

Chapter 284-43 WAC

HEALTH CARRIERS AND HEALTH PLANS

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**DISPOSITION OF SECTIONS FORMERLY
 CODIFIED IN THIS CHAPTER**

284-43-040 Review and approval of certified health plan provider selection, termination, and dispute resolution provisions. [Statutory Authority: RCW 48.01.030, 48.02.060 (3)(a), 48.43.140, 43.72.100(4) and 43.72.100(6). WSR 94-23-056, § 284-43-040, filed 11/14/94, effective 12/15/94.] Repealed by WSR 98-04-005 (Matter No. R 97-3), filed 1/22/98, effective 2/22/98. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243.

284-43-100 Health carrier standards for women's right to directly access certain health care practitioners for women's health care services. [Statutory Authority: RCW 48.02.-060, 48.18.120, 48.20.450, 48.20.460, 48.44.020, 48.44.050, 48.44.070, 48.46.200 and 48.46.243. WSR 96-16-050 (Matter No. R 95-10), § 284-43-100, filed 8/1/96, effective 9/1/96.] Repealed by WSR 98-04-005 (Matter No. R 97-3), filed 1/22/98, effective 2/22/98. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243.

284-43-210 Access plan. [Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.030, 48.46.200. WSR 00-04-034 (Matter No. R 99-2), § 284-43-210, filed 1/24/00, effective 1/1/01. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. WSR 98-04-005 (Matter No. R 97-3), § 284-43-210, filed 1/22/98, effective 2/22/98.] Repealed by WSR 08-17-037 (Matter No. R 2008-17), filed 8/13/08, effective 9/13/08. Statutory Authority: RCW 48.02.060.

284-43-340 Effective date. [Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. WSR 98-04-005 (Matter No. R 97-3), § 284-43-340, filed 1/22/98, effective 2/22/98.] Repealed by WSR 14-10-017 (Matter No. R 2013-22), filed 4/25/14, effective 5/26/14. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.460, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.44.050, 48.46.200, 48.20.450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. §§ 156.230, 156.235, and 156.245.

284-43-610 Definitions. [Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.43.055, 48.44.050, 48.46.100 and 48.46.200. WSR 99-24-075 (Matter No. R 98-17), § 284-43-610, filed 11/29/99, effective 12/30/99.] Repealed by WSR 01-03-033 (Matter No. R 2000-02), filed 1/9/01, effective 7/1/01. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.100, 48.46.200, 48.43.505, 48.43.510, 48.43.515, 48.43.520, 48.43.525, 48.43.530, 48.43.535.

284-43-700 Purpose. [Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. WSR 98-04-005 (Matter No. R 97-3), § 284-43-700, filed 1/22/98, effective 2/22/98.] Repealed by WSR 08-09-022 (Matter No. R 2008-01), filed 4/7/08, effective 5/8/08. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.44.050, 48.46.030, 48.46.200.

284-43-710 Portability of health insurance benefits. [Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.030, 48.46.200. WSR 00-04-034 (Matter No. R 99-2), § 284-43-710, filed 1/24/00, effective 2/24/00. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.-060(2), 48.46.200 and 48.46.243. WSR 98-04-005 (Matter No. R 97-3), § 284-43-710, filed 1/22/98, effective 2/22/98.] Repealed by WSR 08-09-022 (Matter No. R 2008-01), filed 4/7/08, effective 5/8/08. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.44.050, 48.46.030, 48.46.200.

284-43-720 Guaranteed issue and restrictions on the denial, exclusion, or limitation of health benefits for preexisting conditions. [Statutory Authority: RCW 48.02.060, 48.18.-120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.030, 48.46.200. WSR 00-04-034 (Matter No. R 99-2), § 284-43-720, filed 1/24/00, effective 2/24/00. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. WSR 98-04-005 (Matter No. R 97-3), § 284-43-720, filed 1/22/98, effective 2/22/98.] Repealed by WSR 08-09-022 (Matter No. R 2008-01), filed 4/7/08, effective 5/8/08. Statutory Authority: RCW 48.02.060, 48.20.-450, 48.20.460, 48.44.050, 48.46.030, 48.46.200.

284-43-730 Guaranteed renewability—Health insurance. [Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. WSR 98-04-005 (Matter No. R 97-3), § 284-43-730, filed 1/22/98, effective 2/22/98.] Repealed by WSR 08-09-022 (Matter No. R 2008-01), filed 4/7/08, effective 5/8/08. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.44.050, 48.46.030, 48.46.200.

