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Chapter 284-170 WAC

HEALTH BENEFIT PLAN MANAGEMENT

SUBCHAPTER A

GENERAL PROVISIONS

WAC 284-170-130 Definitions. Except as defined in other subchapters and unless the context requires otherwise, the following definitions shall apply throughout this chapter.

(1) "Adverse determination" has the same meaning as the definition of adverse benefit determination in RCW 48.43.005, and includes:

(a) The determination includes any decision by a health carrier's designee utilization review organization that a

request for a benefit under the health carrier's health benefit plan does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part for the benefit;

(b) The denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit based on a determination by a health carrier or its designee utilization review organization of a covered person's eligibility to participate in the health carrier's health benefit plan;

(c) Any prospective review or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment in whole or in part for a benefit;

(d) A rescission of coverage determination; or

(e) A carrier's denial of an application for coverage.

(2) "Allowed amount" has the meaning set forth in RCW 48.43.005.

(3)(a) "Audio-only telemedicine" means the delivery of health care services through the use of audio-only technology, permitting real-time communication between the patient at the originating site and the provider, for the purpose of diagnosis, consultation, or treatment.

(b) "Audio-only telemedicine" does not include:

(i) The use of facsimile, email, or text messages, unless the use of text-like messaging is necessary to ensure effective communication with individuals who have a hearing, speech, or other disability; or

(ii) The delivery of health care services that are customarily delivered by audio-only technology and customarily not billed as separate services by the provider, such as the sharing of laboratory results.

(4) "Authorization" or "certification" means a determination by the carrier that an admission, extension of stay, or other health care service has been reviewed and, based

on the information provided, meets the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness in relation to the applicable health plan.

(5) "Clinical review criteria" means the written screens, or screening procedures, decision rules, medical protocols, or clinical practice guidelines used by the carrier as an element in the evaluation of medical necessity and appropriateness of requested admissions, procedures, and services, including prescription drug benefits, under the auspices of the applicable health plan. Clinical approval criteria has the same meaning as clinical review criteria.

(6) "Covered health condition" means any disease, illness, injury or condition of health risk covered according to the terms of any health plan.

(7) "Covered person" or "enrollee" means an individual covered by a health plan including a subscriber, policyholder, or beneficiary of a group plan.

(8) "Disciplining authority" has the meaning set forth in RCW 18.130.020.

(9) "Distant site" has the meaning set forth in RCW 48.43.735.

(10) "Emergency medical condition" has the meaning set forth in RCW 48.43.005.

(11) "Emergency services" has the meaning set forth in RCW 48.43.005.

(12) "Enrollee point-of-service cost-sharing" or "cost-sharing" has the meaning set forth in RCW 48.43.005.

(13) "Established relationship" means the provider providing audio-only telemedicine has access to sufficient health records to ensure safe, effective, and appropriate care services and:

(a) The covered person has had, within the past three years, at least one in-person appointment, or at least one real-time interactive appointment using both audio and video technology, with:

(i) The provider providing audio-only telemedicine;

(ii) A provider employed at the same medical group, at the same clinic, or by the same integrated delivery system operated

by a carrier licensed under chapter 48.44 or 48.46 RCW as the provider providing audio-only telemedicine; or

(iii) A locum tenens or other provider who is the designated back up or substitute provider for the provider providing audio-only telemedicine who is on leave and is not associated with an established medical group, clinic, or integrated delivery system operated by a carrier licensed under chapter 48.44 or 48.46 RCW; or

(b) The covered person was referred to the provider providing audio-only telemedicine by another provider who has:

(i) Had, within the past three years, at least one in-person appointment, or at least one real-time interactive appointment using both audio and video technology, with the covered person; and

(ii) Provided relevant medical information to the provider providing audio-only telemedicine.

(iii) A referral includes circumstances in which the provider who has had at least one in-person appointment, or at least one real-time interactive appointment using both audio and

video technology, with the covered person participates in the audio-only telemedicine encounter with the provider to whom the covered person has been referred.

(14) "Expedited prior authorization request" has the meaning set forth in RCW 48.43.830.

(15) "Facility" means an institution providing health care services including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory, and imaging centers, and rehabilitation and other therapeutic settings, and as defined in RCW 48.43.005.

(16) "Formulary" means a listing of drugs used within a health plan.

(17) "Grievance" has the meaning set forth in RCW 48.43.005.

