OFFICE of the INSURANCE COMMISSIONER
WASHINGTON STATE

Patty Kuderer - Insurance commissioner

As required by

The Washington State Administrative Procedures Act

Chapter 34.05 RCW

Matter No. **R 2025-10**

CONCISE EXPLANATORY STATEMENT; RESPONSIVENESS SUMMARY; RULE DEVELOPMENT PROCESS; AND IMPLEMENTATION PLAN

Relating to the adoption of

Implementation of SSB 5579

December 23, 2025

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Section 1: Introduction

Revised Code of Washington (RCW) 34.05.325(6) requires the Office of the Insurance Commissioner (OIC) to prepare a "concise explanatory statement" (CES) prior to filing a rule for permanent adoption. The CES shall:

1. Identify the Commissioner's reason's for adopting the rule;
2. Describe differences between the proposed rule and the final rule (other than editing changes) and the reasons for the differences; and
3. Summarize and respond to all comments received regarding the proposed rule during the official public comment period, indicating whether or not the comment resulted in a change to the final rule, or the Commissioner's reasoning in not incorporating the change requested by the comment; and
4. Be distributed to all persons who commented on the rule during the official public comment period and to any person who requests it.

Section 2: Reasons for Adopting the Rule

This CR-103 (referred to in this CES as "final rule") implements SSB 5579 (codified at RCW 48.43.732). This law regulates public statements by health carriers and certain health care facilities and providers regarding potential contract expirations and terminations. The final rule ensures that interested organizations understand their rights and obligations under the new law.

Section 3: Rule Development Process

The Commissioner filed the CR-101 for this rulemaking with the Washington State Register on July 22, 2025 (WSR 25-15-141). The comment period for the CR-101 began on July 22, 2025 and closed on August 22, 2025. The OIC received three comment letters on the CR-101.

The Commissioner released a prepublication draft on September 24, 2025. The comment period for this draft opened on September 24, 2025 and closed on October 3, 2025. The OIC received four comment letters on the prepublication draft.

The Commissioner held a public interested parties meeting regarding the first prepublication draft on October 1, 2025, in which 16 individuals participated.

The Commissioner filed the CR-102 (referred to in this CES as the "proposed rule") on November 1, 2025 (WSR 25-22-098). The comment period for the CR-102 began on November 4, 2025, and closed on December 10, 2025. The OIC received five comment letters on the CR-102.

The OIC held a public hearing on the proposed rule text on December 9, 2025. The hearing was administered by Nico Janssen, Senior Policy Analyst, as a virtual meeting. Testimony was presented by:

- Delana Avery, North Olympic Healthcare Network

OIC filed the final rule (CR-103) with the Code Reviser on December 23, 2025, and the rule will become effective on January 23, 2026.

Section 4: Differences Between Proposed and Final Rule

OIC made the following technical changes to the final rule:

1. WAC 284-170-441(2) of the final rule clarifies that the section (regarding public statement restrictions) does not apply to terminations that are:

   (a) For cause;

   (b) Due to the death of a provider;

   (c) Due to the permanent closure of the health care facility or the practice of a health care provider;

   (d) Due to the retirement of a health care provider.

2. WAC 284-170-131(7) of the final rule defines "public statement" to include communication "made accessible to the public." The proposed rule defined public statement to include communication made "to…the general public."

3. WAC 284-170-131(7) includes a new sentence stating: ""Public statement" does not include communications that are internally shared within a carrier, health care facility or health care provider organization solely for business planning purposes."

These changes are technical and clarifying in nature and are not substantially different than the proposed rule. They carry out the underlying statute (RCW 48.43.732) and clarify OIC's intent in the proposed rule.

Section 5: Responsiveness Summary

The OIC received a total of 12 comments regarding R 2025-10, inclusive of the CR-101, prepublication draft, and CR-102. The following section of this CES summarizes the comments by topic and/or WAC section. It then provides the Commissioner's responses to the comments and whether changes were made in the rule language at any point in the rulemaking process.

