

**Chapter 48.43 RCW
INSURANCE REFORM**

Sections

- 48.43.001 Intent.
- 48.43.005 Definitions.
- 48.43.007 Availability of price and quality information—
Transparency tools for members—Requirements.
- 48.43.008 Enrollment in employer-sponsored health plan—Person
eligible for medical assistance.
- 48.43.009 Health care sharing ministries.
- 48.43.012 Health plans—Preexisting conditions—Rules.
- 48.43.01211 Health plans—Eligibility—Health status-related factors
—Rules.
- 48.43.0122 Individual health benefit plans—Open enrollment and
special enrollment periods—Rules—Enforcement.
- 48.43.0123 Health plans—Rescission of coverage—Rules.
- 48.43.0124 Health plans—Cost sharing for essential health benefits
—Rules.
- 48.43.0125 Essential health benefits—Annual or lifetime dollar
limits.
- 48.43.0126 Summary of benefits and explanation of coverage—
Standards and requirements—Notice of modification—
Fines—Standards for definitions of health insurance
terms—Rules.
- 48.43.0127 Group health plans—Waiting period—Rules.
- 48.43.0128 Nongrandfathered health plans and plans issued or
renewed on or after January 1, 2022—Prohibited
discrimination—Rules.
- 48.43.016 Utilization management standards and criteria—Health
carrier requirements—Definitions.
- 48.43.0161 Prior authorization practices—Carrier annual reporting
requirements—Commissioner's standardized report.
- 48.43.021 Personally identifiable health information—Restrictions
on release.
- 48.43.022 Enrollee identification card—Social security number
restriction.
- 48.43.023 Pharmacy identification cards—Rules.
- 48.43.028 Eligibility to purchase certain health benefit plans—
Small employers and small groups.
- 48.43.035 Group health benefit plans—Guaranteed issue and
continuity of coverage—Exceptions.
- 48.43.038 Individual health plans—Guarantee of continuity of
coverage—Exceptions.
- 48.43.039 Grace period—Notification or information—Information
concerning delinquencies or nonpayment of premiums—
Defined.
- 48.43.041 Individual health benefit plans—Mandatory benefits.
- 48.43.043 Colorectal cancer examinations and laboratory tests—
Required benefits or coverage.
- 48.43.045 Health plan requirements—Annual reports—Exemptions.
- 48.43.047 Health plans—Minimum coverage for preventive services—
No cost-sharing requirements.

- 48.43.049 Health carrier data—Information from annual statement—
Format prescribed by commissioner—Public
availability.
- 48.43.055 Procedures for review and adjudication of health care
provider complaints—Requirements.
- 48.43.059 Payments made by a second-party payment process—
Definition.
- 48.43.065 Right of individuals to receive services—Right of
providers, carriers, and facilities to refuse to
participate in or pay for services for reason of
conscience or religion—Requirements.
- 48.43.071 Health care information—Requirement to provide free
copy to covered person appealing denial of social
security benefits—Exceptions.
- 48.43.072 Required reproductive health care coverage—Restrictions
on copayments, deductibles, and other form of cost
sharing.
- 48.43.0725 Reproductive health plan coverage—Immediate postpartum
contraception devices.
- 48.43.073 Required abortion coverage—Limitations.
- 48.43.074 Qualified health plans—Single invoice billing—
Certification of compliance required in the
segregation plan for premium amounts attributable to
coverage of abortion services.
- 48.43.076 Digital breast examinations—Cost sharing.
- 48.43.078 Digital breast tomosynthesis—Intent to ensure women
with access—Commissioner's and health care
authority's duty to clarify mandates.
- 48.43.081 Anatomic pathology services—Payment for services—
Definitions.
- 48.43.083 Chiropractor services—Participating provider agreement
—Health carrier reimbursement.
- 48.43.085 Health carrier may not prohibit its enrollees from
contracting for services outside the health care
plan.
- 48.43.087 Contracting for services at enrollee's expense—Mental
health care practitioner—Conditions—Exception.
- 48.43.091 Health carrier coverage of outpatient mental health
services—Requirements.
- 48.43.093 Health carrier coverage of emergency medical services—
Requirements—Conditions.
- 48.43.094 Pharmacist provided services—Health plan requirements.
- 48.43.096 Medication synchronization policy required for health
plans covering prescription drugs—Requirements—
Definitions.
- 48.43.0961 Continuity of coverage for health plans covering
prescription drugs for behavioral health.
- 48.43.097 Filing of financial statements—Every health carrier.
- 48.43.105 Preparation of documents that compare health carriers—
Immunity—Due diligence.
- 48.43.115 Maternity services—Intent—Definitions—Patient
preference—Clinical sovereignty of provider—Notice
to policyholders—Application.
- 48.43.121 Ground ambulance services organizations—Coverage.