284-43-810 Coverage for mental health services. [Statutory Authority: RCW 48.02.060, 48.30.010, 48.44.050, 48.46.200, 48.30.040, 48.44.110 and 48.46.400. WSR 99-19-032 (Matter No. R 98-7), § 284-43-810, filed 9/8/99, effective 10/9/99.] Repealed by WSR 08-09-021 (Matter No. R 2008-02), filed 4/7/08, effective 5/8/08. Statutory Authority: RCW 48.02.060, 48.18.120(2), 48.20.450, 48.20.460, 48.44.050, 48.46.200. Later promulgation, see RCW 48.20.580, 48.21.240, 48.44.341 and 48.46.-291.

284-43-821 Maternity and pregnancy-related exclusions, limitations and conditions in individual plans. [Statutory Authority: 2000 c 79 and RCW 48.43.041, 48.44.020, and 48.46.060. WSR 01-03-035 (Matter No. R 2000-03), § 284-43-821, filed 1/9/01, effective 7/1/01.] Repealed by WSR 01-19-001 (Matter No. R 2001-02), filed 9/5/01, effective 10/6/01. Statutory Authority: RCW 48.02.060, 48.18.480, 48.20.450, 48.20.460, 48.21.045, 48.30.010, 48.30.300, 48.41.110, 48.41.170, 48.42.010, 48.42.040, 48.42.100, 48.43.012, 48.43.025, 48.43.035, 48.43.041, 48.43.115, 48.43.520, 48.44.020, 48.44.023, 48.44.050, 48.44.220, 48.46.060, 48.46.066, 48.46.110, 48.46.200, 49.60.010, 49.60.030, 49.60.120, 49.60.178, 49.60.220.

284-43-823 Maternity and pregnancy-related exclusions, limitations and conditions in group plans. [Statutory Authority: 2000 c 79 and RCW 48.43.041, 48.44.020, and 48.46.060. WSR 01-03-035 (Matter No. R 2000-03), § 284-43-823, filed 1/9/01, effective 7/1/01.] Repealed by WSR 01-19-001 (Matter No. R 2001-02), filed 9/5/01, effective 10/6/01. Statutory Authority: RCW 48.02.060, 48.18.480, 48.20.450, 48.20.460, 48.21.045, 48.30.010, 48.30.300, 48.41.110, 48.41.170, 48.42.010, 48.42.040, 48.42.100, 48.43.012, 48.43.025, 48.43.035, 48.43.041, 48.43.115, 48.43.520, 48.44.020, 48.44.023, 48.44.050, 48.44.220, 48.46.060, 48.46.066, 48.46.110, 48.46.200, 49.60.010, 49.60.030, 49.60.120, 49.60.178, 49.60.220.

284-43-824 Effective date. [Statutory Authority: 2000 c 79 and RCW 48.43.041, 48.44.020, and 48.46.060. WSR 01-03-035 (Matter No. R 2000-03), § 284-43-824, filed 1/9/01, effective 2/9/01.] Repealed by WSR 01-19-001 (Matter No. R 2001-02), filed 9/5/01, effective 10/6/01. Statutory Authority: RCW 48.02.060, 48.18.480, 48.20.450, 48.20.460, 48.21.045, 48.30.010, 48.30.300, 48.41.110, 48.41.170, 48.42.010, 48.42.040, 48.42.100, 48.43.012, 48.43.025, 48.43.035, 48.43.041, 48.43.115, 48.43.520, 48.44.020, 48.44.023, 48.44.050, 48.44.220, 48.46.060, 48.46.066, 48.46.110, 48.46.200, 49.60.010, 49.60.030, 49.60.120, 49.60.178, 49.60.220.

284-43-900 Authority and purpose. [Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066. WSR 98-04-011 (Matter No. R 97-2), § 284-43-900, filed 1/23/98, effective 3/1/98.] Repealed by WSR 05-07-006 (Matter No. R 2004-05), filed 3/3/05, effective 4/3/05. Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200.

