
SUBSTITUTE SENATE BILL 5393

State of Washington

68th Legislature

2023 Regular Session

By Senate Health & Long Term Care (originally sponsored by Senators Robinson, Dhingra, Hasegawa, Keiser, Randall, Valdez, and C. Wilson)

READ FIRST TIME 02/17/23.

1 AN ACT Relating to addressing affordability through health care
2 provider contracting; reenacting and amending RCW 41.05.017; adding a
3 new section to chapter 48.43 RCW; and creating new sections.

4 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

5 NEW SECTION. **Sec. 1.** (1) The legislature finds that:

6 (a) The health care system is a comprehensive and interconnected
7 entity;

8 (b) Health care costs and spending continue to rise and
9 significantly outgrow inflation and the United States gross domestic
10 product per capita;

11 (c) According to the health care cost institute, from 2015 to
12 2019 the average health care spending per person reached \$6,000, an
13 increase of 21 percent. Health care prices accounted for nearly two-
14 thirds of this increase in spending after adjusting for inflation;

15 (d) According to a Milbank memorial fund issue brief, mitigating
16 the price impacts of health care provider consolidation,
17 consolidation of health care providers into health systems with
18 market power is a primary driver of high health care prices. Further,
19 the issue brief explains, competition in the health care market
20 exists in three areas: (i) Competition between health care providers
21 for inclusion in health plan networks; (ii) competition between

1 health carriers in health plan enrollment; and (iii) competition
2 between health care providers for in-network patients;

3 (e) A 2020 report to congress on medicare payment policy from the
4 medicare payment advisory commission found "the preponderance of
5 evidence suggests that hospital consolidation leads to higher prices.
6 These findings imply that hospitals seek higher prices from insurers
7 and will get them when they have greater bargaining power." Further,
8 the report noted that "a recent study found that hospital and insurer
9 concentration both increase premiums in the affordable care act
10 marketplace"; and

11 (f) Significant vertical and horizontal consolidation has already
12 occurred in the health care market. In 2010, the five largest
13 hospital systems in Washington state had 30 hospitals, which grew to
14 49 hospitals by 2021. According to a 2020 American medical
15 association survey, nearly 40 percent of patient care physicians were
16 employed directly by a hospital or a practice owned at least
17 partially by a hospital or health system, an increase from just 23.5
18 percent in 2012. According to a 2020 study published in health
19 affairs, 72 percent of hospitals were affiliated with a hospital
20 system in 2018.

21 (2) Therefore, the legislature intends to prohibit the use of
22 certain contractual provisions often used by providers, hospitals,
23 health systems, and carriers with significant market power and to
24 direct the insurance commissioner, in collaboration with the office
25 of the attorney general, to study other states' regulatory approaches
26 to address affordability of health plan rates with the goal of
27 increasing health care competition, lowering health care prices, and
28 increasing affordability for consumers.

29 NEW SECTION. **Sec. 2.** A new section is added to chapter 48.43
30 RCW to read as follows:

31 (1) Except as provided in subsections (2), (3), and (4) of this
32 section, for health plans issued or renewed on or after January 1,
33 2024, a provider contract between a hospital or any affiliate of a
34 hospital and a health carrier may not directly include any of the
35 following provisions:

- 36 (a) An all-or-nothing clause;
- 37 (b) An antisteering clause;
- 38 (c) An antitiering clause; or

1 (d) Any clause that sets provider compensation agreements or
2 other terms for affiliates of the hospital that will not be included
3 as participating providers in the agreement.

4 (2) Subsection (1)(b) and (c) of this section apply only to
5 carrier networks in which tiering is based on quality metrics filed
6 with the office of the insurance commissioner and described in detail
7 in the provider contract.

