RULE-MAKING ORDER
PERMANENT RULE ONLY

CR-103P (October 2017)
(Implements RCW 34.05.360)

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: November 19, 2019
TIME: 11:36 PM

WSR 19-23-085

Agency: Office of the Insurance Commissioner

Effective date of rule:

Permanent Rules

☒ 31 days after filing.

☐ Other (specify) _____ **(If less than 31 days after filing, a specific finding under RCW 34.05.380(3) is required and should be stated below)**

Any other findings required by other provisions of law as precondition to adoption or effectiveness of rule?

☐ Yes ☒ No If Yes, explain:

Purpose: The purpose of this rule is to adopt rules necessary to implement and administer the Balance Billing Protection Act (Chapter 427, Laws of 2019), ensuring that consumers are protected from wrongful balance billing.

Citation of rules affected by this order:

New: WAC 284-43B-010 through -080
Repealed:
Amended: WAC 284-170-480
Suspended:

Statutory authority for adoption: RCW 48.02.060, RCW 48.49.060, RCW 48.49.110

Other authority:

PERMANENT RULE (Including Expedited Rule Making)

Adopted under notice filed as WSR 19-20-112 on October 2, 2019. (date).

Describe any changes other than editing from proposed to adopted version:

The final rule differs from the proposed rule in two respects.

The proposed rule included a definition of "same or similar geographic area" in WAC 284-43B-010. It defined the term as the geographic methodology adopted for the All Payer Claims Database (APCD) data set developed under RCW 43.371.100. OIC received multiple comments indicating that this methodology was intended to apply to development of the database, and that it was not appropriate to apply it to carriers' calculation of consumer cost-sharing under WAC 284-43B-020(1) or to establishment of commercially reasonable amounts under WAC 284-43B-030. Designation of geographic areas for purposes of calculating in-network provider payment rates would be inconsistent with the Balance Billing Protection Act, which directs carriers to use their median in-network rates as a basis for calculating enrollee cost-sharing. Carriers have established geographic regions in place for purposes of calculating their in-network and out-of-network provider payment rates. For these reasons, and awareness of the upcoming January 1, 2020 effective date of the BBPA, the final rule does not include a definition of "same or similar geographic area". However, the All Payer Claims Database dataset will utilize the OIC geographic rating areas established in WAC 284-43-6701 for purposes of determining median allowed amount and median billed charge amounts in the database.

The final rule revises the language of WAC 284-43B-050(4) to make a technical clarification regarding the provider network contracts that are to be posted by health care providers and facilities on their websites.

If a preliminary cost-benefit analysis was prepared under RCW 34.05.328, a final cost-benefit analysis is available by contacting:

Name: Tabba Alam
Address: PO Box 40360, Olympia, WA 98502
Phone: 360-725-7170

Fax:
TTY:
Email: TabbaA@oic.wa.gov
Web site: www.insurance.wa.gov
Other:

Note: If any category is left blank, it will be calculated as zero. No descriptive text.

Count by whole WAC sections only, from the WAC number through the history note. A section may be counted in more than one category.

The number of sections adopted in order to comply with:

Federal statute:	New		Amended		Repealed	
Federal rules or standards:	New		Amended		Repealed	
Recently enacted state statutes:	New	8	Amended	1	Repealed	

The number of sections adopted at the request of a nongovernmental entity:

	New		Amended		Repealed	

The number of sections adopted on the agency's own initiative:

	New		Amended		Repealed	

The number of sections adopted in order to clarify, streamline, or reform agency procedures:

	New		Amended		Repealed	

The number of sections adopted using:

Negotiated rule making:	New		Amended		Repealed	
Pilot rule making:	New		Amended		Repealed	
Other alternative rule making:	New		Amended		Repealed	

Date Adopted: 11/19/19	**Signature:**
Name: Mike Kreidler	Mike Kreidler
Title: Insurance Commissioner	

Chapter 284-43B WAC
BALANCE BILLING

NEW SECTION

WAC 284-43B-010 Definitions. (1) The definitions in RCW 48.43.005 apply throughout this chapter unless the context clearly requires otherwise, or the term is defined otherwise in subsection (2) of this section.