The OIC received comments from:

- Washington state Hospital Association
- Association of Washington Healthcare Plans
- Providence Health & Services
- Premera Blue Cross
- Cambia Health Solutions
- MultiCare

Comment	Response
General	
Several commentors said they support the statutory goals of SSB 5579, including transparency regarding contract terminations and ensuring timely, accurate notices to enrollees. One commentor requested that OIC ensure that the final rule align with federal and state requirements governing timing, notice standards, and continuity of care protections. One commentor thanked OIC for its work on the rule, stating that the proposed rule and prepublication draft align reasonably well to the language of SSB 5579 and its legislative intent; however, this commentor requested several specific changes.	OIC appreciates these comments. OIC addresses these commentors' specific requests in the following sections of this responsiveness summary.
Applicability of SSB 5579 to Medicare Advantage	
A commentor voiced concern with the effect of SSB 5579 on Medicare Advantage patients whose provider may be leaving a Medicare Advantage insurer's network. Specifically, the commentor stated that SSB 5579 is preventing a health care facility from informing their Medicare Advantage patients of an upcoming contract	The federal statute governing Medicare Advantage includes a broad preemption clause (42 C.F.R. § 422.402). This clause preempts state laws related to Medicare Advantage plans "other than State licensing laws of State laws relating to plan solvency)…" Accordingly, carriers, health care facilities, and health care providers *are not subject* to SSB 5579's

termination during open enrollment. The commentor feels this restriction will harm patients because they will enroll in a health plan that will not contract with their provider after the termination date of the contract.	public statement restrictions or notice requirements related to Medicare Advantage enrollees or patients. OIC did not make a change in the final rule language as the result of this comment. OIC determined that such change was not necessary, as federal Medicare Advantage preemption of state laws is clear and longstanding. In addition, OIC will make this exemption clear in giving affected entities instructions for submitting notices under RCW 48.43.732.
Contract terminations – exempt circumstances	
Two commentors requested that the final rule exempt circumstances where a provider relationship ends outside of a contractual termination event, in particular, death of a provider, permanent practice closure, and retirement. The commentors stated that these situations do not follow standard contracting timelines, and carriers must often notify members immediately once the information becomes available. Applying the full requirements of SSB 5579 to these scenarios would delay member communication and would not align with the purpose of the statute.	OIC made a technical change in the final rule adopting the commenters' request. Specifically, WAC 284-170-441(2) clarifies that the section does not apply to terminations that are: (c) For cause; (d) Due to the death of a provider; (c) Due to the permanent closure of the health care facility or the practice of a health care provider; or (d) Due to the retirement of a health care provider. This change aligns with the intent of the Legislature in enacting RCW 48.43.732, which relates to contracts that are expiring or are being terminated by a provider without cause. The death or retirement of a provider or permanent closure of a health care facility or practice are in essence a termination for cause.

A commentor requested clarification of the scope of "public statement," stating the proposed rule's definition creates uncertainty about whether carriers may be held responsible for statements issued by providers, health systems, or unaffiliated entities regarding the status of ongoing negotiations or potential terminations. The commentor requested confirmation that only communications issued directly by the carrier fall within the definition of a public statement under this rule.	OIC did not make the requested change. First, the statute and final rule clearly delineate between violations by carriers versus violations by health care facilities and health care providers. An example of this delineation is the separate enforcement authority and process for carrier violations versus facility/provider violations in RCW 48.43.732(6). OIC will refer potential violations of RCW 48.43.732 by health care facilities and providers to the Department of Health or the appropriate health professional licensing or disciplining authority. Second, to the commentor's concern that the proposed rule could hold carriers responsible for violations by "unaffiliated entities," OIC notes that RCW 48.43.732(1) requires that carriers/facilities/providers not "make *or cause to be made* public statements…until 45 days prior to the termination date…" (emphasis added). In the proposed and final rule, OIC defines the statutory phrase "cause to be made" to mean "initiating, arranging, or directing another entity to make a public statement defined in this section." (WAC 284-170-131(1)). Consistent with the Legislature's intentional use of the phrase "cause to be made," the final rule clarifies that if a carrier/facility/provider *causes a public statement to be made*, and that statement is ultimately made by an entity other than the carrier, the action may still constitute a violation on the part of the carrier. Regarding enforcement, OIC would look