- 48.43.125 Coverage at a long-term care facility following hospitalization—Definition.
- 48.43.135 Hearing instruments—Coverage.
- 48.43.176 Eosinophilic gastrointestinal associated disorder—Elemental formula.
- 48.43.180 Denturist services.
- 48.43.185 General anesthesia services for dental procedures.
- 48.43.190 Payment of chiropractic services—Parity.
- 48.43.195 Contraceptive drugs—Twelve-month refill coverage.
- DISCLOSURE OF MATERIAL TRANSACTIONS
- 48.43.200 Disclosure of certain material transactions—Report—Information is confidential.
- 48.43.205 Material acquisitions or dispositions.
- 48.43.210 Asset acquisitions—Asset dispositions.
- 48.43.215 Report of a material acquisition or disposition of assets—Information required.
- 48.43.220 Material nonrenewals, cancellations, or revisions of ceded reinsurance agreements.
- 48.43.225 Report of a material nonrenewal, cancellation, or revision of ceded reinsurance agreements—Information required.
- MISCELLANEOUS
- 48.43.290 Coverage for prescribed durable medical equipment and mobility enhancing equipment—Sales and use taxes—Definitions.
- RISK-BASED CAPITAL STANDARDS FOR HEALTH CARRIERS
- 48.43.300 Definitions.
- 48.43.305 Report of RBC levels—Distribution of report—Formula for determination—Commissioner may make adjustments.
- 48.43.310 Company action level event—Required RBC plan—Commissioner's review—Notification—Challenge by carrier.
- 48.43.315 Regulatory action level event—Required RBC plan—Commissioner's review—Notification—Challenge by carrier.
- 48.43.320 Authorized control level event—Commissioner's options.
- 48.43.325 Mandatory control level event—Commissioner's duty—Regulatory control.
- 48.43.330 Carrier's right to hearing—Request by carrier—Date set by commissioner.
- 48.43.335 Confidentiality of RBC reports and plans—Use of certain comparisons prohibited—Certain information intended solely for use by commissioner.
- 48.43.340 Powers or duties of commissioner not limited—Rules.
- 48.43.345 Foreign or alien carriers—Required RBC report—Commissioner may require RBC plan—Mandatory control level event.
- 48.43.350 No liability or cause of action against commissioner or department.
- 48.43.355 Notice by commissioner to carrier—When effective.
- 48.43.360 Initial RBC reports—Calculation of initial RBC levels—Subsequent reports.

- 48.43.366 Self-funded multiple employer welfare arrangements.
- 48.43.370 RBC standards not applicable to certain carriers.
- PRESCRIPTION DRUG UTILIZATION MANAGEMENT
- 48.43.400 Prescription drug utilization management—Definitions.
- 48.43.410 Prescription drug utilization management—Clinical review criteria—Requirement to be evidence-based and updated regularly.
- 48.43.420 Prescription drug utilization management—Exception request process—Conditions, requirements, and time frames for approval or denial of requests—Emergency fill coverage—Notice of new policies and procedures.
- 48.43.430 Prescription medication—Maximum charge at point of sale—Requirements.
- 48.43.435 Prescription medication—Cost-sharing calculation—Application—Rules.
- 48.43.440 Human immunodeficiency virus postexposure prophylaxis drugs—Cost sharing and prior authorization.
- HEALTH CARE PATIENT PROTECTION
- 48.43.500 Intent—Purpose—2000 c 5.
- 48.43.505 Enrollee's and protected individual's right to privacy and confidential services—Health carrier or insurer duties—Requests for confidential communications—Rules.
- 48.43.5051 Requests for confidential communications—Monitoring and ensuring compliance—Standardized form for submission of requests—Rules.
- 48.43.510 Carrier required to disclose health plan information—Marketing and advertising restrictions—Rules.
- 48.43.515 Access to appropriate health services—Enrollee options—Rules.
- 48.43.517 Enrollment of child participating in medical assistance program—Employer-sponsored health plan.
- 48.43.520 Requirement to maintain a documented utilization review program description and written utilization review criteria—Rules.
- 48.43.525 Prohibition against retrospective denial of health plan coverage—Rules.
- 48.43.530 Requirement for carriers to have comprehensive grievance and appeal processes—Carrier's duties—Procedures—Appeals—Rules.
- 48.43.535 Independent review of health care disputes—System for using certified independent review organizations—Rules.
- 48.43.537 Health care disputes—Certifying independent review organizations—Application—Restrictions—Maximum fee schedule for conducting reviews—Rules.
- 48.43.540 Requirement to designate a licensed medical director—Exemption.
- 48.43.545 Standard of care—Liability—Causes of action—Defense—Exception.
- 48.43.550 Delegation of duties—Carrier accountability.