(2) The following definitions shall apply throughout this chapter:

(a) "Allowed amount" means the maximum portion of a billed charge a health carrier will pay, including any applicable enrollee cost-sharing responsibility, for a covered health care service or item rendered by a participating provider or facility or by a nonparticipating provider or facility.

(b) "Balance bill" means a bill sent to an enrollee by an out-of-network provider or facility for health care services provided to the enrollee after the provider or facility's billed amount is not fully reimbursed by the carrier, exclusive of permitted cost-sharing.

(c) "Emergency medical condition" means a medical, mental health, or substance use disorder condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain or emotional distress, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical, mental health, or substance use disorder treatment attention to result in a condition (i) placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

(d) "Emergency services" means a medical screening examination, as required under section 1867 of the Social Security Act (42 U.S.C. 1395dd), that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate that emergency medical condition, and further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient. Stabilize, with respect to an emergency medical condition, has the meaning given in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

(e) "Facility" means a hospital licensed under chapter 70.41 RCW or an ambulatory surgical facility licensed under chapter 70.230 RCW.

(f) "In-network" or "participating" means a provider or facility that has contracted with a carrier or a carrier's contractor or subcontractor to provide health care services to enrollees and be reimbursed by the carrier at a contracted rate as payment in full for the health care services, including applicable cost-sharing obligations. A single case reimbursement agreement between a provider or facility and a carrier used for the purpose described in WAC 284-170-200 constitutes a contract exclusively for purposes of this definition under the

Balance Billing Protection Act and is limited to the services and parties to the agreement.

(g) "Median in-network contracted rate for the same or similar service in the same or similar geographical area" means the median amount negotiated for an emergency or surgical or ancillary service for participation in the carrier's health plan network with in-network providers of emergency or surgical or ancillary services furnished in the same or similar geographic area. If there is more than one amount negotiated with the health plan's in-network providers for the emergency or surgical or ancillary service in the same or similar geographic area, the median in-network contracted rate is the median of these amounts. In determining the median described in the preceding sentence, the amount negotiated for each claim for the same or similar service with each in-network provider is treated as a separate amount (even if the same amount is paid to more than one provider or to the same provider for more than one claim). If no per-service amount has been negotiated with any in-network providers for a particular service, the median amount must be calculated based upon the service that is most similar to the service provided. For purposes of this subsection "median" means the middle number of a sorted list of reimbursement amounts negotiated with in-network providers with respect to a certain emergency or surgical or ancillary service, with each paid claim's negotiated reimbursement amount separately represented on the list, arranged in order from least to greatest. If there is an even number of items in the sorted list of negotiated reimbursement amounts, the median is found by taking the average of the two middle-most numbers.

(h) "Offer to pay," "carrier payment," or "payment notification" means a claim that has been adjudicated and paid by a carrier to an out-of-network or nonparticipating provider for emergency services or for surgical or ancillary services provided at an in-network facility.

(i) "Out-of-network" or "nonparticipating" means a provider or facility that has not contracted with a carrier or a carrier's contractor or subcontractor to provide health care services to enrollees.

(j) "Provider" means 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 an employee or agent of a person acting in the course and scope of his or her employment, that provides emergency services, or surgical or ancillary services at an in-network facility.

(k) "Surgical or ancillary services" means surgery, anesthesiology, pathology, radiology, laboratory, or hospitalist services.

NEW SECTION

WAC 284-43B-020 Balance billing prohibition and consumer cost-sharing. (1) If an enrollee receives any emergency services from an out-of-network facility or provider, or any nonemergency surgical or ancillary services at an in-network facility from an out-of-network provider:

(a) The enrollee satisfies his or her obligation to pay for the health care services if he or she pays the in-network cost-sharing amount specified in the enrollee's or applicable group's health plan contract. The enrollee's obligation must be determined using the

carrier's median in-network contracted rate for the same or similar service in the same or similar geographical area. The carrier must provide an explanation of benefits to the enrollee and the out-of-network provider that reflects the cost-sharing amount determined under this subsection.

(b) The carrier, out-of-network provider, or out-of-network facility, and any agent, trustee, or assignee of the carrier, out-of-network provider, or out-of-network facility must ensure that the enrollee incurs no greater cost than the amount determined under (a) of this subsection.