	to the parties involved and case-specific facts.
Two commentors requested that the proposed rule's definitions of "notice" and "public statement" be modified to allow hospitals, providers, and carriers to have follow-up conversations with patients/enrollees for care planning and care changes because of an expected contract termination.	OIC did not make this change in the final rule. OIC assumes the commentors are referring to "follow up" or "subsequent" care planning conversations that occur *45 days or less* before the date of contract termination or expiration. In this case, a care planning conversation would be permitted under RCW 48.43.732 even if it included disclosure of a potential contract termination/expiration. In this case, the only restriction on this type of care planning conversation would be if the conversation met the definition of a "notice" in the final rule, in which case it would still be permitted but would need to use OIC's standard template or receive OIC's prior approval. For reference, the final rule defines "notices" to 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." (WAC 284-170-131(4)). Hence, verbal care planning conversations would be fully permitted in this specific circumstance. Alternatively, if the commentor means care planning conversations that occur *more than 45 days* before the date of a contract termination/expiration and disclose such termination/expiration, the statute and final rule inherently prohibit

	those conversations as a "public statement" made more than 45 days before the contract termination/expiration date. These conversations, even if verbal or one-on-one, may lead to an individual patient/enrollee sharing the potential contract termination dates and information characterizing the negotiations to the public or to other enrollees, which would run counter to the Legislature's intent for a "quiet period" more than 45 days before a potential contract termination date.
Multiple commentors asked that the definition of "general public" be narrowed. One commentor asked that the definition be limited to communications targeted to groups of patients, health plan members and the population at large, not internal leaders, vendors, employer benefit managers, insurance brokers, nor other stakeholders. The commentor voiced concern that the proposed rule's definition would allow broad interpretation, causing confusion with implementation. A separate commentor similarly asked that carrier communications to insurance producers be exempted from the definition of "general public."	OIC made two technical changes in the final rule in response to these comments. WAC 284-170-131(7) of the final rule now defines "public statement" to include communication "made accessible to the public." This is in contrast to the proposed rule, which had defined public statement to include communication made "to…the general public." This wording adds precision to the meaning of "public statement" and removes the term "general public," which could be read more broadly. Additionally, this same subsection includes a new sentence stating: ""Public statement" does not include communications that are internally shared within a carrier, health care facility or health care provider organization exclusively for business planning purposes." These technical changes do not add a new obligation for affected entities or change OIC's interpretation of statute in the proposed rule. Rather, the changes add precision to an existing definition from the proposed rule.

A commentor asked that the proposed rule's definition of "notice" be narrowed to clarify that SSB 5579 only apply to the initial contract termination notice sent by carriers and health care providers, which is the understanding of the intent of the law. The commentor feels the proposed rule definition is too broad, exceeds statutory authority, and appears to capture any subsequent communications that either party may send to patients and enrollees that could include additional resources and continuity of care updates.	OIC did not make the requested change. RCW 48.43.732(4)(b) applies the enrollee/patient notice requirements to "notices developed pursuant to this section." The Legislature did not grant a specific exemption for subsequent notices to patients/enrollees. Moreover, the statute uses the plural term "notices" and not the singular term "notice," or "the original notice." In Sec. 1 of SSB 5579, the Legislature found that "notices to health plan members by carriers, health care providers, or health care facilities during contract terminations have created concerns for enrollees, patients, and affected communities." The Legislature went on to state its intent "to provide consistent policies for communication with enrollees and affected communities regarding potential contract terminations." (SSB 5579(1)). The final rule requires that notices, whether they be the original notice or a subsequent notice, must use OIC's standard template or receive OIC's prior approval. The final rule's provides a definition of "notice" within WAC 284-170-131(4). Exempting subsequent notices from the standard template and/or OIC approval requirements would run counter to both the statutory language and its stated intent for "consistent policies for communication." However, OIC notes that carriers, facilities and providers may make other "public statements," as defined in the final rule, within the 45 day period before the potential contract termination

	without using OIC's standard template or receiving OIC's prior approval.
A commentor asked that the prepublication draft's definition of "public statement" be changed to exempt confidential, one-on-one conversations between carriers and members who directly inquire about potential network changes.	OIC did not make the requested change. RCW 48.43.732(1) includes "directly communicating with impacted health plan enrollees and patients, regarding such expiration or termination…" as part of the description of "public statement." OIC believes that confidential, one-on-one conversations between carriers and members who directly inquire about potential network changes would represent a direct communication with an impacted enrollee about an expiration/termination, which the Legislature has expressly restricted. Moreover, OIC believes that exempting these types of conversations from the scope of "public statement" would be counter to the Legislature's intent to reduce confusion and concern from enrollees and patients. In OIC's experience regulating provider contracts and health plan networks, most potential contract terminations that SSB 5579 speaks to are resolved *before* the termination date (that is, an agreement is reached and the provider/facility remains in the carrier's network without interruption to the enrollee/patient). OIC acknowledges that this is not *always* the case, however, it occurs in most cases. Hence, even a confidential, one-on-one conversation within the "quiet period" could confuse or concern an enrollee given the unknown outcome the

