RULE-MAKING ORDER

CR-103P (May 2009)
(Implements RCW 34.05.360)

Agency: Office of the Insurance Commissioner

Permanent Rule Only

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:

Insurance Commissioner Matter No. R 2014-08

In May 2014, the OIC completed the first phase of rulemaking to clarify its expectations for health insurance issuers' provider networks. This "phase 2" of rulemaking offers additional guidance to issuers on the implementation of phase 1 network access standards. The rules require that issuers document and maintain their networks to provide ongoing access. They also ensure that network-related processes and procedures do not serve as a barrier to access.

Citation of existing rules affected by this order:

Repealed:

Amended: WAC 284-43-251, 284-43-300, 284-43-310, 284-43-320, 284-43-330

Suspended:

Statutory authority for adoption: 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

Other authority:

PERMANENT RULE (Including Expedited Rule Making)

Adopted under notice filed as WSR **15-13-117** on June 16, 2015.

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

- WAC 284-43-202 (3)(a) Added specificity to the timeframe for reporting changes to a network.
- WAC 284-43-225(2) Added "These records must be retained for a period of ten years:"
- WAC 284-43-300 Deleted "Provider networks must include and maintain every provider category and type necessary to deliver covered services."
- WAC 284-43-310 (1)(b) Deleted "practitioners"
- WAC 284-43-320 (14) Added effective date and safe harbor.

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

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Date adopted: December 14, 2015

NAME (TYPE OR PRINT)
Mike Kreidler

SIGNATURE

TITLE
Insurance Commissioner

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: December 14, 2015
TIME: 2:53 PM

WSR 16-01-074

(COMPLETE REVERSE SIDE)

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	3	Repealed	
Federal rules or standards:	New		Amended	0	Repealed	
Recently enacted state statutes:	New		Amended	1	Repealed	

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

	New		Amended		Repealed	

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

	New	2	Amended	4	Repealed	

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

	New	2	Amended	5	Repealed	

The number of sections adopted using:

Negotiated rule making:	New		Amended		Repealed	
Pilot rule making:	New		Amended		Repealed	
Other alternative rule making:	New	2	Amended	5	Repealed	

NEW SECTION

WAC 284-43-202 Maintenance of sufficient provider networks. (1) An issuer must maintain and monitor its provider networks on an ongoing basis for compliance with the network access standards set forth in WAC 284-43-200. This includes an issuer of a stand-alone dental plan offered through the exchange or a stand-alone dental plan offered outside the exchange for the purpose of providing the essential health benefit category of pediatric oral benefits, which must maintain and monitor its networks for compliance with WAC 284-43-200(14). An issuer must report to the commissioner, within the time frames stated in this section, any changes affecting the ability of its network providers and facilities to furnish covered services to enrollees.

(2) An issuer must notify the OIC in writing within five business days of either receiving or issuing a written notice of potential contract termination that would affect the network's ability to meet the standards set forth in WAC 284-43-200. Notice of potential termination must include an issuer's preliminary determination of whether an alternate access delivery request must be filed and the documentation supporting that determination. The issuer's notice must be submitted electronically following the submission instructions on the commissioner's web site.

(a) If the issuer determines that an alternate access delivery request must be submitted to comply with WAC 284-43-200(15), the issuer has ten business days to submit the request and supporting documentation for the alternate access delivery request in accordance with WAC 284-43-220 (3)(d).

(b) If, after reviewing the issuer's preliminary determination that an alternate access delivery request is not necessary, the OIC determines that an alternate access delivery request is required to comply with WAC 284-43-200(15), the issuer has five business days to submit the request and supporting documentation for the alternate access delivery request in accordance with WAC 284-43-220 (3)(d).

(c) If the OIC determines that a network is out of compliance with WAC 284-43-200 and the issuer has failed to report this change to the OIC, the issuer must, within one business day of notification by the OIC, submit an alternate access delivery request in accordance with WAC 284-43-200(15) and supporting documentation for the alternate access delivery request in accordance with WAC 284-43-220(3)(d).

(3) An issuer of a health plan must maintain and monitor, on an ongoing basis, the ability and clinical capacity of its network providers and facilities to furnish covered health plan services to enrollees. An issuer must notify the commissioner in writing within fifteen days of a change in its network as described below:

(a) A reduction, by termination or otherwise, of ten percent or more in the number of either specialty providers, mental health providers, or facilities participating in the network;

(i) The initial time frame for measuring this reduction is from the network's initial approval date until the January 1st following the initial approval date.