(c)(i) For emergency services provided to an enrollee, the out-of-network provider or out-of-network facility, and any agent, trustee, or assignee of the out-of-network provider or out-of-network facility may not balance bill or otherwise attempt to collect from the enrollee any amount greater than the amount determined under (a) of this subsection. This does not impact the provider's ability to collect a past due balance for an applicable in-network cost-sharing amount with interest;

(ii) For emergency services provided to an enrollee in an out-of-network hospital located and licensed in Oregon or Idaho, the carrier must hold an enrollee harmless from balance billing; and

(iii) For nonemergency surgical or ancillary services provided at an in-network facility, the out-of-network provider and any agent, trustee, or assignee of the out-of-network provider may not balance bill or otherwise attempt to collect from the enrollee any amount greater than the amount determined under (a) of this subsection. This does not impact the provider's ability to collect a past due balance for an applicable in-network cost-sharing amount with interest.

(d) For emergency services and nonemergency surgical or ancillary services provided at an in-network facility, the carrier must treat any cost-sharing amounts determined under (a) of this subsection paid or incurred by the enrollee for an out-of-network provider or facility's services in the same manner as cost-sharing for health care services provided by an in-network provider or facility and must apply any cost-sharing amounts paid or incurred by the enrollee for such services toward the enrollee's maximum out-of-pocket payment obligation.

(e) If the enrollee pays an out-of-network provider or out-of-network facility an amount that exceeds the in-network cost-sharing amount determined under (a) of this subsection, the provider or facility must refund any amount in excess of the in-network cost- sharing amount to the enrollee within thirty business days of the provider or facility's receipt of the enrollee's payment. Simple interest must be paid to the enrollee for any unrefunded payments at a rate of twelve percent per annum beginning on the first calendar day after the thirty business days.

(2) The carrier must make payments for health care services described in section 6, chapter 427, Laws of 2019, provided by an out-of-network provider or facility directly to the provider or facility, rather than the enrollee.

(3) A health care provider or facility, or any of its agents, trustees or assignees may not require a patient at any time, for any procedure, service, or supply, to sign or execute by electronic means, any document that would attempt to avoid, waive, or alter any provision of this section.

NEW SECTION

WAC 284-43B-030 Out-of-network claim payment and dispute resolution. The allowed amount paid to an out-of-network provider for health care services described under section 6, chapter 427, Laws of 2019, shall be a commercially reasonable amount, based on payments for the same or similar services provided in the same or a similar geographic area.

(1) Within thirty calendar days of receipt of a claim from an out-of-network provider or facility, the carrier shall offer to pay the provider or facility a commercially reasonable amount. Payment of an adjudicated claim shall be considered an offer to pay. The amount actually paid to an out-of-network provider by a carrier may be reduced by the applicable consumer cost-sharing determined under WAC 284-43B-020 (1)(a). The date of receipt by the provider or facility of the carrier's offer to pay is five calendar days after a transmittal of the offer is mailed to the provider or facility, or the date of transmittal of an electronic notice of payment. The claim submitted by the out-of-network provider or facility to the carrier must include the following information:

(a) Patient name;

(b) Patient date of birth;

(c) Provider name;

(d) Provider location;

(e) Place of service, including the name and address of the facility in which, or on whose behalf, the service that is the subject of the claim was provided;

(f) Provider federal tax identification number;

(g) Federal Center for Medicare and Medicaid Services individual national provider identifier number, and organizational national provider identifier number, if the provider works for an organization or is in a group practice that has an organization number;

(h) Date of service;

(i) Procedure code; and

(j) Diagnosis code.

(2) If the out-of-network provider or facility wants to dispute the carrier's offer to pay, the provider or facility must notify the carrier no later than thirty calendar days after receipt of the offer to pay or payment notification from the carrier. A carrier may not require a provider or facility to reject or return payment of the adjudicated claim as a condition of putting the payment into dispute.

(3) If the out-of-network provider or facility disputes the carrier's offer to pay, the carrier and provider or facility have thirty calendar days after the provider or facility receives the offer to pay to negotiate in good faith.

(4) If the carrier and the out-of-network provider or facility do not agree to a commercially reasonable payment amount within the thirty-calendar day period under subsection (3) of this section, and the carrier, out-of-network provider or out-of-network facility chooses to pursue further action to resolve the dispute, the dispute shall be resolved through arbitration, as provided in section 8, chapter 427, Laws of 2019.