	negotiation and the reasonable chance that an agreement will be reached. Moreover, an enrollee who is informed of a potential contract termination may then publicly release that information. As previously discussed, a carrier that "causes to be made" this type of "public statement" may be considered in violation of RCW 48.43.732. As previously stated, in pursuing any enforcement action OIC would look to the parties involved and facts specific to the potential violation.
A commentor suggested that, for cleaner drafting, the definition of "specific legal obligation" in the prepublication draft be changed by striking "…obligating a carrier, health care provider, or health care facility…"	OIC did not make this change in the proposed rule or final rule language. OIC appreciates the suggestion for cleaner drafting to avoid redundancy. However, OIC believes the suggestion could alter the meaning of the definition. OIC intentionally included the phrase "obligating a carrier, health care provider, or health care facility…" in the definition to make clear the entities it applies to.
A commentor asked that the definitions of "control" and "otherwise affiliated with" or "affiliated with" be clarified to ensure entities related to the carrier, such as a pharmacy benefit manager, are subject to the same requirements and restrictions concerning communications under RCW 48.43.732.	OIC did not make the requested change. However, to the commentor's concern, OIC notes that pharmacy benefit manager communications to enrollees regarding potential contract terminations/expirations *may be* considered a violation of RCW 48.43.732 if they were "caused to be made" by a party to the contract termination/expiration and otherwise met the criteria of RCW 48.43.732. As stated previously in this summary, for any enforcement related to a carrier, OIC would look to the parties involved and facts specific to the case.
WAC 284-170-365: Continuity of care protections	

Multiple commenters requested that OIC change WAC 284-170-365(2) of the prepublication draft and proposed rule to state that continuity of care rights begin on the date of a notice of potential contract termination to enrollees, rather than the date of termination. These commentors believe that this provision contradicts the federal No Surprises Act (42 U.S.C.300gg-113). One of these commentors also requested that OIC change the prepublication draft language to align the state continuity of care rights in WAC 284-170-365(1) with the federal No Surprises Act.	OIC did not make the requested changes as part of either the proposed or final rule. The federal "continuity of care" provision at issue is in 42 USC § 300gg-113. OIC interprets this provision to require that the continuity of care period begins on the *date of the contract termination*, not on the date of the carrier's notice to the enrollee regarding a *potential termination that has not yet occurred*. 42 USC § 300gg-113(a)(2)(A) requires the plan or issuer to— "notify each individual enrolled under such plan or coverage who is a continuing care patient with respect to a provider or facility at the time of termination described in paragraph (1) affecting such provider or facility on a timely basis of such termination and such individual's right to elect continued transitional care from such provider or facility under this section;" Subsection (2)(C) further provides that this continuity of care right applies— "…during the period beginning on the date on which the notice under subparagraph (A) is provided and ending on the earlier of— (i) the 90-day period beginning on such date; or (ii) the date on which such individual is no longer a continuing care patient with respect to such provider or facility.

	Subsection (d)(3) also provides a definition of "terminated" as below: "The term "terminated" includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud." OIC interprets 42 USC § 300gg-113 to require that carrier notices of contract terminations be sent "at the time of termination," and therefore, that the continuity of care period effectively begin on the date of termination, because it is the same date of the notice. OIC has authority to enforce the federal continuity of care provision in the No Surprises Act (42 U.S.C.300gg-113) (see CMS FAQ and KFF issue brief). The provision of the final rule is consistent with federal law. [anything from CMS or other states/evidence? Want to quote phrases in the language of the CoC provision of NSA?] The No Suprises Act provides continuity of care rights that allow certain enrollees and patients to continue receiving care from their current facility or provider at the in-network cost sharing rate for a limited time following a contract termination, i.e. 90 days. This is a critical protection for patients, especially those undergoing active treatment for a serious illness. A patient/enrollee losing access to an in-network provider is likely to have to pay substantially more, which may result in the patient/enrollee no longer being able to afford care from that provider and foregoing needed care. This can lead to