(ii) After the January 1st following the network's initial approval date, the time frame for measuring this reduction is from January 1st to the following January 1st.

(b) Termination or reduction of a specific type of specialty provider on the American Board of Medical Specialties list of specialty

and subspecialty certificates, where there are fewer than two of the specialists in a service area;

(c) An increase or reduction of twenty-five percent or more in the number of enrollees in the service area since the annual approval date;

(d) A reduction of five percent or more in the number of primary care providers in the service area who are accepting new patients;

(e) The termination or expiration of a contract with a hospital or any associated hospital-based medical group within a service area;

(f) A fifteen percent reduction in the number of providers or facilities for a specific chronic condition or disease participating in the network where the chronic condition or disease affects more than five percent of the issuer's enrollees in the service area. For purposes of monitoring, chronic illnesses are those conditions identified (or recognized) by the Centers for Medicare and Medicaid Services within the most current version of the Centers for Medicare and Medicaid Chronic Conditions Data Warehouse (CCW) data base available on the CMS.gov web site; or

(g) Written notice to the commissioner must include the issuer's preliminary determination whether the identified changes in the network require an alternate access delivery request in accordance with WAC 284-43-220 (3)(d).

(i) If the issuer determines that an alternate access delivery request must be submitted, the issuer has ten business days to submit the request and supporting documentation for the alternate access delivery request in accordance with WAC 284-43-220 (3)(d).

(ii) If, after reviewing the issuer's preliminary determination that an alternate access delivery request is not required, the OIC determines that an alternate access delivery request is required, the issuer has five business days to submit the request and supporting documentation for the alternate access delivery request in accordance with WAC 284-43-220 (3)(d).

(iii) If the OIC determines that a network is out of compliance with these standards and the issuer has failed to report this change to the OIC, the issuer must, within one business day of notification by the OIC, submit an alternate access delivery request in accordance with WAC 284-43-200(15) and supporting documentation for the alternate access delivery request in accordance with WAC 284-43-220 (3)(d).

(4) An issuer of a stand-alone dental plan offered through the exchange or of a stand-alone dental plan offered outside the exchange for the purpose of providing the essential health benefit category of pediatric oral benefits must maintain and monitor, on an ongoing basis, the ability and clinical capacity of its network providers and facilities to furnish covered services to enrollees. An issuer must notify the commissioner in writing within fifteen days of the change in its network as described below:

(a) A reduction, by termination or otherwise, of ten percent or more in the number of specialty providers in the network since the initial approval date;

(b) An increase or reduction of twenty-five percent or more in the number of enrollees in the service area since the annual approval date;

(c) A reduction of five percent or more in the number of providers of preventive and general dentistry accepting new patients in the service area;

(d) Notice to the commissioner must include the issuer's preliminary determination whether an alternate access delivery request must

be submitted with supporting documentation in accordance with WAC 284-43-220 (3)(d).

(i) If the issuer determines that an alternate access delivery request must be submitted, the issuer has ten business days to submit the request and supporting documentation in accordance with WAC 284-43-220 (3)(d).

(ii) If after reviewing the issuer's preliminary determination that an alternate access delivery request is not required, the OIC determines that an alternate access delivery request is required, the issuer has five business days to submit the request and supporting documentation for the request in accordance with WAC 284-43-220 (3)(d).

(iii) If the OIC determines that a network is not in compliance with these standards and the issuer has failed to report this change to the OIC, the issuer must, within one business day of notification by the OIC, submit an alternate access delivery request in accordance with WAC 284-43-200(15) and supporting documentation for the request in accordance with WAC 284-43-220 (3)(d).

(5) The following network access standards must be met on an ongoing basis:

(a) The actuarial projections of health care costs submitted as part of a premium rate filing must continue to be based on the actual network the issuer proposes for the health plan's service areas.

(b) A practice that is not currently accepting new patients may be included in a provider network for purposes of reporting network access, but must not be used to justify network access for anticipated enrollment growth.

(c) An issuer must have and maintain in its network a sufficient number and type of providers to whom direct access is required under RCW 48.43.515 (2) and (5) and 48.42.100 to accommodate all new and existing enrollees in the service areas.

