WSR 26-01-200
PERMANENT RULES
OFFICE OF THE
INSURANCE COMMISSIONER

[Insurance Commissioner Matter R 2025-10—Filed December 23, 2025, 3:57 p.m., effective January 23, 2026]

Effective Date of Rule: Thirty-one days after filing.

Purpose: 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.

Citation of Rules Affected by this Order: New WAC 284-170-131, 284-170-365, 284-170-441, 284-170-443, 284-170-445, and 284-170-447; and amending WAC 284-170-360 and 284-170-421.

Statutory Authority for Adoption: RCW 48.02.060 and 48.43.732(5).

Adopted under notice filed as WSR 25-22-098 on November 4, 2025.

Changes Other than Editing from Proposed to Adopted Version: The office of the insurance commissioner 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; or

(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."

A final cost-benefit analysis is available by contacting Rules Coordinator, P.O. Box 40260, Olympia, WA 98504, phone 360-725-7000, email rulescoordinator@oic.wa.gov.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 6, Amended 2, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: December 23, 2025.

Patty Kuderer
Insurance Commissioner

RDS-6767.3

NEW SECTION

WAC 284-170-131 Definitions applicable to RCW 48.43.732. The following definitions apply only to RCW 48.43.732 and WAC 284-170-441, 284-170-445, and 284-170-447.

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

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

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

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

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

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

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

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

(7) "Public statement" means written or verbal communication, whether made electronically, orally, or through physical documents, by health care providers, health care facilities, carriers, or health care providers employed by, contracted with, or otherwise affiliated with a health care facility:

(a) Made to health plan enrollees or patients; or

(b) Made accessible to the public.

"Public statement" includes, but is not limited to, notices, press releases, opinion articles such as op-eds, web pages, emails, social media posts, letters, communication through electronic health records, and individual verbal, written, or electronic communications. "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.

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

AMENDATORY SECTION (Amending WSR 16-07-144, filed 3/23/16, effective 4/23/16)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NEW SECTION

WAC 284-170-365 Continuity of care protections. (1) Each carrier 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 60 days following notice of termination to the enrollees; or

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

(i) Notice to enrollees must include information of the enrollee's right of access to the terminating provider for an additional 60 days.

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

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

AMENDATORY SECTION (Amending WSR 16-07-144, filed 3/23/16, effective 4/23/16)

WAC 284-170-421 Provider contracts—Standards—Hold harmless provisions. The execution of a contract by an issuer does not relieve the issuer of its obligations to any enrollee for the provision of

health care services, nor of its responsibility for compliance with statutes or regulations. In addition to the contract form filing requirements of this subchapter, all individual provider and facility contracts must be in writing and available for review upon request by the commissioner.

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

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

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

((~~"~~))(a) {Name of provider or facility} hereby agrees that in no event, including, but not limited to nonpayment by {name of issuer}, {name of issuer's} insolvency, or breach of this contract will {name of provider or facility} bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against an enrollee or person acting on their behalf, other than {name of issuer}, for services provided pursuant to this contract. This provision does not prohibit collection of {deductibles, copayments, coinsurance, and/or payment for noncovered services}, which have not otherwise been paid by a primary or secondary issuer in accordance with regulatory standards for coordination of benefits, from enrollees in accordance with the terms of the enrollee's health plan.

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

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

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

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

(f) If {name of provider or facility} contracts with other providers or facilities who agree to provide covered services to enrollees of {name of issuer} with the expectation of receiving payment directly or indirectly from {name of issuer}, such providers or facilities must agree to abide by the provisions of (a), (b), (c), (d), and (e) of this subsection.((~~"~~))

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

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

(b) If this provider contract expires by its own terms or one party gives notice to the other party of an intended termination without cause in accordance with the terms of this provider contract, provider/facility and carrier may not make or cause to be made public statements regarding such expiration or termination until 45 days prior to the termination date of the provider contract.

(c) Except for notifications to enrollees/patients that the contract termination is no longer applicable, such as in the case of a rescission of the contract termination, all notices sent to enrollees and patients under this contract termination provision must either:

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

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

(iii) Provider/facility and carrier may send enrollees and patients the notices described in this subsection electronically rather than by physical mail if the enrollee or patient has consented to receive electronic communications.

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

(e) Provider/facility acknowledges that, for potential violations of RCW 48.43.732 and WAC 284-170-441 and 284-170-445 by health care providers and health care facilities (as those terms are defined in RCW 48.43.005), if the commissioner has cause to believe that any health care provider or health care facility has violated the requirements of RCW 48.43.732 or WAC 284-170-441 or 284-170-445, the commissioner may submit information to the department of health or the appropriate health care facility or provider licensing or disciplining entity.

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

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

((~~(5)~~)) (7) An issuer must notify participating providers and facilities of their responsibilities with respect to the health issuer's applicable administrative policies and programs, including but not limited to payment terms, utilization review, quality assessment and improvement programs, credentialing, grievance, appeal and adverse benefit determination procedures, data reporting requirements, pharmacy benefit substitution processes, confidentiality requirements and any applicable federal or state requirements.

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

(a) Participating providers and facilities must be given reasonable notice of not less than ((~~sixty~~)) 60 days of changes that affect provider or facility compensation or that affect health care service delivery unless changes to federal or state law or regulations make such advance notice impossible, in which case notice must be provided as soon as possible.