(18) "Health care provider" or "provider" means:

(a) A person regulated under Title 18 RCW or chapter 70.127 RCW, to practice health or health-related services or otherwise

practicing health care services in this state consistent with state law; or

(b) An employee or agent of a person described in (a) of this subsection, acting in the course and scope of his or her employment.

(19) "Health care service" or "health service" means that service offered or provided by health care facilities and health care providers relating to the prevention, cure, or treatment of illness, injury, or disease.

(20) "Health carrier" or "carrier" has the meaning as defined in RCW 48.43.005. ~~means a disability insurance company regulated under chapter 48.20 or 48.21 RCW, a health care service contractor as defined in RCW 48.44.010, and a health maintenance organization as defined in RCW 48.46.020, and includes "issuers" as that term is used in The Patient Protection and Affordable Care Act (P.L. 111-148, as amended (2010)).~~

(21) "Health plan" or "plan" means any individual or group policy, contract, or agreement offered by a health carrier to

provide, arrange, reimburse, or pay for health care service except the following:

(a) Long-term care insurance governed by chapter 48.84 RCW;

(b) Medicare supplemental health insurance governed by chapter 48.66 RCW;

(c) Limited health care service offered by limited health care service contractors in accordance with RCW 48.44.035;

(d) Disability income;

(e) Coverage incidental to a property/casualty liability insurance policy such as automobile personal injury protection coverage and homeowner guest medical;

(f) Workers' compensation coverage;

(g) Accident only coverage;

(h) Specified disease and hospital confinement indemnity when marketed solely as a supplement to a health plan;

(i) Employer-sponsored self-funded health plans;

(j) Dental only and vision only coverage; and

(k) Plans deemed by the insurance commissioner to have a short-term limited purpose or duration, or to be a student-only plan that is guaranteed renewable while the covered person is enrolled as a regular full-time undergraduate or graduate student at an accredited higher education institution, after a written request for such classification by the carrier and subsequent written approval by the insurance commissioner.

(22) "Hospital" has the meaning set forth in RCW 48.43.735.

(23) "Indian health care provider" means:

(a) The Indian Health Service, an agency operated by the U.S. Department of Health and Human Services established by the Indian Health Care Improvement Act, Section 601, 25 U.S.C. Sec. 1661;

(b) An Indian tribe, as defined in the Indian Health Care Improvement Act, Section 4(14), 25 U.S.C. Sec. 1603(14), that operates a health program under a contract or compact to carry out programs of the Indian Health Service pursuant to the Indian Self-Determination and Education Assistance Act (ISDEAA), 25 U.S.C. Sec. 450 et seq.;

(c) A tribal organization, as defined in the Indian Health Care Improvement Act, Section 4(26), 25 U.S.C. Sec. 1603(26), that operates a health program under a contract or compact to carry out programs of the Indian Health Service pursuant to the ISDEAA, 25 U.S.C. Sec. 450 et seq.;

(d) An Indian tribe, as defined in the Indian Health Care Improvement Act, Section 4(14), 25 U.S.C. Sec. 1603(14), or tribal organization, as defined in the Indian Health Care Improvement Act, Section 4(26), 25 U.S.C. Sec. 1603(26), that operates a health program with funding provided in whole or part pursuant to 25 U.S.C. Sec. 47 (commonly known as the Buy Indian Act); or

(e) An urban Indian organization that operates a health program with funds in whole or part provided by Indian Health Service under a grant or contract awarded pursuant to Title V of the Indian Health Care Improvement Act, Section 4(29), 25 U.S.C. Sec. 1603(29).

(24) "Managed care plan" means a health plan that coordinates the provision of covered health care services to a

covered person through the use of a primary care provider and a network.

(25) "Medically necessary" or "medical necessity" in regard to mental health services and pharmacy services is a carrier determination as to whether a health service is a covered benefit because the service is consistent with generally recognized standards within a relevant health profession.

(26) "Mental health provider" means a health care provider or a health care facility authorized by state law to provide mental health services.

(27) "Mental health services" means in-patient or out-patient treatment including, but not limited to, partial hospitalization, residential treatment, out-patient facility-based treatment, intensive outpatient treatment, emergency services, or prescription drugs to manage, stabilize, or ameliorate the effects of a mental disorder listed in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric

Association, including diagnoses and treatment for substance use disorder.

(28) "Network" means the group of participating providers and facilities providing health care services to a particular health plan or line of business (individual, small, or large group). A health plan network for issuers offering more than one health plan may be smaller in number than the total number of participating providers and facilities for all plans offered by the carrier.