(5)(a) To initiate arbitration, the carrier, provider, or facility must provide written notification to the commissioner and the noninitiating party no later than ten calendar days following completion of the period of good faith negotiation under subsection (3) of this

section. The written notification to the commissioner must be made electronically and provide dates related to each of the time period limitations described in subsections (1) through (4) of this section.

(b) If an out-of-network provider or out-of-network facility chooses to address multiple claims in a single arbitration proceeding as provided in section 8, chapter 427, Laws of 2019, notification must be provided no later than ten calendar days following completion of the period of good faith negotiation under subsection (3) of this section for the most recent claim that is to be addressed through the arbitration. All of the claims at issue must:

(i) Involve identical carrier and provider or facility parties;

(ii) Involve claims with the same or related current procedural terminology codes relevant to a particular procedure; and

(iii) Occur within a two month period of one another, such that the earliest claim that is the subject of the arbitration occurred no more than two months prior to the latest claim that is the subject of the arbitration. For purposes of this subsection, a provider or facility claim occurs on the date the service is provided to a patient or, in the case of inpatient facility admissions, the date the admission ends.

(c) A notification submitted to the commissioner later than ten calendar days following completion of the period of good faith negotiation will be considered untimely and will be rejected. A party that has submitted an untimely notice is permanently foreclosed from seeking arbitration related to the claim or claims that were the subject of the untimely notice.

(d) Within seven calendar days of receipt of notification from the initiating party, the commissioner must provide the parties with a list of approved arbitrators or entities that provide arbitration. The arbitrator selection process must be completed within twenty calendar days of receipt of the original list of arbitrators from the commissioner, as follows:

(i) If the parties are unable to agree on an arbitrator from the original list sent by the commissioner, they must notify the commissioner within five calendar days of receipt of the original list of arbitrators. The commissioner must send the parties a list of five arbitrators within five calendar days of receipt of notice from the parties under this subsection.

(ii) If, after the opportunity to veto up to two of the five named arbitrators on the list of five arbitrators sent by the commissioner to the parties, more than one arbitrator remains on the list, the parties must notify the commissioner within five calendar days of receipt of the list of five arbitrators. The commissioner will choose the arbitrator from among the remaining arbitrators on the list.

(e) For purposes of this subsection, the date of receipt of a list of arbitrators is the date of electronic transmittal of the list to the parties by the commissioner. The date of receipt of notice from the parties to the commissioner is the date of electronic transmittal of the notice to the commissioner by the parties.

(6) If a noninitiating party fails to timely respond without good cause to a notice initiating arbitration, the initiating party will choose the arbitrator.

NEW SECTION

WAC 284-43B-040 Determining whether an enrollee's health plan is subject to the requirements of the act. To implement section 7, chapter 427, Laws of 2019, carriers must make information regarding whether an enrollee's health plan is subject to the requirements of chapter 427, Laws of 2019, available to providers and facilities using the most current version of the Health Insurance Portability and Accountability Act (HIPAA) mandated X12 Health Care Eligibility Benefit Response (271) transaction information through use of a standard message that is placed in a standard location within the 271 transaction. The designated lead organization for administrative simplification in Washington state, after consultation with carriers, providers and facilities through a new or an existing workgroup or committee, must post the language of the standard message and the location within the 271 transaction in which the message is to be placed on its website on or before November 1, 2019. This information also must be posted on the website of the office of the insurance commissioner.

NEW SECTION

WAC 284-43B-050 Notice of consumer rights and transparency. (1) The commissioner shall develop a standard template for a notice of consumer rights under the Balance Billing Protection Act. The notice may be modified periodically, as determined necessary by the commissioner. The notice template will be posted on the public website of the office of the insurance commissioner.

(2) The standard template for the notice of consumer rights under the Balance Billing Protection Act must be provided to consumers enrolled in any health plan issued in Washington state as follows:

(a) Carriers must:

(i) Include the notice in the carrier's communication to an enrollee, in electronic or any other format, that authorizes nonemergency surgical or ancillary services at an in-network facility;

(ii) Post the notice on their website in a prominent and relevant location, such as in a location that addresses coverage of emergency services and prior authorization requirements for nonemergency surgical or ancillary services performed at in-network facilities; and

(iii) Provide the notice to any enrollee upon request.

