H-1788.1

SECOND SUBSTITUTE HOUSE BILL 1589

State of Washington 69th Legislature 2025 Regular Session

By House Appropriations (originally sponsored by Representatives Bronoske, Macri, Shavers, Pollet, and Reed)

READ FIRST TIME 02/28/25.

AN ACT Relating to the relationships between health carriers and contracting providers; amending RCW 48.49.135; adding new sections to chapter 48.43 RCW; creating new sections; prescribing penalties; providing an effective date; and providing an expiration date.

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

Sec. 1. RCW 48.49.135 and 2022 c 263 s 18 are each amended to read as follows:

(1) When determining the adequacy of a proposed provider network or the ongoing adequacy of an in-force provider network, the commissioner must review the carrier's proposed provider network or in-force provider network to determine whether the network includes a sufficient number of contracted providers of emergency medicine, anesthesiology, pathology, radiology, neonatology, surgery, hospitalist, intensivist((~~,~~)), and diagnostic services, including radiology and laboratory services at or for the 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.

(2)(a) When determining the adequacy of a proposed provider network or the ongoing adequacy of an in-force provider network, the commissioner may allow a carrier to submit an alternate access

delivery request. The commissioner shall define the circumstances under which a carrier may submit an alternate access delivery request and the requirements for submission and approval of such a request in rule. To submit an alternate access delivery request, a carrier shall:

(i) Ensure that enrollees will not bear any greater cost of receiving services under the alternate access delivery request than if the provider or facility was contracted with the carrier or make other arrangements acceptable to the commissioner;

(ii) Provide substantial evidence of good faith efforts on its part to contract with providers or facilities. If a carrier is submitting an alternate access delivery request for the same service and geographic area as a previously approved request, the carrier shall provide new or additional evidence of good faith efforts to contract associated with the current request;

(iii) Demonstrate that there is not an available provider or facility with which the carrier can contract to meet the commissioner's provider network standards; and

(iv) For services for which balance billing is prohibited under RCW 48.49.020, notify out-of-network providers or facilities that deliver the services referenced in the alternate access delivery request within five days of submitting the request to the commissioner. Any notification provided under this subsection shall include contact information for carrier staff who can provide detailed information to the affected provider or facility regarding the submitted alternate access delivery request.

(b) For services for which balance billing is prohibited under RCW 48.49.020, a carrier may not treat its payment of nonparticipating providers or facilities under this chapter or P.L. 116-260 (enacted December 27, 2020) as a means to satisfy network access standards established by the commissioner unless all requirements of this subsection are met.

(i) If a carrier is unable to obtain a contract with a provider or facility delivering services addressed in an alternate access delivery request to meet network access requirements, the carrier may ask the commissioner to amend the alternate access delivery request if the carrier's communication to the commissioner occurs at least three months after the effective date of the alternate access delivery request and demonstrates substantial evidence of good faith efforts on its part to contract for delivery of services during that

three-month time period. If the carrier has demonstrated substantial evidence of good faith efforts on its part to contract, the commissioner shall allow a carrier to use the dispute resolution process provided in RCW 48.49.040 to determine the amount that will be paid to providers or facilities for services referenced in the alternate access delivery request. The commissioner may determine by rule the associated processes for use of the dispute resolution process under this subsection.

(ii) Once notification is provided by the carrier to a provider or facility under (a) of this subsection, a carrier is not responsible for reimbursing a provider's or facility's charges in excess of the amount charged by the provider or facility for the same or similar service at the time the notification was provided. The provider or facility shall accept this reimbursement as payment in full.

(3) When determining the adequacy of a carrier's proposed provider network or the ongoing adequacy of an in-force provider network, beginning January 1, 2023, the commissioner shall require that the carrier's proposed provider network or in-force provider network include a sufficient number of contracted behavioral health emergency services providers.

(4) When determining the ongoing adequacy of an in-force provider network, the commissioner shall determine whether providers included in a carrier's network are actually providing services to the carrier's enrollees. For purposes of implementing this subsection, the commissioner shall adopt, by rule, a uniform data request form and may adopt additional requirements consistent with this subsection. When adopting the form, the commissioner shall consider the model data request form developed by the Bowman family foundation's mental health treatment and research institute. The commissioner shall publish, on the commissioner's website, the results of evaluations conducted under this subsection.