(d) Issuers that use the following network models must maintain and monitor the continuity and coordination of care that enrollees receive: Networks that include medical home or medical management services in lieu of providing access to specialty or ancillary services through primary care provider referral, and networks where the issuer requires providers to whom an enrollee has direct access to notify the enrollee's primary care provider of treatment plans and services delivered. For these models, an issuer must perform continuity and coordination of care in a manner consistent with professionally recognized evidence-based standards of practice, across the health plan network. The baseline for such coordination is maintenance and monitoring as often as is necessary, but not less than once a year:

(i) The systems or processes for integration of health care services by medical and mental health providers;

(ii) The exchange of information between primary and specialty providers;

(iii) Appropriate diagnosis, treatment, and referral practices;

(iv) Access to treatment and follow-up for enrollees with coexisting conditions including, but not limited to, a mental health condition coexisting with a chronic health condition.

(6) This section is effective for all plans, whether new or renewed, with effective dates on or after January 1, 2016.

NEW SECTION

WAC 284-43-225 Issuer recordkeeping—Provider networks. (1) An issuer must make available to the commissioner upon request its records, contracts, and agreements related to its provider networks.

(a) Records to support proof of good faith contracting efforts must be retained for seven years.

(b) Signed contracts, reimbursement agreements, and associated accounting records must be retained for ten years after the contract is terminated.

(2) Beginning January 1, 2016, an issuer must be able to provide to the commissioner upon request the following information for a time period specified by the commissioner. These records must be retained for a period of ten years:

(a) The number of requests submitted for prior authorization for services by all providers and facilities;

(b) The total number of such requests processed; and

(c) The total number of such requests denied.

AMENDATORY SECTION (Amending WSR 01-03-033, filed 1/9/01, effective 7/1/01)

WAC 284-43-251 ((~~Covered person's~~)) Enrollee's access to providers. (1) Each ((~~carrier~~)) issuer must allow ((~~a covered person~~)) an enrollee to choose a primary care provider who is accepting new patients from a list of participating providers. ((~~Covered persons~~))

(a) Enrollees also must be permitted to change primary care providers at any time with the change becoming effective ((~~no~~)) not later than the beginning of the month following the ((~~covered person's~~)) 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.

((~~(2)~~)) (3) Each ((~~carrier~~)) issuer must have a process whereby ((~~a covered person~~)) an enrollee with a complex or serious medical condition or ((~~psychiatric~~)) 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 ((~~covered person's~~)) en-

rollee'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 ((~~carrier~~)) issuer performance of utilization review functions.

((~~(3) Each carrier shall provide covered persons~~)) (4) Each issuer must provide enrollees with direct access to the participating chiropractor of the ((~~covered person's~~)) enrollee's choice for covered chiropractic health care without the necessity of prior referral. Nothing in this subsection ((~~shall prevent carriers~~)) prevents issuers from restricting ((~~covered persons~~)) 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.

((~~(4) Each carrier~~)) (5) Each issuer must provide, upon the request of ((~~a covered person~~)) an enrollee, access by the ((~~covered person~~)) enrollee to a second opinion regarding any medical diagnosis or treatment plan from a qualified participating provider of the ((~~covered person's~~)) enrollee's choice. The ((~~carrier~~)) issuer may not impose any charge or cost upon the ((~~covered person~~)) enrollee for such second opinion other than ((~~a~~)) the charge or cost imposed for the same service in otherwise similar circumstances.

((~~(5) Each carrier~~)) (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 ((~~covered persons or,~~)) 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 ((~~covered persons shall~~)) enrollees must include information of the ((~~covered person's~~)) enrollee's right of access to the terminating provider for an additional sixty days.

(ii) The provider's relationship with the ((~~carrier~~)) 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 ((~~carrier~~)) issuer assign new ((~~covered persons~~)) enrollees to the terminated provider.

((~~(6) Each carrier shall~~)) (7) Each issuer must make a good faith effort to assure that written notice of a termination ((~~within fifteen working days of receipt or issuance of a notice of termination is provided to all covered persons~~)) 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.

AMENDATORY SECTION (Amending WSR 98-04-005, filed 1/22/98, effective 2/22/98)

WAC 284-43-300 Provider and facility contracts with ((~~health carriers~~)) issuers—Generally. ((~~A health carrier~~)) (1) An issuer contracting with providers or facilities for health care service delivery to ((~~covered persons shall~~)) enrollees must satisfy all the requirements contained in this subchapter. ((~~The health carrier shall ensure that providers and facilities subcontracting with these providers and facilities under direct contract with the carrier also satisfy the requirements of this subchapter.~~))

(2) An issuer must ensure that subcontractors of its contracted providers and facilities comply with the requirements of this subchapter. An issuer's obligation to comply with these requirements is nondelegable; the issuer is not exempt from these requirements because it relied upon a third-party vendor or subcontracting arrangement.