	care disruption, higher costs, and confusion for the patient/enrollee. OIC understands that some carriers may be interpreting the continuity of care protection in the No Surprises Act (42 U.S.C.300gg-113) to begin on the date of enrollee notification of a potential contract termination, not on the date of termination. To the extent that carriers are interpreting the provision in this manner, it does not provide enrollees with 90 days of continuity of care protections. Until a contract is terminated, a health care provider is in network. To allow the 90-day period to begin to run from a date that is 45 days prior to the contract termination would mean a carrier limits the continuity of care protection to 45 days, i.e. the date from contract termination to 45 days following contract termination. The final rule provision is therefore more protective of patients/enrollees than what the commentors request.
A commentor requests that WAC 284-170-365(1) of the proposed rule be expanded beyond primary care to specialty services, such as active cancer treatment or specialty treatment for chronic conditions.	OIC did not make the requested change. The state statute (cite) governing this provision is limited to primary care. Though OIC acknowledges that the federal and state protections are inconsistent, OIC concludes it lacks statutory authority to expand the rights beyond primary care within WAC 284-170-365(1). OIC notes that the federal continuity of care provision discussed above (42 U.S.C.300gg-113) would cover certain specialty services, such as active cancer treatment or chronic conditions, if the patient met the "continuing care patient" definition in that provision.

WAC 284-170-421: Provider contract standards	
One commentor asked that WAC 284-170-421(4) of the prepublication draft and the proposed rule be changed to allow carriers to define the provider with whom they are contracting and themselves one time at the beginning of the contract provision, and subsequently allow the use of terms "provider" and "plan" to refer to the specific entities to which the contract applies."	OIC made the requested change to the proposed rule and retained the same language in the final rule. However, rather than using the terms "provider" and "plan," the provision uses the terms "provider/facility" and "carrier" because those terms conform to RCW 48.43.732 and existing language in WAC 284-170. After the first bracket for "{name of provider/facility and name of carrier}" in WAC 284-170-421(4), all subsequent references to the parties are to "provider/facility and carrier" and do not require the parties to re-state their legal names in each place. Hence, carriers and facilities/providers may forego listing their full legal names as part of the required contract language in subsection (4) after listing their legal names at the beginning of the provision.
A commentor voiced concern that WAC 284-170-421(4) of the prepublication draft creates operational and legal concerns by prescribing specific regulatory language, for example, because contract amendments would be needed whenever laws change. Additionally, the commentor raised concerns that subsections (4)(e) and (4)(f) inappropriately require carriers to include OIC enforcement provisions in third-party contracts with providers. The commentor recommended only retaining subsection (4)(a), which is the general provision requiring both parties to comply with the applicable RCWs and WACs.	OIC did not make the requested changes in either the proposed or final rule. RCW 48.43.732(5) requires that by January 1, 2027, "the requirements of this section must be included in all provider contracts," and further requires that the commissioner "develop template language for inclusion in provider contracts by rule." WAC 284-170-421(4)'s template language for provider contracts describes the requirements in detail so that all parties to the contract clearly understand their rights and obligations under the new law without having to look up a statutory or regulatory citation. Describing the requirements thoroughly, rather than limiting references to statutory and regulatory sections, promotes

	understanding and awareness of RCW 48.43.732's requirements and increases the likelihood of compliance by affected entities.
In response to both the prepublication draft and proposed rule, a commentor requested removal of the following language in WAC 284-170-421(4): "This provision must be placed in the provisions of the provider contract addressing contract expirations or terminations." The commentor does not believe this language should be part of the base contract language but instead that it should be included in the addendum that is specific to Washington-regulated insurance carriers. The commentor believes that including the language in the base contract suggests that these provisions would apply to self-insured plans not governed by the state and would cause confusion.	OIC did not make the requested change in either the proposed or final rule. To make RCW 48.43.732's requirements clear and transparent to all contract parties, the template language should be part of the "base contract" and not an addendum. While OIC appreciates the commentor's concern regarding potential confusion about applicability to self-funded group health plans, OIC notes that other required provider contract language prescribed in WAC 284-170-421 also does not apply to self-funded group health plans. Additionally, nothing precludes a carrier and facility/provider from placing the required provision in a state specific regulatory addendum that may be used with a national or multistate contract to address compliance in Washington state.
Responding to the proposed rule, a commentor noted that the language in subsection (6) that pertains to penalties for improper collection from enrollees seems to make more sense in its original location following subsection (3) rather than following the new provisions related to SSB 5579. The commentor asked OIC to re-order the subsections in this manner, stating that carriers often follow the order they are listed in the WAC.	OIC did not make the requested change. OIC did not feel it necessary to re-order the subsections containing provider contract language in this manner. The prohibition on improper collection of cost-sharing amounts from enrollees that the commentor cites is a well-established requirement.
WAC 284-170-441: Public statements regarding contract terminations	