(29) "Originating site" means the physical location of a patient receiving health care services through telemedicine, and includes those sites described in WAC 284-170-433.

(30) "Out-patient therapeutic visit" or "out-patient visit" means a clinical treatment session with a mental health provider of a duration consistent with relevant professional standards used by the carrier to determine medical necessity for the particular service being rendered, as defined in Physicians Current Procedural Terminology, published by the American Medical Association.

(31) "Participating provider" and "participating facility" mean a facility or provider who, under a contract with the health carrier or with the carrier's contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, from the health carrier rather than from the covered person.

(32) "Patient consent" means a voluntary and informed decision by a patient, following an explanation by the provider or auxiliary personnel under the general supervision of the provider presented in a manner understandable to the patient that is free of undue influence, fraud or duress, to consent to a provider billing the patient or the patient's health plan for an audio-only telemedicine service under RCW 48.43.735 or WAC 284-170-433.

(33) "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing.

(34) "Pharmacy services" means the practice of pharmacy as defined in chapter 18.64 RCW and includes any drugs or devices as defined in chapter 18.64 RCW.

(35) "Primary care provider" means a participating provider who supervises, coordinates, or provides initial care or continuing care to a covered person, and who may be required by the health carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person.

(36) "Preexisting condition" means any medical condition, illness, or injury that existed any time prior to the effective date of coverage.

(37) "Premium" means all sums charged, received, or deposited by a health carrier as consideration for a health plan or the continuance of a health plan. Any assessment or any "membership," "policy," "contract," "service," or similar fee or charge made by a health carrier in consideration for a health plan is deemed part of the premium. "Premium" shall not include amounts paid as enrollee point-of-service cost-sharing.

(38) "Real time communication" means synchronous and live communication between a provider and a patient. It does not include delayed or recorded messages, such as email, facsimile or voicemail.

(39) "Same amount of compensation" means providers are reimbursed by a carrier using the same allowed amount for telemedicine services as they would if the service had been provided in-person unless negotiation has been undertaken under RCW 48.43.735 or WAC 284-170-433. Where consumer cost-sharing applies to telemedicine services, the consumer's payment combined with the carrier's payment must be the same amount of compensation, or allowed amount, as the carrier would pay the provider if the telemedicine service had been provided in person. Where an alternative payment methodology other than fee-for-service payment would apply to an in-person service, "same amount of compensation" means providers are reimbursed by a carrier using the same alternative payment methodology that would be used for the same service if provided in-person, unless

negotiation has been undertaken under RCW 48.43.735 or WAC 284-170-433.

(40) "Service area" means the geographic area or areas where a specific product is issued, accepts members or enrollees, and covers provided services. A service area must be defined by the county or counties included unless, for good cause, the commissioner permits limitation of a service area by zip code. Good cause includes geographic barriers within a service area, or other conditions that make offering coverage throughout an entire county unreasonable.

(41) "Small group plan" means a health plan issued to a small employer as defined under RCW 48.43.005 comprising from one to 50 eligible employees.

(42) "Standard prior authorization request" has the meaning set forth in RCW 48.43.830.

(43) "Store and forward technology" has the meaning set forth in RCW 48.43.735.

(44) "Substance use disorder services" means in-patient or out-patient treatment including, but not limited to, partial

hospitalization, residential treatment, or out-patient facility-based treatment, intensive outpatient treatment, emergency services, or prescription drugs to manage, stabilize, or ameliorate the effects of a substance use disorder listed in the most current version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) published by the American Psychiatric Association, including diagnoses and treatment for substance use disorder.

(45) "Substitute drug" means a prescription medication, drug or therapy that a carrier covers based on an exception request. When the exception request is based on therapeutic equivalence, a substitute drug means a therapeutically equivalent substance as defined in chapter 69.41 RCW.

(46) "Supplementary pharmacy services" or "other pharmacy services" means pharmacy services involving the provision of drug therapy management and other services not required under state and federal law but that may be rendered in connection with dispensing, or that may be used in disease prevention or disease management.

(47) "Telemedicine" means the delivery of health care services through the use of interactive audio and video technology or audio-only technology, permitting real-time communication between the patient at the originating site and the provider, for the purpose of diagnosis, consultation, or treatment. For purposes of this chapter, "telemedicine" does not include facsimile, email, or text messaging, unless the use of text-like messaging is necessary to ensure effective communication with individuals who have a hearing, speech, or other disability.