AMENDATORY SECTION (Amending WSR 98-04-005, filed 1/22/98, effective 2/22/98)

WAC 284-43-310 Selection of participating providers—Credentialing and unfair discrimination. (1) ((~~Health carrier selection~~)) An issuer must develop standards for selecting participating providers ((~~and facilities shall be developed by the carrier~~)), for primary care providers, and for each health care provider or facility license ((~~or~~)) and professional specialty. The standards ((~~shall~~)) must be used in determining the selection of health care providers and facilities by the ((~~health carrier~~)) issuer. The standards ((~~shall~~)) must be consistent with rules or standards established by the state department of health or other regulatory authority established in Title 18 RCW for health care providers specified in RCW 18.130.040. Selection criteria ((~~shall~~)) must not be established in a manner that would:

(a) ((~~That would allow a health carrier~~)) Allow an issuer to avoid risk by excluding providers or facilities because they are located in geographic areas that contain populations presenting a risk of higher than average claims, losses, or health services utilization; ((~~or~~))

(b) ((~~That would~~)) Exclude providers or facilities because they treat or specialize in treating persons presenting a risk of higher than average claims, losses, or health services utilization or because they treat or specialize in treating minority or special populations; or

(c) Discriminate regarding participation in the network solely based on the provider or facility type or category if the provider is acting within the scope of their license.

(2) The provisions of subsection (1)((~~(a) and (b)~~)) of this section ((~~shall~~)) must not be construed to prohibit ((~~a carrier~~)) an issuer from declining to select a provider or facility who fails to meet other legitimate selection criteria of the ((~~carrier~~)) issuer. The purpose of these provisions is to prevent ((~~network creation and provider or facility selection to serve as a substitute for~~)) prohibited

health risk avoidance or prohibited discrimination through network creation and provider or facility selection.

(3) The provisions of this subchapter do not require ((~~a health carrier~~)) an issuer to employ, to contract with, or retain more providers or facilities than are necessary to comply with the network ((~~adequacy~~)) access standards of this chapter.

(4) ((~~A health carrier shall~~)) An issuer must make its selection standards for participating providers and facilities available for review upon request by the commissioner.

AMENDATORY SECTION (Amending WSR 99-21-016, filed 10/11/99, effective 11/11/99)

WAC 284-43-320 Provider contracts—Standards—Hold harmless provisions. The execution of a contract by ((~~a health carrier shall~~)) an issuer does not relieve the ((~~health carrier~~)) issuer of its obligations to any ((~~covered person~~)) 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 ((~~shall~~)) must be in writing and available for review upon request by the commissioner.

(1) ((~~A health carrier shall~~)) 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 ((~~shall~~)) must govern with respect to coverage provided to ((~~covered persons~~)) enrollees.

((~~(2)~~)) (3) Each participating provider and participating facility contract ((~~shall~~)) must contain the following provisions ((~~or variations approved by the commissioner~~)):

"(a) ((")){Name of provider or facility} hereby agrees that in no event, including, but not limited to nonpayment by {name of ((~~carrier~~)) issuer}, {name of ((~~carrier's~~)) issuer's} insolvency, or breach of this contract ((~~shall~~)) will {name of provider or facility} bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against ((~~a covered person~~)) an enrollee or person acting on their behalf, other than {name of ((~~carrier~~)) issuer}, for services provided pursuant to this contract. This provision ((~~shall~~)) 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 ((~~carrier~~)) issuer in accordance with regulatory standards for coordination of benefits, from ((~~covered persons~~)) enrollees in accordance with the terms of the ((~~covered person's~~)) enrollee's health plan.((")

(b) ((")){Name of provider or facility} agrees, in the event of {name of ((~~carrier's~~)) issuer's} insolvency, to continue to provide the services promised in this contract to ((~~covered persons~~)) enroll-

ees of {name of ((~~carrier~~)) issuer} for the duration of the period for which premiums on behalf of the ((~~covered person~~)) enrollee were paid to {Name of ((~~carrier~~)) issuer} or until the ((~~covered person's~~)) 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 ((~~covered person's~~)) enrollee's health plan.((")))

