HOUSE BILL REPORT
HB 1889

As Reported by House Committee On:
Health Care & Wellness

Title: An act relating to network access.

Brief Description: Concerning network access.

Sponsors: Representatives Cody, Schmick, Tharinger, Riccelli and Macri.

Brief History:
Committee Activity:
Health Care & Wellness: 1/24/22, 1/31/22 [DP].

Brief Summary of Bill

- Changes requirements relating to provider networks for health benefit plans.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: Do pass. Signed by 13 members: Representatives Cody, Chair; Bateman, Vice Chair; Schmick, Ranking Minority Member; Caldier, Assistant Ranking Minority Member; Bronoske, Davis, Macri, Maycumber, Riccelli, Rude, Simmons, Stonier and Tharinger.

Minority Report: Without recommendation. Signed by 2 members: Representatives Harris and Ybarra.

Staff: Jim Morishima (786-7191).

Background:

A health carrier is required by federal and state law to maintain adequate provider

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networks. Under network access rules adopted by the Insurance Commissioner (Commissioner), such networks must be sufficient in numbers and types of providers and facilities to assure to the extent feasible that all covered services are accessible in a timely manner appropriate for an enrollee's condition. For each service area, the health carrier must demonstrate that a comprehensive range of services are readily available without unreasonable delay to all enrollees and that emergency services are continuously available without unreasonable delay.

Insurance Commissioner Review of Provider Networks.

A health carrier's networks are subject to approval by the Commissioner. A health carrier must submit documentation of its provider networks to the Commissioner when (or before) it files a newly offered health plan. The Commissioner evaluates the adequacy of filed provider networks using a variety of factors, including the location of participating providers and facilities, the location of enrollees, the number of enrollees with certain health conditions, and the availability of licensed health facilities in the service area. When evaluating a carrier's networks, the Commissioner must give due consideration to the relative availability of health providers and facilities. If the Commissioner determines that a network is inadequate, the Commissioner may permit the carrier to propose changes within 60 days.

When determining the adequacy of a proposed provider network or the ongoing adequacy of an in-force provider network, the Commissioner must consider whether the network includes a sufficient number of contracted providers of emergency and surgical or ancillary services at or for the health carrier's contracted in-network hospitals or ambulatory surgical facilities to reasonably ensure enrollees have in-network access to covered benefits delivered at that facility.

Alternate Access Delivery Systems.

A health carrier may propose an alternate access delivery system in several circumstances, including when the carrier is unable to contract with sufficient providers or facilities to meet network adequacy standards or when a provider or facility type becomes unavailable after the health carrier's network is approved. An alternate access delivery system must provide access to medically necessary care on a reasonable basis without detriment to an enrollee's health at no greater cost to the enrollee. The health carrier must show evidence of good faith efforts to contract with providers or facilities before the Commissioner may approve an alternate access delivery system.

Changes to Provider Networks.

A health carrier is required to maintain and monitor its provider networks on an ongoing basis and must report any changes affecting the network's ability to furnish covered services to enrollees. For example, a health carrier must notify the Commissioner within five

business days of receiving or issuing a written notice of potential contract termination that may affect the network's ability to meet network access standards. A change in a provider's network may, under some circumstances, trigger the need for an alternate access delivery request.

Summary of Bill:

Insurance Commissioner Review of Provider Networks.

A health carrier must file provider network materials in compliance with rules adopted by the Insurance Commissioner (Commissioner). Beginning January 1, 2023, the Commissioner must review and approve provider networks prior to use, review health carriers' provider networks submitted with health plan filings, and actively monitor carriers' provider networks throughout the plan year for compliance with network access requirements.

The Commissioner must review and enforce (instead of consider whether) network access requirements to verify the network includes a sufficient number of contracted providers of emergency and surgical or ancillary services at or for the health carrier's contracted in-network hospitals or ambulatory surgical facilities to reasonably ensure enrollees have in-network access to covered benefits delivered at that facility.

Alternate Access Delivery Systems.

Beginning January 1, 2023, when a health carrier files an alternate access delivery request, the Commissioner must review and approve or disapprove the request and actively monitor the health carrier's compliance with each approved alternate access delivery request. The health carrier must notify all providers and facilities listed in the alternate access delivery request at the time of filing. The Commissioner may take enforcement action against health carriers that are not in compliance with these requirements and other network access requirements.

Beginning November 1, 2024, the Commissioner must submit an annual report to the appropriate committees of the Legislature on the use of alternate access delivery systems. The report must analyze the use of alternate access delivery systems by specialty, provider and facility type, and geographic region.

Changes to Provider Networks.

A health carrier must maintain and monitor its provider networks on an ongoing basis for compliance with network access standards adopted by the Commissioner. Beginning January 1, 2023, prior to the termination of a contract with a health care provider, the health carrier must provide at least 120 days' notice to the Commissioner, the provider, and

enrollees.

Appropriation: None.

Fiscal Note: Preliminary fiscal note available.

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

Staff Summary of Public Testimony:

(In support) Washington is a leader in network access standards. This bill is meant to supplement the Insurance Commissioner's (Commissioner's) efforts to help address the aggressive tactics of health carriers. The passage of the Balance Billing Protection Act (BBPA) has changed the contracting landscape and enforcement must follow suit. Providers want to be in-network and are acting in good faith, but have been experiencing contract terminations and unilateral rate reductions. If providers do not accept these reductions, they are forced into arbitration, which makes the BBPA rate the default rate. This is leading to many providers and facilities to be forced out of provider networks. No notice is being provided to providers or patients. This is causing access issues for patients, who should be kept out of disagreements between providers and health carriers. This bill provides the Commissioner with additional resources and provides greater transparency. This bill will level the playing field and ensure that networks and provider contracts are scrutinized. This bill will require providers to be notified when health carriers may alternate access delivery requests (AADRs). The bill does not require contracting or payment of billed charges and does not allow providers to collude to game the system.

(Opposed) This bill erodes incentives for providers to contract with health carriers, which will increase costs to consumers. The Commissioner already has strong standards and adequate enforcement authority. The 120-day notice requirement for contract terminations will have unintended consequences. Health carriers are already required to act in good faith before proposing an AADR. Health carriers file AADRs in advance to ensure networks are in place if provider contracts are terminated—if a provider realizes they will be part of an AADR, it will make them reluctant to contract.

(Other) Washington's network access standards are among the strongest in the nation. The Commissioner engages in ongoing monitoring of provider networks and takes enforcement actions when access standards are violated. This bill may have unintended consequences and cause enrollee confusion. For example, it may require contract termination notices when a provider's contract is unlikely to be terminated. It also may require 120 days' notice when a provider's license is revoked, which may not be possible. The Commissioner is committed to network access standards and enforcement of those standards.

Persons Testifying: (In support) Erik Penner; Amy Brackenbury, Washington State Society of Anesthesiologists; David Kimberling, Washington Managed Imaging; Dominique Coco, Washington State Society of Pathologists; and Sean Graham, Washington State Medical Association.

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

(Other) Jane Beyer, Office of the Insurance Commissioner.

Persons Signed In To Testify But Not Testifying: None.