[Statutory Authority: RCW 48.02.060, 48.43.0961, 2023 c 325, 48.43.735, 2024 c 215, 48.43.047, 2024 c 314, and 89 F.R. 37522. WSR 24-24-067 (Matter R 2024-05), s 284-170-130, filed 11/27/24, effective 12/28/24. Statutory Authority: RCW 48.02.060, 48.43.735, 48.44.050, 48.46.200, 48.200.040, and 48.200.900. WSR 23-24-034 (Matter R 2023-07), § 284-170-130, filed 11/30/23, effective 1/1/24. Statutory Authority: RCW 48.02.060 and 48.43.735. WSR 22-22-104 (Matter R 2022-03), § 284-170-130, filed 11/2/22, effective 12/3/22. Statutory Authority: RCW 48.43.735(9). WSR 21-24-029, § 284-170-130, filed 11/22/21, effective 12/23/21. Statutory Authority: RCW 48.02.060 and 48.43.765. WSR 21-01-094 (Matter No. R 2019-05), § 284-170-130,

filed 12/11/20, effective 1/11/21. Statutory Authority: RCW 48.02.060. WSR 16-07-144 (Matter No. R 2016-01), § 284-170-130, filed 3/23/16, effective 4/23/16.]

NEW SECTION

WAC 284-170-131 Definitions applicable to RCW 48.43.732.

The following definitions apply only to RCW 48.43.732 and WAC 284-170-441, 445, and 447.

(1) "Cause to be made" means initiating, arranging, or directing another entity to make a public statement defined in this section.

(2) "Control" including the terms "controlled by" and "common control" means the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of a health care provider or health care facility, such as through ownership of voting securities, membership rights, or by contract.

(3) "Health care provider" and "health care facility" have the same meaning as defined in RCW 48.43.005.

(4) "Notices" mean letters or other written notifications sent directly to enrollees, by physical mail or electronically, including communicating through enrollees' electronic health records or portals, regarding expiring or terminating provider contracts described in RCW 48.43.732 and this section.

(5) "Otherwise affiliated with" or "affiliated with" means:

(a) A health care provider that directly, indirectly, or through one or more intermediaries, is controlled by or is under common control or ownership with a facility; or

(b) A health care provider that operates all or a substantial part of the health care services or property of a facility under a lease, management, or operating agreement.

(6) "Provider contract" has the same meaning as defined in RCW 48.43.732.

(7) "Public statement" means written or verbal communication, whether made electronically, orally, or through physical documents, by health care providers, health care

facilities, carriers, or health care providers employed by, contracted with, or otherwise affiliated with a health care facility to health plan enrollees, patients, or the general public. "Public statement" includes, but is not limited to, notices, press releases, opinion articles such as op-eds, webpages, emails, social media posts, letters, communication through electronic health records, and individual verbal, written or electronic communications.

(8) "Specific legal obligation" and "legal obligation" means a statutory, regulatory, judicial, or other legal requirement obligating a carrier, health care provider, or health care facility to take a specific action.

SUBCHAPTER B

HEALTH CARE NETWORKS

WAC 284-170-360 Enrollee's access to providers. (1) Each issuer must allow an enrollee to choose a primary care provider who is accepting new patients from a list of participating providers.

(a) Enrollees also must be permitted to change primary care providers at any time with the change becoming effective not later than the beginning of the month following the enrollee's request for the change.

(b) The issuer must ensure at all times that there are a sufficient number of primary care providers in the service area accepting new patients to accommodate new enrollees if the plan is open to new enrollment, and to ensure that existing enrollees have the ability to change primary care providers.

(2) Each issuer must allow an enrolled child direct access to a pediatrician from a list of participating pediatricians within their network who are accepting new patients.

(a) Enrollees must be permitted to change pediatricians at any time, with the change becoming effective not later than the

beginning of the month following the enrollee's request for the change.

(b) Each issuer must ensure at all times that there are a sufficient number of pediatricians in the service area accepting new patients to accommodate new enrollees if the plan is open to new enrollment, and to ensure that existing enrolled children have the ability to change pediatricians.

(3) Each issuer must have a process whereby an enrollee with a complex or serious medical condition or mental health or substance use disorder, including behavioral health condition, may receive a standing referral to a participating specialist for an extended period of time. The standing referral must be consistent with the enrollee's medical or mental health needs and plan benefits. For example, a one-month standing referral would not satisfy this requirement when the expected course of treatment was indefinite. However, a referral does not preclude issuer performance of utilization review functions.