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

(1)(a) Prior to entering into or renewing a contract with a health care provider, a health carrier shall offer the provider a meaningful opportunity to negotiate the terms of the contract. Any negotiations conducted under this subsection must be in good faith. The following conduct violates this subsection:

(i) Failure to furnish the provider with the name and contact information of a person the carrier has designated as the primary contact for contract negotiations;

(ii) When a contract is being renewed, failure to furnish the provider with a copy of the new contract with all changes indicated with strikeouts for deletions and underlining for new material along with a clean copy of the revised contract that incorporates amendments into the body of the contract and into any relevant exhibit or addendum;

(iii) Providing a standalone amendatory exhibit or addendum that requires the provider to conduct the provider's own analysis to produce a revised contract or agreement integrating amendments into the body of the contract or its relevant exhibits or addenda;

(iv) Refusal to negotiate with:

(A) Providers with separate type 1 national provider identifiers issued by the centers for medicare and medicaid services who are part of the same group practice; or

(B) A group of providers who are employed or affiliated with an organization that has a type 2 national provider identifier issued by the centers for medicare and medicaid services;

(v) Failure to furnish the provider with a fee schedule no less than 60 days in advance of the execution of the contract in a manner that does not require access to a secure website or other portal, such as by mailing a hard copy to the provider or by emailing an electronic copy to the provider; or

(vi) Any other conduct determined, in rules adopted by the commissioner, to violate this subsection.

(b) A health carrier's provider contract filings must include an attestation signed by both the health carrier and the provider that the requirements of (a) of this subsection were met. A contract filing is incomplete without the attestation required under this subsection and may not be approved by the commissioner. The commissioner shall, by rule, develop a standard form for the attestation required under this subsection.

(c) A health carrier shall annually report to the commissioner the number of provider negotiations that failed to result in the attestation required under (b) of this subsection.

(2) Provider contracts entered into or renewed on or after the effective date of this section may not include:

(a) An all-or-nothing clause; or

(b) A requirement that the provider accept a discounted rate for services provided to enrollees under any other health plan or insurance product.

(3) A health carrier shall provide contract and payment policy updates in a manner that does not require access to a secure website or other portal, such as by mailing a hard copy to the provider or by emailing an electronic copy to the provider.

(4) A health carrier may not penalize a provider who appeals an adverse benefit determination by the health carrier in any way, including by charging a fee for the appeal or any external review of the appeal.

(5) This section applies to a health care benefit manager acting on behalf of the carrier.

(6) If the commissioner finds that a health carrier or a health care benefit manager has violated this section, the commissioner may, in addition to the commissioner's authority under RCW 48.02.080 and 48.200.050:

(a) Impose a fine on the health carrier or health care benefit manager of up to $5,000 per violation;

(b) Issue an order requiring corrective action against the health carrier, the health care benefit manager, or both the health carrier and the health care benefit manager; or

(c) Both impose a fine and issue an order under (a) and (b) of this subsection.

(7) For purposes of this section:

(a) "Affiliate of a health carrier" means any provider related to a health carrier or hospital in any way by virtue of any form or amount of common control, operation, or management.

(b) "All-or-nothing clause" means a provision in a provider contract that requires a provider to contract with multiple health plans or other insurance products offered by, or associated with, the health carrier.

(c) "Health care benefit manager" has the same meaning as provided in RCW 48.200.020.

(d) In addition to the definition in RCW 48.43.005, "health carrier" also includes a limited health care service contractor offering dental only coverage and a health carrier offering dental only coverage.

(8) Any trade secrets or other confidential information disclosed to the commissioner under this section are confidential and exempt from public disclosure under chapter 42.56 RCW.

(9) This section does not apply to negotiations between a health carrier and a provider who is:

(a) An employee of the health carrier;

(b) An employee of an affiliate of the health carrier;

(c) Employed by a hospital or any affiliate of a hospital or health system; or

(d) Employed by an entity that owns or operates multistate provider clinics.

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

(1) Using data from the statewide all-payer health care claims database established under chapter 43.371 RCW, the commissioner shall analyze trends in allowed amounts for a representative sample of the most commonly billed current procedural terminology codes for a representative sample of the health professions impacted by this act.

(2) The commissioner shall report the results of this analysis to the health care committees of the legislature on January 1st of each year, beginning January 1, 2027. The report must include an analysis of allowed amounts compared to data in previous years' reports submitted under this section.

(3) This section expires January 31, 2031.

NEW SECTION. **Sec. 4.** The insurance commissioner may adopt any rules necessary to implement this act consistent with RCW 48.02.060.

NEW SECTION. **Sec. 5.** Sections 1 and 2 of this act take effect January 1, 2027.

NEW SECTION. **Sec. 6.** If specific funding for the purposes of this act, referencing this act by bill or chapter number, is not provided by June 30, 2025, in the omnibus appropriations act, this act is null and void.

--- END ---