8 (3) Subsection (1)(a) and (d) of this section do not:

9 (a) Apply to the extent that they would prevent a hospital,
10 provider, or health carrier from participating in a state-sponsored
11 health care program, federally funded health care program, or state
12 or federal grant opportunity;

13 (b) Apply to the extent that they would prevent a hospital,
14 provider, or health carrier from participating in agreements that
15 involve, in whole or in part, value-based purchasing arrangements
16 structured to reduce unnecessary utilization, improve health
17 outcomes, and contain health care costs, including any agreement that
18 involves financial risk including, but not limited to:

- 19 (i) Clinically integrated networks;
- 20 (ii) Accountable care organizations;
- 21 (iii) Managed care arrangements; or
- 22 (iv) Bundled payment arrangements;

23 (c) Apply to specialized services that are centralized in a
24 single hospital within a health system's service area;

25 (d) Allow carriers to exclude a hospital or an affiliate, or
26 specific hospital services, where 50 percent or more of total charges
27 for such hospital or affiliate, or specific hospital services, are
28 for medicaid patients, including fee for service and managed care,
29 and medicare patients, including medicare advantage, according to the
30 most recent medicare cost report or department of health year end
31 financials for that hospital or affiliate; or

32 (e) Allow carriers to refuse to credential new physicians or
33 ancillary providers, who otherwise meet all proper credentialing
34 requirements of the carrier, who become employed by a hospital,
35 physician group, or its affiliates where such hospital or physician
36 group have an existing provider compensation agreement with the
37 carrier.

38 (4) This section does not prohibit a hospital certified as a
39 critical access hospital by the centers for medicare and medicaid
40 services or an independent hospital certified as a sole community

1 hospital by the centers for medicare and medicaid services from
2 negotiating payment rates and methodologies on behalf of an
3 individual health care practitioner or a medical group that the
4 hospital is affiliated with.

5 (5) This section does not apply to independent health care
6 provider groups including, but not limited to, emergency physicians,
7 anesthesiologists, radiologists, pathologists, and hospitalists, that
8 contract with hospitals to provide facility-based services, and are
9 not otherwise affiliated with a hospital.

10 (6) For the purposes of this section:

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

14 (b) An "all-or-nothing clause" means a provision of a provider
15 contract that requires a health carrier to contract with multiple
16 hospitals or affiliates of a hospital owned or controlled by the same
17 single entity. "All-or-nothing clause" also means a provision of a
18 provider contract that requires a hospital or provider to accept
19 multiple product lines offered by a health carrier.

20 (c) "Antisteering clause" means a provision of a provider
21 contract that restricts the ability of a health carrier to encourage
22 an enrollee to obtain a health care service from a competitor of the
23 hospital or an affiliate of the hospital, including offering
24 incentives to encourage enrollees to utilize specific health care
25 providers.

26 (d) "Antitiering clause" means a provision in a provider contract
27 that requires a health carrier to place a hospital or any affiliate
28 of the hospital in a tier or a tiered provider network reflecting the
29 lowest or lower enrollee cost-sharing amounts.

30 (e) "Control" means the possession, directly, of the power to
31 direct the management and policies of a person, whether through
32 ownership of voting securities, membership rights, by contract, or
33 otherwise.

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

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

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

38 (i) "Tiered provider network" means a network that identifies and
39 groups providers and facilities into specific groups to which
40 different provider reimbursement, enrollee cost sharing, or provider

1 access requirements, or any combination thereof, apply as a means to
2 manage cost, utilization, quality, or to otherwise incentivize
3 enrollee or provider behavior.

4 **Sec. 3.** RCW 41.05.017 and 2022 c 236 s 3, 2022 c 228 s 2, and
5 2022 c 10 s 2 are each reenacted and amended to read as follows:

6 Each health plan that provides medical insurance offered under
7 this chapter, including plans created by insuring entities, plans not
8 subject to the provisions of Title 48 RCW, and plans created under
9 RCW 41.05.140, are subject to the provisions of RCW 48.43.500,
10 70.02.045, 48.43.505 through 48.43.535, 48.43.537, 48.43.545,
11 48.43.550, 70.02.110, 70.02.900, 48.43.190, 48.43.083, 48.43.0128,
12 48.43.780, 48.43.435, 48.43.815, section 2 of this act, and chapter
13 48.49 RCW.

14 NEW SECTION. **Sec. 4.** The insurance commissioner may adopt rules
15 necessary to implement this act.

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