the services and what is actually reimbursed. We need to address these underlying issues, or we will limit the viability of hospitals. Most mergers occur because one of the entities is unsustainable and many hospitals in the state would not be open if they did not have an affiliation.

We know that pharmaceutical costs are the fastest growing costs and there are many other factors to the rising costs, including labor. We need to consider all of the drivers of costs to make sound policy. This bill threatens the viability of care.

(Other) A number of health plans are supportive of the underlying intent of the bill and supported it last year. This bill prohibits a few contracting provisions that the Sutter settlement deemed anticompetitive and bad for consumers. These provisions make health care more expensive and do not increase quality. Nothing in this bill modifies the carrier's responsibility to have an adequate network and the plans have no interest in putting providers out of business. There is some concern with the structure of the bill in how all-or-nothing clauses are addressed in this version. They are usually woven into the agreement, rather than a specific clause. There should also be an exception for value-based purchasing.

There are some concerns around how the affordability provisions would work. For example, it is unclear how the OIC would implement the affordability standards in a fair way. Once the contracts are filed, the amounts are already agreed upon, so if it was rejected the carrier would have to go back to the provider with something they may not accept.

There are questions as to the intent to cover fully capitated dental plans.

Persons Testifying: (In support) Representative Eileen Cody, prime sponsor; Sam Hatzenbeler, Economic Opportunity Institute; and Jane Beyer, Office of the Insurance Commissioner.

(Opposed) Sean Graham, Washington State Medical Association; Doug Ross; Bill Robertson, MultiCare Health System; Jacqueline Cabe, UW Medicine; Sean Gregory, PeaceHealth; Peter Rutherford, Confluence Health; and Chelene Whiteaker, Washington State Hospital Association.

(Other) Melissa Johnson, Willamette Dental Group; Chris Bandoli, Association of Washington Healthcare Plans; and Gary Strannigan, Premera Blue Cross.

Persons Signed In To Testify But Not Testifying: None.