(4) Each issuer must provide enrollees with direct access to the participating chiropractor of the enrollee's choice for

covered chiropractic health care without the necessity of prior referral. Nothing in this subsection prevents issuers from restricting enrollees to seeing only chiropractors who have signed participating provider agreements or from utilizing other managed care and cost containment techniques and processes such as prior authorization for services. For purposes of this subsection, "covered chiropractic health care" means covered benefits and limitations related to chiropractic health services as stated in the plan's medical coverage agreement, with the exception of any provisions related to prior referral for services.

(5) Each issuer must provide, upon the request of an enrollee, access by the enrollee to a second opinion regarding any medical diagnosis or treatment plan from a qualified participating provider of the enrollee's choice. The issuer may not impose any charge or cost upon the enrollee for such second opinion other than the charge or cost imposed for the same service in otherwise similar circumstances.

~~(6) Each issuer must cover services of a primary care provider whose contract with the plan or whose contract with a subcontractor is being terminated by the plan or subcontractor without cause under the terms of that contract:~~

~~(a) For at least sixty days following notice of termination to the enrollees; or~~

~~(b) In group coverage arrangements involving periods of open enrollment, only until the end of the next open enrollment period.~~

~~(i) Notice to enrollees must include information of the enrollee's right of access to the terminating provider for an additional sixty days.~~

~~(ii) The provider's relationship with the issuer or subcontractor must be continued on the same terms and conditions as those of the contract the plan or subcontractor is terminating, except for any provision requiring that the issuer assign new enrollees to the terminated provider.~~

~~(7) Each issuer must make a good faith effort to assure that written notice of a termination is provided at least thirty days prior to the effective date of the termination to all enrollees who are patients seen on a regular basis by the provider or facility whose contract is terminating, irrespective of whether the termination was for cause or without cause. When a termination for cause provides less than thirty days notice to the carrier or provider, an issuer must make a good faith effort to assure that written notice of termination is provided immediately to all enrollees.~~

[Statutory Authority: RCW 48.02.060. WSR 16-07-144 (Matter No. R 2016-01), recodified as § 284-170-360, filed 3/23/16, effective 4/23/16. WSR 16-01-074, recodified as § 284-43-9983, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.43.055, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.43.730, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.200. WSR 16-01-074 (Matter No. R 2014-08), § 284-43-251, filed 12/14/15, effective 1/14/16. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010,

48.44.050, 48.46.100, 48.46.200, 48.43.505, 48.43.510, 48.43.515, 48.43.520, 48.43.525, 48.43.530, 48.43.535. WSR 01-03-033 (Matter No. R 2000-02), § 284-43-251, filed 1/9/01, effective 7/1/01.]

NEW SECTION

WAC 284-170-365 Continuity of care protections. (1) Each issuer must cover services of a primary care provider whose contract with the plan or whose contract with a subcontractor is being terminated by the plan or subcontractor without cause under the terms of that contract:

(a) For at least sixty days following notice of termination to the enrollees; or

(b) In group coverage arrangements involving periods of open enrollment, only until the end of the next open enrollment period.

(i) Notice to enrollees must include information of the enrollee's right of access to the terminating provider for an additional sixty days.

(ii) The provider's relationship with the issuer or subcontractor must be continued on the same terms and conditions as those of the contract the plan or subcontractor is terminating, except for any provision requiring that the issuer assign new enrollees to the terminated provider.

(2) Each issuer must provide continuity of care services beginning on the date of contract termination to enrollees pursuant to section 133 of the no surprises act (42 U.S.C. 300gg-113) and any implementing federal regulations.

SUBCHAPTER C

PROVIDER CONTRACTS AND PAYMENT

WAC 284-170-421 Provider contracts—Standards—Hold harmless provisions. The execution of a contract by an issuer does not relieve the issuer of its obligations to any enrollee for the provision of health care services, nor of its responsibility for compliance with statutes or regulations. In addition to the contract form filing requirements of this subchapter, all individual provider and facility contracts must

be in writing and available for review upon request by the commissioner.

(1) An issuer must establish a mechanism by which its participating providers and facilities can obtain timely information on patient eligibility for health care services and health plan benefits, including any limitations or conditions on services or benefits.

(2) Nothing contained in a participating provider or a participating facility contract may have the effect of modifying benefits, terms, or conditions contained in the health plan. In the event of any conflict between the contract and a health plan, the benefits, terms, and conditions of the health plan must govern with respect to coverage provided to enrollees.