(d) ((")))){Name of provider or facility} may not bill the ((~~covered person~~)) enrollee for covered services (except for deductibles, copayments, or coinsurance) where {name of ((~~carrier~~)) 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 ((~~{or identifying citations appropriate to the contract form}~~)) 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 ((~~carrier's} covered persons~~)) 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 ((~~covered persons~~)) 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 ((~~covered persons~~)) enrollees of {name of ((~~carrier~~)) issuer} with the expectation of receiving payment directly or indirectly from {name of ((~~carrier~~)) issuer}, such providers or facilities must agree to abide by the provisions of (a), (b), (c), (d), and (e) of this subsection ((~~{or identifying citations appropriate to the contract form}~~))."

((~~(3)~~)) (4) The contract ((~~shall~~)) must inform participating providers and facilities that willfully collecting or attempting to collect an amount from ((~~a covered person~~)) 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).

((~~(4) A health carrier shall~~)) (5) An issuer must notify participating providers and facilities of their responsibilities with respect to the health ((~~carrier's~~)) 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.

(6) An issuer must make all documents, procedures, and other administrative policies and programs referenced in the contract ((~~must be~~)) 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 ((~~and~~)) 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 ((~~shall~~)) 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.

((~~(5) The following provision is a restatement of a statutory requirement found in RCW 48.43.075 included here for ease of reference:~~)) (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.

(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."

((~~(6) A health carrier shall~~))

(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 ((~~the grievances or complaints of covered persons subject to applicable state and federal laws related to the confidentiality of medical or health records.~~

~~(7) A health carrier~~)) 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.

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

(10) Whether the termination was for cause, or without cause, the issuer must make a good faith effort to ((~~assure that~~)) ensure written notice of a termination ((~~within fifteen working days of receipt or issuance of a notice of 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 ((~~covered persons~~)) enrollees who are patients seen:

(a) On a regular basis ((~~by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause. Where a contract termination involves a~~)) by a specialist;

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

(c) By a primary care provider((~~, that carrier shall make a good faith effort to assure that notice is provided to all covered persons who are patients of that primary care provider.~~

~~(8) A health carrier~~)).

(11) An issuer is responsible for ensuring that participating providers and facilities furnish covered services to ((~~covered persons~~)) each enrollee without regard to the ((~~covered person's~~)) 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.

((~~(9) A health carrier shall~~)) (12) 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 ((~~health carrier~~)) issuer that jeopardizes patient health or welfare or that may violate state or federal law.

((~~(10) The following provision is a restatement of a statutory requirement found in RCW 48.43.085: "Notwithstanding any other provision of law, no health carrier subject to the jurisdiction of the state of Washington may prohibit directly or indirectly its enrollees from freely contracting at any time to obtain any health care services outside the health care plan on any terms or conditions the enrollees choose. Nothing in this section shall be construed to bind a carrier for any services delivered outside the health plan."~~

~~(11)~~)) (13) Every participating provider contract ((~~shall~~)) must contain procedures for the fair resolution of disputes arising out of the contract.

(14) 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).

AMENDATORY SECTION (Amending WSR 13-16-045, filed 7/31/13, effective 8/31/13)

WAC 284-43-330 Participating provider—Filing and approval. (1) ((~~A health carrier must file with the commissioner thirty calendar days prior to use sample contract forms proposed for use with its participating providers and facilities.~~

~~(2) A health carrier shall submit material changes to a sample contract form to the commissioner thirty calendar days prior to use. Carriers shall indicate in the filing whether any change affects a provision required by this chapter.~~)) 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 ((~~contracts~~)) the contract template must be indicated through strike outs for deletions and underlines for new material. ((~~Alternatively, carriers may refile a sample contract that incorporates changes along with a copy of the contract addendum or amendment and any correspondence that will be sent to providers and facilities sufficient for a clear determination of contract changes. Changes not affecting a provision required by this chapter are deemed approved upon filing.~~)) 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 ((~~of a sample contract or a material change to a sample contract form by a health carrier~~)), the ((~~change or~~)) 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 ((~~health carrier shall~~)) issuer must maintain provider and facility contracts at its principal place of business in the state, or the ((~~health carrier shall~~)) 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 284-43-220 (3)(b) to ensure that all provider and facility contracts are current and signed if the provider or facility 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.