Within the prepublication draft, a commentor stated that, since WAC 284-170-441 pertains to both contracts that are expiring by their own terms and those terminating because of party exercising termination without cause, they assume the intent of "termination date of the provider contract" would also apply to an earlier date of termination based on a notice of termination without cause rather than only the date of expiration written in the original contract itself. The commentor stated that the prepublication draft could be interpreted as only applying in the case of an expiration. The commentor asked OIC to clarify.	The commentor correctly identified a technical issue in the last sentence of this section. OIC made a corresponding change within the proposed rule, which was retained in the final rule. In WAC 284-170-441, OIC added "expiration or" at the end of the section to clarify that the section also applies to an earlier date of termination rather than only the date of expiration written in the original contract itself.
Alternate Access Delivery Requests	
Multiple commentors stated concerns about a potential conflict between Alternate Access Delivery Requests (AADRs) and RCW 48.43.732. The commentor stated that AADRs do not meet the definition of "public statement" as defined in SB 5579 or the prepublication draft, but AADR reports are available to the public once submitted to the OIC, creating a potential for them to be disclosed well before the 45 day period in SB 5579. The commentors asked OIC to address this issue in the final rule or to adopt an internal process which aligns the date in which AADRs are made available publicly with the timeframes established in SB 5579.	OIC did not make changes in the final rule as a result of these comments. OIC acknowledges there is inconsistency between the time periods for public statement restrictions under SSB 5579 (RCW 48.43.732) and AADR requests. AADR requests are public records under the Public Records Act (RCW 42.56). OIC does not have statutory authority to exempt AADRs from the Public Records Act. SSB 5579 did not provide an exemption for AADRs. Therefore, OIC is not amending the final rule to exempt AADRs from public disclosure. How the OIC will address the AADR posting process is outside this rulemaking; however, OIC will review the process for consistency with SSB 5579 and WAC 284-170-230.
WAC 284-170-445: Provider contract terminations under RCW 48.43.732—Notice requirements.	

Responding to both the prepublication draft and proposed rule, multiple commentors requested that OIC define a timeframe for its approval of notice templates that do not solely utilize OIC's standard template language. Relatedly, multiple commentors requested that OIC add rule language providing that notices OIC does not approve within a day number (30 or 15 days), those notices are deemed approve for us.	OIC did not make the requested changes. It is not necessary to define a timeframe for OIC's review. OIC will work in good faith with affected entities to review notices so they can be used in a timely manner. In addition, should proposed notices submitted to OIC require extensive revisions or communication between OIC and the submitting party, the overall review period may not be limited to 15 or 30 days. In those cases, allowing a non-approved notice to be sent because a certain number of days has elapsed would be counter to SSB 5579's requirement that notices be approved prior to use and the Legislature's intent for consistent communications to enrollees/patients.
In response to the prepublication draft, a commentor requested OIC provide in rule a timeframe in which non-standard notices must be filed by carriers before the contract termination.	OIC made a change to the proposed rule, retained in the final rule, to address this request. In WAC 284-170-445(2)(b), OIC added language stating that: "Carriers, health care providers, and facilities must submit proposed notices to the commissioner a minimum of 14 business days in advance of the date they intend to deliver such notice to the enrollee/patient."
Responding to the prepublication draft, a commentor stated that when a provider rescinds their contract termination, it is standard business practice to send members a retraction notification to ensure they know their provider is staying in the network. The commentor asked that OIC change the rule language to acknowledge that other communications, like a retraction	OIC accepted the commentor's requested change in the proposed rule and retained that change in the final rule. Specifically, WAC 284-170-445(4) states: (4) Notifications to enrollees/patients that the contract termination is no longer applicable, such as a rescission of the contract