(3) Each participating provider and participating facility contract must contain the following provisions:

"(a) {Name of provider or facility} hereby agrees that in no event, including, but not limited to nonpayment by {name of issuer}, {name of issuer's} insolvency, or breach of this contract will {name of provider or facility} bill, charge,

collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against an enrollee or person acting on their behalf, other than {name of issuer}, for services provided pursuant to this contract. This provision does not prohibit collection of {deductibles, copayments, coinsurance, and/or payment for noncovered services}, which have not otherwise been paid by a primary or secondary issuer in accordance with regulatory standards for coordination of benefits, from enrollees in accordance with the terms of the enrollee's health plan.

(b) {Name of provider or facility} agrees, in the event of {name of issuer's} insolvency, to continue to provide the services promised in this contract to enrollees of {name of issuer} for the duration of the period for which premiums on behalf of the enrollee were paid to {Name of issuer} or until the enrollee's discharge from inpatient facilities, whichever time is greater.

(c) Notwithstanding any other provision of this contract, nothing in this contract shall be construed to modify the rights and benefits contained in the enrollee's health plan.

(d) {Name of provider or facility} may not bill the enrollee for covered services (except for deductibles, copayments, or coinsurance) where {name of issuer} denies payments because the provider or facility has failed to comply with the terms or conditions of this contract.

(e) {Name of provider or facility} further agrees (i) that the provisions of (a), (b), (c), and (d) of this subsection shall survive termination of this contract regardless of the cause giving rise to termination and shall be construed to be for the benefit of {name of issuer's} enrollees, and (ii) that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between {name of provider or facility} and enrollees or persons acting on their behalf.

(f) If {name of provider or facility} contracts with other providers or facilities who agree to provide covered services to enrollees of {name of issuer} with the expectation of receiving

payment directly or indirectly from {name of issuer}, such providers or facilities must agree to abide by the provisions of (a), (b), (c), (d), and (e) of this subsection.

(4) Beginning January 1, 2027, each provider contract, as defined in RCW 48.43.732, must contain a provision entitled "ENROLLEE/PATIENT NOTICE REQUIREMENTS FOR EXPIRING OR TERMINATING CONTRACTS." This provision must be placed in the provisions of the provider contract addressing contract expirations or terminations. This provision must include the following language:

(a){Name of provider or facility and name of carrier} agree to follow all applicable requirements of RCW 48.43.732 and corresponding regulations at WAC 284-170-441, 445, and 447.

(b) If this provider contract expires by its own terms or one party gives notice to the other party of an intended termination without cause in accordance with the terms of this provider contract, {Name of provider or facility and Name of carrier} may not make or cause to be made public statements

regarding such expiration or termination until forty five days prior to the termination date of the provider contract.

(c) All notices sent to enrollees and patients under this contract termination provision must either:

(i) Solely utilize the standard template language posted on the website of the office of the insurance commissioner under WAC 284-170-445, with no modifications to the text of the template other than to insert the specific information requested in the bracketed sections of the template. Notices complying with this subsection may be sent to enrollees and patients without the commissioner's review or prior approval; or

(ii) Receive the commissioner's prior approval if the notice does not solely utilize the template language. Notices described in this subsection must be reviewed and approved by the commissioner prior to being used.

(iii) {Name of provider or facility and name of carrier} may send enrollees and patients the notices described in this subsection electronically rather than by physical mail if the

enrollee or patient has consented to receive electronic communications.

(e) {Name of carrier} acknowledges that, for violations of RCW 48.43.732 and WAC 284-170-441 and 445 by carriers, the commissioner may pursue enforcement actions under RCW 48.02.080 or impose a civil monetary penalty upon carriers of up to $100 per non-complaint notice, per day, per enrollee to whom the notice has been sent in advance of the 45-day period established under WAC 284-170-441.

(f) {Name of provider or facility} acknowledges that, for potential violations of RCW 48.43.732 and WAC 284-170-441 and 445 by health care providers and health care facilities (as those terms are defined in RCW 48.43.005), if the commissioner has cause to believe that any health care provider or health care facility has violated the requirements of RCW 48.43.732 or WAC 284-170-441 or 445, the commissioner may submit information

to the department of health or the appropriate health care facility or provider licensing or disciplining entity.

(5) A provider contract cannot, by its terms or other provisions, waive or include language that is inconsistent with the prohibited conduct and requirements set forth in RCW 48.43.732.