MISCELLANEOUS

- 48.43.600 Overpayment recovery—Carrier.
- 48.43.605 Overpayment recovery—Health care provider.
- 48.43.650 Fixed payment insurance products—Commissioner's annual report.
- 48.43.670 Plan or contract renewal—Modification of wellness program.
- 48.43.680 Lifetime limit on transplants—Definition.
- 48.43.690 Assessments under RCW 70.290.040 considered medical expenses.
- 48.43.700 Exchange—Plans that a carrier must offer—Review—Rules.
- 48.43.705 Plans offered outside of exchange.
- 48.43.710 Certification as qualified health plan not an exemption.
- 48.43.715 Individual and small group market—Selection of benchmark plan—Minimum requirements—Criteria—List of state-mandated health benefits.
- 48.43.720 Reinsurance and risk adjustment programs—Affordable care act—Rules.
- 48.43.725 Exclusion of mandated benefits from health plan—Carrier requirements—Notice—Fees—Commissioner's duties.
- 48.43.730 Carrier must file provider contracts and compensation agreements with commissioner—Approval or disapproval—Confidentiality—Hearings—Rules—Definitions.
- 48.43.731 Health care benefit management contracts—Carrier filing requirements—Notice to enrollees—Confidentiality of filings.
- 48.43.733 Rates and forms of group health benefit plans—Timing of filings—Exceptions—Rules.
- 48.43.734 Health carrier rate filings—Review of surplus, capital, and profit levels.
- 48.43.735 Reimbursement of health care services provided through telemedicine or store and forward technology—Audio-only telemedicine.
- 48.43.740 Dental only plan—Emergency dental conditions—Definitions.
- 48.43.743 Dental only plan—Annual data statement—Contents—Public use—Definition.
- 48.43.745 Dental only plan—Denturist services.
- 48.43.750 Health care provider credentialing applications—Use of electronic database by health carriers.
- 48.43.755 Health care provider credentialing applications—Use of electronic database by providers.
- 48.43.757 Health care provider credentialing applications—Reimbursement requirements.
- 48.43.760 Opioid use disorder—Coverage without prior authorization.
- 48.43.761 Withdrawal management services—Substance use disorder treatment services—Prior authorization—Utilization review—Medical necessity review.
- 48.43.762 Opioid overdose reversal medication bulk purchasing and distribution program.
- 48.43.764 Standard set of criteria—Authority review.

- 48.43.765 Health carrier network adequacy—Mental health and substance abuse treatment.
 - 48.43.767 Behavioral health services—Network access.
 - 48.43.770 Individual market health plan availability—Annual report.
 - 48.43.775 Qualified health plan participation—Reimbursement rate for other health plans.
 - 48.43.780 Cap on enrollee's required payment amount for specific drugs and equipment—Cost-sharing requirements.
 - 48.43.785 COVID-19 personal protective equipment expenses—Health care provider reimbursement.
 - 48.43.790 Behavioral services—Next-day appointments.
 - 48.43.795 Qualified health plans—Acceptance of premium and cost-sharing assistance.
 - 48.43.800 Primary care expenditures assessment—Review.
 - 48.43.805 Prescription drug upper payment limit—Rules.
 - 48.43.810 Biomarker testing—Standards—Construction.
 - 48.43.815 Donor human milk—Standards.
 - 48.43.820 Consolidated appropriations act enforcement—Implementation of federal regulations.
 - 48.43.825 Certified peer specialist services—Network access standards.
 - 48.43.830 Prior authorization.
 - 48.43.835 Physician assistants—Coverage.
- CONSTRUCTION
- 48.43.902 Effective date—1996 c 312.
 - 48.43.904 Construction—Chapter applicable to state registered domestic partnerships—2009 c 521.