notification, are exempt from the notice template and OIC approval requirements.	termination, are not subject to the requirements of this section.
A commentor requested that OIC provide a confirmation receipt for submissions of notices that do not solely utilize the standard template.	OIC did not make the requested change. The OIC has posted filing instructions on its website. Health carriers, health care providers, and health care facilities will submit their request through email to our dedicated mailbox. A confirmation receipt is not necessary because the filer will have email documentation confirming the date and time the request was made to OIC. Additionally, the requestor may use email functionality to request information for delivery and read request.
WAC 284-170-447: Enforcement—Public statements and notices regarding contract terminations	
In response to the prepublication draft, a commentor voiced concern that WAC 284-170-447(3) is unclear as to whether enforcement applies only to actions taken after January 1, 2026, or whether there is potential for retroactive enforcement of actions taken after July 27, 2025. The commentor recommended clarifying that enforcement will apply only to actions taken on or after January 1, 2026, providing certainty and a clear safe harbor during the transition period.	OIC made the requested change in the proposed rule and retained that language in the final rule. Specifically, WAC 284-179-447(1) clarifies that OIC may pursue enforcement actions by carriers "on or after January 1, 2026…"

Section 6: Implementation Plan

A. Implementation and enforcement of the rule.

OIC will implement and enforce this final rule through the activities of multiple divisions and units. The Rates, Forms and Provider Networks (RFPN) division will oversee, review and approve notices to enrollees/consumers, review provider contracts for compliance, and make referrals to the Department of Health or the appropriate health profession organizations for potential violations by facilities/providers. The Legal Affairs division will be responsible for enforcement related to carriers. The Policy Division, with consultation from other divisions, will

continue open communication with affected entities regarding their obligations and rights.

B. How the Agency intends to inform and educate affected persons about the rule.

OIC Policy staff will distribute the final rule and this Concise Explanatory Statement (CES) to all interested parties by posting and sharing the documents through the OIC's standard rulemaking listserv. The OIC Policy Division will post the CR-103 documents on the OIC's website.

Type of Inquiry	Division
Notices, provider contracts, and referrals to Department of Health	Rates, Forms and Provider Networks Division
Consumer assistance	Consumer Protection Division
Rule content	Policy Division
Authority for rules	Legal Affairs Division
Enforcement of rule	Legal Affairs Division
Market Compliance	Company Supervision Division

C. How the Agency intends to promote and assist voluntary compliance for this rule.

OIC will respond to inquiries from entities covered by the law. OIC has published final templates to be used for notices; the final rule allows OIC to modify the templates, as needed. OIC will review notices not solely using the standard template and work with affected entities on such submissions. As stated earlier in this CES, regarding enforcement actions applying to carriers and referrals of potential violations by providers/facilities, OIC will look to the parties involved and facts specific to each case.

D. How the Agency intends to evaluate whether the rule achieves the purpose for which it was adopted.

OIC will monitor provider contracts, contract termination activities, notices sent to enrollees and patients, and consumer complaints toward evaluating whether the rule achieves its purpose and effectuates the Legislature's intent to "provide consistent policies for communication with enrollees and affected communities regarding potential contract terminations." (SSB 5579(1)).

Appendix A

CR-102 Hearing Summary

Summarizing Memorandum
To: Patty Kuderer, Insurance Commissioner
From: Nico Janssen, Presiding Official, Hearing on Rulemaking

Matter No. R 2025-10

Topic of Rulemaking: This memorandum summarizes the hearing on the above-named rule making, held on December 9, 2025 at 10:30 am on Zoom, over which I presided in your stead.

The following agency personnel were present:

- Joyce Brake
- Remy McKnight
- Laura Walker
- Sarah Volpone
- Eric Villar
- Joanne Najdzin

In attendance and testifying:

- Delana Avery, North Olympic Healthcare Network

Attendees:

- Amber Novack
- Angelica Sanchez
- Beau Brown
- Beau Reitz
- Christina Mojica
- Christine Davis
- Delana Avery
- Denyse Bayer
- Jane Douthit
- Liz Pressley
- Matthew Sinnott
- Melanie Anderson
- Merlene Converse
- Scott Norman
- Stephanie Walker

Contents of the presentations made at hearing:

- Delana Avery, North Olympic Healthcare Network, expressed concern that SSB 5579 is not allowing them to notify patients of a potential contract termination involving Medicare Advantage during open enrollment, potentially causing a loss of health care access for those patients.

The hearing was adjourned.

SIGNED this 9th day of December 2025

Nico Janssen
Presiding Official