(64) The contract must inform participating providers and facilities that willfully collecting or attempting to collect an amount from an enrollee knowing that collection to be in violation of the participating provider or facility contract constitutes a class C felony under RCW 48.80.030(5).

(75) An issuer must notify participating providers and facilities of their responsibilities with respect to the health issuer's applicable administrative policies and programs, including but not limited to payment terms, utilization review, quality assessment and improvement programs, credentialing, grievance, appeal and adverse benefit determination procedures, data reporting requirements, pharmacy benefit substitution

processes, confidentiality requirements and any applicable federal or state requirements.

(8~~6~~) An issuer must make all documents, procedures, and other administrative policies and programs referenced in the contract available for review by the provider or facility prior to contracting. An issuer may comply with this subsection by providing electronic access.

(a) Participating providers and facilities must be given reasonable notice of not less than sixty days of changes that affect provider or facility compensation or that affect health care service delivery unless changes to federal or state law or regulations make such advance notice impossible, in which case notice must be provided as soon as possible.

(b)(i) Subject to any termination and continuity of care provisions of the contract, a provider or facility may terminate the contract without penalty if the provider or facility does not agree with the changes, subject to the requirements in subsection (9) of this section.

(ii) A material amendment to a contract may be rejected by a provider or facility. The rejection will not affect the terms of the existing contract. A material amendment has the same meaning as in RCW 48.39.005.

(c) No change to the contract may be made retroactive without the express written consent of the provider or facility.

(d) An issuer must give a provider or facility full access to the coverage and service terms of the applicable health plan for an enrolled patient.

(9~~7~~) Each participating provider and participating facility contract must contain the following provisions:

(a) "No health carrier subject to the jurisdiction of the state of Washington may in any way preclude or discourage their providers from informing patients of the care they require, including various treatment options, and whether in their view such care is consistent with medical necessity, medical appropriateness, or otherwise covered by the patient's service agreement with the health carrier. No health carrier may prohibit, discourage, or penalize a provider otherwise

practicing in compliance with the law from advocating on behalf of a patient with a health carrier. Nothing in this section shall be construed to authorize providers to bind health carriers to pay for any service."

(b) "No health carrier may preclude or discourage patients or those paying for their coverage from discussing the comparative merits of different health carriers with their providers. This prohibition specifically includes prohibiting or limiting providers participating in those discussions even if critical of a carrier."

(10~~8~~) Subject to applicable state and federal laws related to the confidentiality of medical or health records, an issuer must require participating providers and facilities to make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating complaints, grievances, appeals, or review of any adverse benefit determinations of enrollees. An issuer must require providers and facilities to cooperate with audit reviews

of encounter data in relation to the administration of health plan risk adjustment and reinsurance programs.

(11~~9~~) An issuer and participating provider and facility must provide at least sixty days' written notice to each other before terminating the contract without cause.

(12~~10~~) Whether the termination was for cause, or without cause, the issuer must make a good faith effort to ensure written notice of a termination is provided at least thirty days prior to the effective date of the termination or immediately for a termination for cause that results in less than thirty days notice to a provider or carrier to all enrollees who are patients seen:

(a) On a regular basis by a specialist;

(b) By a provider for whom they have a standing referral; or

(c) By a primary care provider.

(13~~1~~) An issuer is responsible for ensuring that participating providers and facilities furnish covered services to each enrollee without regard to the enrollee's enrollment in

the plan as a private purchaser of the plan or as a participant in publicly financed programs of health care services. This requirement does not apply to circumstances when the provider should not render services due to limitations arising from lack of training, experience, skill, or licensing restrictions.

(1412) An issuer must not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the issuer that jeopardizes patient health or welfare or that may violate state or federal law.

(1513) Every participating provider contract must contain procedures for the fair resolution of disputes arising out of the contract.

(1614) Participating provider and facility contracts entered into prior to the effective date of these rules must be amended upon renewal to comply with these rules, and all such contracts must conform to these provisions no later than July 1, 2016. The commissioner may extend the July 1, 2016, deadline for an issuer for an additional one year, if the issuer makes a written request. That request must explain how a good faith

effort at compliance has been made, provide the specific reasons the deadline cannot be met, and state the date the issuer expects to be in compliance (no more than one year beyond July 1, 2016).