(b)(i) Subject to any termination and continuity of care provisions of the contract, a provider or facility may terminate the contract without penalty if the provider or facility does not agree with the changes, subject to the requirements in subsection ((~~(9)~~)) (11) of this section.

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

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

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

((~~(7)~~)) (9) 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."

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

An issuer must require providers and facilities to cooperate with audit reviews of encounter data in relation to the administration of health plan risk adjustment and reinsurance programs.

((~~(9)~~)) (11) An issuer and participating provider and facility must provide at least ((~~sixty~~)) 60 days' written notice to each other before terminating the contract without cause.

((~~(10)~~)) (12) Whether the termination was for cause, or without cause, the issuer must make a good faith effort to ensure written notice of a termination is provided at least ((~~thirty~~)) 30 days prior to the effective date of the termination or immediately for a termination for cause that results in less than ((~~thirty~~)) 30 days notice to a provider or carrier to all enrollees who are patients seen:

(a) On a regular basis by a specialist;

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

(c) By a primary care provider.

((~~(11)~~)) (13) An issuer is responsible for ensuring that participating providers and facilities furnish covered services to each enrollee without regard to the enrollee's enrollment in the plan as a private purchaser of the plan or as a participant in publicly financed programs of health care services. This requirement does not apply to circumstances when the provider should not render services due to limitations arising from lack of training, experience, skill, or licensing restrictions.

((~~(12)~~)) (14) An issuer must not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the issuer that jeopardizes patient health or welfare or that may violate state or federal law.

((~~(13)~~)) (15) Every participating provider contract must contain procedures for the fair resolution of disputes arising out of the contract.

((~~(14)~~)) (16) 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).

NEW SECTION

WAC 284-170-441 Public statements regarding contract terminations. (1) In the case of a provider contract defined in RCW 48.43.732 that is expiring by its own terms or for which one party has given notice to the other party of an intended termination without cause in accordance with the terms of the provider contract, carriers, health care providers and health care facilities, and health care providers employed by, contracted with, or otherwise affiliated with a health care facility may not make or cause to be made public statements regarding such expiration or termination until 45 days prior to the expiration or termination date.

(2) This section does not apply to expirations or terminations that are:

(a) For cause;
(b) Due to the death of a provider;
(c) Due to the permanent closure of a health care facility or the practice of a health care provider;
(d) Due to the retirement of a health care provider.

NEW SECTION

WAC 284-170-443 Provider contract terminations—Notice requirements—General standards. (1) This section applies to any contract termination other than those under RCW 48.43.732.

(2) Each carrier must make a good faith effort to assure that notice of a termination is provided at least 30 days prior to the effective date of the termination to all enrollees who are patients seen on a regular basis by the provider or facility whose contract is terminating, irrespective of whether the termination was for cause or without cause.

(3) When a termination provides less than 30 days notice to the carrier or provider, a carrier must make a good faith effort to assure that written notice of termination is provided immediately to all enrollees.

NEW SECTION

WAC 284-170-445 Provider contract terminations under RCW 48.43.732—Notice requirements. (1) This section applies to provider contracts as set forth in RCW 48.43.732 that are expiring by their own terms or for which one party has given notice to the other party of an intended termination without cause in accordance with the terms of the provider contracts.

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

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

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

(ii) For notices that do not solely utilize the standard template as described in this section, receive the commissioner's prior approval before the notices are sent to enrollees. In determining whether to approve or deny proposed notices, the commissioner may consider, but is not limited to, consideration of: Whether the notices contain the minimum information required by RCW 48.43.732(4); whether the notices clearly inform the enrollee of their options and rights to ac-

cess health care services; whether the notices are generally consistent with the standard template language under this section; and whether the notices make any statements related to the intent or conduct of the other party to the contract dispute.

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

(3) Carriers, health care providers, and health care facilities may send enrollees and patients the notices described in this section electronically rather than by physical mail if the enrollee or patient has consented to receive electronic communications.

(4) Notifications to enrollees/patients that the contract termination is no longer applicable, such as a rescission of the contract termination, are not subject to the requirements of this section.

(5) This section does not apply to expirations or terminations that are:

(a) For cause;

(b) Due to the death of a provider;

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

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

NEW SECTION

WAC 284-170-447 Enforcement—Public statements and notices regarding contract terminations. (1) For violations of RCW 48.43.732 and WAC 284-170-421 (4) and (5), 284-170-441, and 284-170-445 committed by carriers on or after January 1, 2026, the commissioner may pursue enforcement actions under RCW 48.02.080 or impose a civil monetary penalty upon carriers of up to $100 per noncompliant notice, per day, per enrollee to whom the notice has been sent in advance of the 45-day period established under RCW 48.43.732 and WAC 284-170-441.

(2) For potential violations of RCW 48.43.732 and corresponding regulations in WAC 284-170-421 (4) and (5), 284-170-441, and 284-170-445 by health care providers and health care facilities on or after January 1, 2026, if the commissioner has cause to believe that any health care provider or health care facility is in violation, the commissioner may submit information to the department of health or the appropriate health care facility or provider licensing or disciplining entity.

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