(b) Health care facilities and providers must:

(i) For any facility or provider that is owned and operated independently from all other businesses and that has more than fifty employees, upon confirming that a patient's health plan is subject to the Balance Billing Protection Act, include the notice in any communication to a patient, in electronic or any other format, confirming the scheduling of nonemergency surgical or ancillary services at a facility;

(ii) Post the notice on their website, if the provider or facility maintains a website, in a prominent and relevant location near the list of the carrier health plan provider networks with which the provider or facility is an in-network provider; and

(iii) Provide the notice upon request of a patient.

(3) For claims processed on or after July 1, 2020, when processing a claim that is subject to the balance billing prohibition in section 6, chapter 427, Laws of 2019, the carrier must indicate on any form used by the carrier to notify enrollees of the amount the carrier has paid on the claim:

(a) Whether the claim is subject to the prohibition in the act; and

(b) The federal Center for Medicare and Medicaid Services individual national provider identifier number, and organizational national provider identifier number, if the provider works for an organization or is in a group practice that has an organization number.

(4) A facility or health care provider meets its obligation under section 11 or 12, chapter 427, Laws of 2019, to include a listing on its website of the carrier health plan provider networks in which the facility or health care provider participates by posting this information on its website for in-force contracts, and for newly executed contracts within fourteen calendar days of receipt of the fully executed contract from a carrier. If the information is posted in advance of the effective date of the contract, the date that network participation will begin must be indicated.

(5) Not less than thirty days prior to executing a contract with a carrier, a hospital or ambulatory surgical facility must provide the carrier with a list of the nonemployed providers or provider groups that have privileges to practice at the hospital or ambulatory surgical facility or are contracted to provide surgical or ancillary services at the hospital or ambulatory surgical facility. The list must include the name of the provider or provider group, mailing address, federal tax identification number or numbers and contact information for the staff person responsible for the provider's or provider group's contracting. The hospital or ambulatory surgical facility must notify the carrier within thirty days of a removal from or addition to the nonemployed provider list. A hospital or ambulatory surgical facility also must provide an updated list of these providers within fourteen calendar days of a written request for an updated list by a carrier.

(6) An in-network provider must submit accurate information to a carrier regarding the provider's network status in a timely manner, consistent with the terms of the contract between the provider and the carrier.

NEW SECTION

WAC 284-43B-060 Enforcement. (1) If the commissioner has cause to believe that any health facility or provider has engaged in a pattern of unresolved violations of section 6 or 7, chapter 427, Laws of 2019, the commissioner may submit information to the department of health or the appropriate disciplining authority for action.

(2) In determining whether there is cause to believe that a health care provider or facility has engaged in a pattern of unresolved violations, the commissioner shall consider, but is not limited to, consideration of the following:

(a) Whether there is cause to believe that the health care provider or facility has committed two or more violations of section 6 or 7, chapter 427, Laws of 2019;

(b) Whether the health care provider or facility has failed to submit claims to carriers containing all of the elements required in WAC 284-43B-030(1) on multiple occasions, putting a consumer or consumers at risk of being billed for services to which the prohibition in section 6, chapter 427, Laws of 2019 applies;

(c) Whether the health care provider or facility has been nonresponsive to questions or requests for information from the commissioner related to one or more complaints alleging a violation of section 6 or 7, chapter 427, Laws of 2019; and

(d) Whether, subsequent to correction of previous violations, additional violations have occurred.

(3) Prior to submitting information to the department of health or the appropriate disciplining authority, the commissioner may provide the health care provider or facility with an opportunity to cure the alleged violations or explain why the actions in question did not violate section 6 or 7, chapter 427, Laws of 2019.

NEW SECTION

WAC 284-43B-070 Self-funded group health plan opt in. (1) A self-funded group health plan that elects to participate in sections 6 through 8, chapter 427, Laws of 2019, shall provide notice to the commissioner of their election decision on a form prescribed by the commissioner. The completed form must include an attestation that the self-funded group health plan has elected to participate in and be bound by sections 6 through 8, chapter 427, Laws of 2019. The form will be posted on the commissioner's public website for use by self-funded group health plans.

(2) A self-funded group health plan may elect to initiate its participation on January 1st of any year or in any year on the first day of the self-funded group health plan's plan year.