[Statutory Authority: RCW 48.02.060. WSR 16-07-144 (Matter No. R 2016-01), recodified as § 284-170-421, filed 3/23/16, effective 4/23/16. WSR 16-01-074, recodified as § 284-43-9992, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.43.055, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.43.730, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.200. WSR 16-01-074 (Matter No. R 2014-08), § 284-43-320, filed 12/14/15, effective 1/14/16. Statutory Authority: RCW 48.02.060, 48.30.010, 48.43.055, 48.44.050, 48.44.070, 48.46.030, 48.46.200 and 48.46.243. WSR 99-21-016 (Matter No. R 98-21), § 284-43-320, filed 10/11/99, effective 11/11/99. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. WSR 98-04-005 (Matter No. R 97-3), § 284-43-320, filed 1/22/98, effective 2/22/98.]

NEW SECTION

WAC 284-170-441 Public statements regarding contract terminations. In the case of a provider contract defined in RCW 48.43.732 that is expiring by its own terms or for which one party has given notice to the other party of an intended termination without cause in accordance with the terms of the provider contract, issuers, health care providers and health care facilities, and health care providers employed by, contracted with or otherwise affiliated with a health care facility may not make or cause to be made public statements regarding such expiration or termination until forty five days prior to the termination date of the provider contract.

NEW SECTION

WAC 284-170-443 Provider contract terminations - Notice requirements - General standards

(1) This section applies to any contract termination other than those under RCW 48.43.732.

(2) Each issuer must make a good faith effort to assure that notice of a termination is provided at least thirty days prior to the effective date of the termination to all enrollees who are patients seen on a regular basis by the provider or facility whose contract is terminating, irrespective of whether the termination was for cause or without cause.

(3) When a termination provides less than thirty days notice to the carrier or provider, an issuer must make a good faith effort to assure that written notice of termination is provided immediately to all enrollees.

NEW SECTION

WAC 284-170-445 Provider contract terminations under RCW 48.43.732 – Notice requirements

(1) This section applies to provider contracts that are expiring by their own terms or for which one party has given notice to the other party of an intended termination without cause as provided in RCW 48.43.732.

(2) By December 1, 2025, the commissioner shall develop and publish standard enrollee/patient notice templates. The standard enrollee/patient notice templates will be posted on the public website of the office of the insurance commissioner by December 1, 2025. The commissioner may modify the templates periodically, as determined necessary.

(a) Beginning January 1, 2026, all notices sent to enrollees and patients under this section must either:

(i) Solely utilize the standard template language posted on the website of the office of the insurance commissioner under this section, with no modifications to the text of the template other than to insert the specific information required in the bracketed sections of the template. Notices complying with this subsection may be sent to enrollees and patients without the commissioner's review or prior approval; or

(ii) For notices that do not solely utilize the standard template as described in this section, receive the commissioner's prior approval before the notices are sent to enrollees. In determining whether to approve or deny proposed

notices, the commissioner may consider, but is not limited to consideration of: whether the notices contain the minimum information required by RCW 48.43.732(4); whether the notices clearly inform the enrollee of their options and rights to access health care services; whether the notices are generally consistent with the standard template language under this section; and whether the notices make any statements related to the intent or conduct of the other party to the contract dispute.

(b) The commissioner shall develop a process by which issuers, health care providers, and facilities may submit proposed notices to the commissioner under the circumstances described in subsection 2(a)(ii) of this section. Instructions for this process will be posted on the website of the office of the insurance commissioner on or before January 1, 2026.

(3) Issuers, health care providers, and health care facilities may send enrollees and patients the notices described in this section electronically rather than by physical mail if

the enrollee or patient has consented to receive electronic communications.

NEW SECTION

WAC 284-170-447 Enforcement – Public statements and notices regarding contract terminations.

(1) For violations of RCW 48.43.732 and WAC 284-170-421(4)-(5), 441 and 445 by carriers, the commissioner may pursue enforcement actions under RCW 48.02.080 or impose a civil monetary penalty upon carriers of up to $100 per non-complaint notice, per day, per enrollee to whom the notice has been sent in advance of the 45-day period established under RCW 48.43.732 and WAC 284-170-441.

(2) For potential violations of RCW 48.43.732 and WAC 284-170-421(4)-(5), 441 and 445 by health care providers and health care facilities, if the commissioner has cause to believe that any health care provider or health care facility is in

violation, the commissioner may submit information to the department of health or the appropriate health care facility or provider licensing or disciplining entity.

(3) During the period of July 27, 2025 to December 31, 2025, the commissioner will provide informational notices to carriers and health care providers and facilities if the commissioner finds there has been a violation of RCW 48.43.732. Any informational notices issued by the commissioner during this period will be public records and may be subject to disclosure.