S-0584.1

SENATE BILL 5393

State of Washington 68th Legislature 2023 Regular Session

By Senators Robinson, Dhingra, Hasegawa, Keiser, Randall, Valdez, and C. Wilson

Read first time 01/16/23. Referred to Committee on Health & Long Term Care.

AN ACT Relating to addressing affordability through health care provider contracting; reenacting and amending RCW 41.05.017; adding new sections to chapter 48.43 RCW; creating new sections; and providing an expiration date.

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

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

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

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

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

(d) According to a Milbank memorial fund issue brief, mitigating the price impacts of health care provider consolidation, consolidation of health care providers into health systems with market power is a primary driver of high health care prices. Further, the issue brief explains, competition in the health care market exists in three areas: (i) Competition between health care providers

for inclusion in health plan networks; (ii) competition between health carriers in health plan enrollment; and (iii) competition between health care providers for in-network patients;

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

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

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

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

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

(a) An all-or-nothing clause;

(b) An antisteering clause;

(c) An antitiering clause; or

(d) 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.

(2) Subsection (1)(a) of this section does not prohibit a health carrier from voluntarily agreeing to contract with other hospitals owned or controlled by the same single entity, including for a comprehensive population-based payment agreement meeting the criteria of category 4B or higher as set forth in the health care payment learning and action network alternative payment model framework, as it existed on January 1, 2023. If a health carrier voluntarily agrees to contract with other hospitals owned or controlled by the same single entity under subsection (1)(a) of this section, the health carrier must file a declaration with the office of the insurance commissioner that complies with the filing requirements of RCW 48.43.730.

(3) Subsection (1)(a) and (d) of this section do not apply to the limited extent that it would prevent a hospital, provider, or health carrier from participating in:

(a) A state-sponsored health care program, federally funded health care program, or state or federal grant opportunity; or

(b) A value-based purchasing arrangement structured to reduce unnecessary utilization, improve health outcomes, and contain health care costs.

(4) This section does not prohibit a hospital certified as a critical access hospital by the centers for medicare and medicaid services or an independent hospital certified as a sole community hospital by the centers for medicare and medicaid services from negotiating payment rates and methodologies on behalf of an individual health care practitioner or a medical group that the hospital is affiliated with.

(5) A health plan contract between a health carrier and a hospital, physician or physician group, or ancillary provider may not include a clause requiring the health carrier to reimburse a hospital, physician or physician group, or ancillary provider at the acquiror's contract rate when acquired, directly or indirectly, by an acquiror or when the hospital, physician or physician group, or ancillary provider enters into a management, comanagement, professional services, leasing, joint venture, or similar agreement or arrangement with an acquiror. In the event such an event occurs, the acquiror shall notify the health carrier 90 days in advance, or

as soon as reasonably possible of any such acquisition or arrangement.

(6) For health plans issued or renewed on or after January 1, 2024, a contract between a health carrier and a hospital or any affiliate of a hospital shall include an attestation signed by the carrier and the hospital or any affiliate of the hospital, attesting that the contract negotiations did not include discussion of or agreement to any of the contract provisions prohibited under this section.

(7) For the purposes of this section:

(a) "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.

(b) An "all-or-nothing clause" means a provision of a provider contract that requires a health carrier to contract with multiple hospitals or affiliates of a hospital owned or controlled by the same single entity.

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

(d) "Antitiering clause" means a provision in a provider contract 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.

(e) "Control" means 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.

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

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

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

(i) "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.

NEW SECTION. **Sec. 3.** A new section is added to chapter 48.43 RCW to read as follows:

The provisions of section 2 of this act apply to a self-funded group health plan governed by the provisions of the federal employee retirement income security act of 1974 (29 U.S.C. Sec. 1001 et seq.) only if the self-funded group health plan elects to participate in the provisions of section 2 of this act through actions including, but not limited to, direction to any entity administering their group health plan. To elect to participate in these provisions, the self-funded group health plan may provide notice to the commissioner in a manner prescribed by the commissioner, attesting to the plan's participation in section 2 of this act.

NEW SECTION. **Sec. 4.** A new section is added to chapter 48.43 RCW to read as follows:

(1) The insurance commissioner, in collaboration with the office of the attorney general, shall study regulatory approaches used by other states to address affordability of health plan rates and the impact of anticompetitive behaviors on health care affordability. The study should focus on approaches outside of the traditional health plan rate review such as that required by the affordable care act, and shall include, for each state reported on:

(a) The statutory and regulatory authority for the state's affordability activities;

(b) A description of the activities and processes developed by the state; and

(c) Any available research or other findings related to the impact or outcomes of the state's affordability activities.

(2) The insurance commissioner may contract with a third party to conduct all or any portion of the study.

(3) The insurance commissioner and the office of the attorney general shall submit a report and any recommendations to the relevant policy and fiscal committees of the legislature by December 1, 2023.

(4) This section expires July 1, 2024.

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

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

NEW SECTION. **Sec. 6.** The insurance commissioner may adopt rules necessary to implement this act.

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