(3) A self-funded group health plan's election occurs on an annual basis. On its election form, the plan must indicate whether it chooses to affirmatively renew its election on an annual basis or whether it should be presumed to have renewed on an annual basis until the commissioner receives advance notice from the plan that it is terminating its election as of either December 31st of a calendar year or the last day of its plan year. Notices under this subsection must be submitted to the commissioner at least thirty days in advance of the effective date of the election to initiate participation and the effective date of the termination of participation.

(4) Self-funded group health plan sponsors and their third party administrators may develop their own internal processes related to member notification, member appeals and other functions associated with their fiduciary duty to enrollees under the Employee Retirement Income Security Act of 1974 (ERISA).

NEW SECTION

WAC 284-43B-080 Effective date. Chapter 284-43B WAC takes effect on January 1, 2020.

AMENDATORY SECTION (Amending WSR 16-14-106, filed 7/6/16, effective 8/6/16)

WAC 284-170-480 Participating provider—Filing and approval. (1) An issuer must file for prior approval all participating provider agreements and facility agreements thirty calendar days prior to use. If a carrier negotiates a provider or facility contract or a compensation agreement that deviates from an approved agreement, then the issuer must file that negotiated contract or agreement with the commissioner for approval thirty days before use. The commissioner must receive the filings electronically in accordance with chapters 284-44A, 284-46A, and 284-58 WAC.

(2)(a) An issuer may file a provider or facility contract template with the commissioner. A "contract template" is a sample contract and compensation agreement form that the issuer will use to contract with multiple providers or facilities. A contract template must be issued exactly as approved.

(i) When an issuer modifies the contract template, an issuer must refile the modified contract template for approval. All changes to the contract template must be indicated through strike outs for deletions and underlines for new material. The modified template must be issued to providers and facilities upon approval.

(ii) Alternatively, issuers may file the modified contract template for prospective contracting and a contract addendum or amendment that would be issued to currently contracted providers or facilities for prior approval. The filing must include any correspondence that will be sent to a provider or facility that explains the amendment or addendum. The correspondence must provide sufficient information to clearly inform the provider or facility what the changes to the contract will be. All changes to the contract template must be indicated through strike outs for deletions and underlines for new material.

(iii) Changes to a previously filed and approved provider compensation agreement modifying the compensation amount or terms related to compensation must be filed and are deemed approved upon filing if there are no other changes to the previously approved provider contract or compensation agreement.

(b)(i) All negotiated contracts and compensation agreements must be filed with the commissioner for approval thirty calendar days prior to use and include all contract documents between the parties.

(ii) If the only negotiated change is to the compensation amount or terms related to compensation, it must be filed and is deemed approved upon filing.

(3) If the commissioner takes no action within thirty calendar days after submission, the form is deemed approved except that the commissioner may extend the approval period an additional fifteen calendar days upon giving notice before the expiration of the initial thirty-day period. Approval may be subsequently withdrawn for cause.

(4) The issuer must maintain provider and facility contracts at its principal place of business in the state, or the issuer must have access to all contracts and provide copies to facilitate regulatory review upon twenty days prior written notice from the commissioner.

(5) Nothing in this section relieves the issuer of the responsibility detailed in WAC 284-170-280 (3)(b) to ensure that all provider and facility contracts are current and signed if the provider or fa-

cility is listed in the network filed for approval with the commissioner.

(6) If an issuer enters into a reimbursement agreement that is tied to health outcomes, utilization of specific services, patient volume within a specific period of time, or other performance standards, the issuer must file the reimbursement agreement with the commissioner thirty days prior to the effective date of the agreement, and identify the number of enrollees in the service area in which the reimbursement agreement applies. Such reimbursement agreements must not cause or be determined by the commissioner to result in discrimination against or rationing of medically necessary services for enrollees with a specific covered condition or disease. If the commissioner fails to notify the issuer that the agreement is disapproved within thirty days of receipt, the agreement is deemed approved. The commissioner may subsequently withdraw such approval for cause.

(7) Provider contracts and compensation agreements must clearly set forth the carrier provider networks and applicable compensation agreements associated with those networks so that the provider or facility can understand their participation as an in-network provider and the reimbursement to be paid. The format of such contracts and agreements may include a list or other format acceptable to the commissioner so that a reasonable person will understand and be able to identify their participation and the reimbursement to be paid as a contracted provider in each provider network.