284-43-955 Effective date. [Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066. WSR 98-04-011 (Matter No. R 97-2), § 284-43-955, filed 1/23/98, effective 3/1/98.] Repealed by

- WSR 05-07-006 (Matter No. R 2004-05), filed 3/3/05, effective 4/3/05. Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200.
- 284-43-970 Purpose and scope. [Statutory Authority: RCW 48.02.-060, 48.18.120(2), 48.20.450, 48.44.050, 48.46.200, and P.L. 111-148 and the interim final regulations issued June 28, 2010, found at Vol. 75 F.R. 37187-37241, and codified in 45 C.F.R. Parts 144, 146 and 147. WSR 11-13-068 (Matter No. R 2010-16), § 284-43-970, filed 6/15/11, effective 7/16/11.] Repealed by WSR 14-08-036 (Matter No. R 2014-01), filed 3/26/14, effective 4/26/14. Statutory Authority: RCW 48.02.060, 48.18.120(2), 48.44.050, 48.46.200 and 45 C.F.R. Parts 144, 146 and 147.
- 284-43-975 Definitions. [Statutory Authority: RCW 48.02.060, 48.18.120(2), 48.20.450, 48.44.050, 48.46.200, and P.L. 111-148 and the interim final regulations issued June 28, 2010, found at Vol. 75 F.R. 37187-37241, and codified in 45 C.F.R. Parts 144, 146 and 147. WSR 11-13-068 (Matter No. R 2010-16), § 284-43-975, filed 6/15/11, effective 7/16/11.] Repealed by WSR 14-08-036 (Matter No. R 2014-01), filed 3/26/14, effective 4/26/14. Statutory Authority: RCW 48.02.060, 48.18.120(2), 48.44.050, 48.46.200 and 45 C.F.R. Parts 144, 146 and 147.
- 284-43-980 Preexisting conditions. [Statutory Authority: RCW 48.02.060, 48.18.120(2), 48.20.450, 48.44.050, 48.46.200, and P.L. 111-148 and the interim final regulations issued June 28, 2010, found at Vol. 75 F.R. 37187-37241, and codified in 45 C.F.R. Parts 144, 146 and 147. WSR 11-13-068 (Matter No. R 2010-16), § 284-43-980, filed 6/15/11, effective 7/16/11.] Repealed by WSR 14-08-036 (Matter No. R 2014-01), filed 3/26/14, effective 4/26/14. Statutory Authority: RCW 48.02.060, 48.18.120(2), 48.44.050, 48.46.200 and 45 C.F.R. Parts 144, 146 and 147.
- 284-43-985 Enrollment of persons under age nineteen. [Statutory Authority: RCW 48.02.060, 48.18.120(2), 48.20.450, 48.44.050, 48.46.200, and P.L. 111-148 and the interim final regulations issued June 28, 2010, found at Vol. 75 F.R. 37187-37241, and codified in 45 C.F.R. Parts 144, 146 and 147. WSR 11-13-068 (Matter No. R 2010-16), § 284-43-985, filed 6/15/11, effective 7/16/11.] Repealed by WSR 14-08-036 (Matter No. R 2014-01), filed 3/26/14, effective 4/26/14. Statutory Authority: RCW 48.02.060, 48.18.120(2), 48.44.050, 48.46.200 and 45 C.F.R. Parts 144, 146 and 147.

SUBCHAPTER A

GENERAL PROVISIONS

WAC 284-43-110 Purpose. The purpose of this chapter is to establish uniform regulatory standards for health carriers and to create minimum standards for health plans that ensure consumer access to the health care services promised in these health plans.

[Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. WSR 98-04-005 (Matter No. R 97-3), § 284-43-110, filed 1/22/98, effective 2/22/98.]

WAC 284-43-120 Applicability and scope. This chapter shall apply to all health plans and all health carriers subject to the jurisdiction of the state of Washington except as otherwise expressly provided in this chapter. Health carriers are responsible for compliance with the provisions of this chapter and are responsible for the compliance of any person or organization acting on behalf of or at the direction of the carrier, or acting pursuant to carrier standards or requirements concerning the coverage of, payment for, or provision of health care services. A carrier may not offer as a defense to a violation of any provision of this chapter that the violation arose from the act or omission of a participating provider or

facility, network administrator, claims administrator, or other person acting on behalf of or at the direction of the carrier, or acting pursuant to carrier standards or requirements under a contract with the carrier rather than from the direct act or omission of the carrier. Nothing in this chapter shall be construed to permit the direct regulation of health care providers or facilities by the office of the insurance commissioner.

[Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.030, 48.46.200. WSR 00-04-034 (Matter No. R 99-2), § 284-43-120, filed 1/24/00, effective 2/24/00. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. WSR 98-04-005 (Matter No. R 97-3), § 284-43-120, filed 1/22/98, effective 2/22/98.]

WAC 284-43-125 Compliance with state and federal laws. Health carriers shall comply with all Washington state and federal laws relating to the acts and practices of carriers and laws relating to health plan benefits.

[Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.030, 48.46.200. WSR 00-04-034 (Matter No. R 99-2), § 284-43-125, filed 1/24/00, effective 2/24/00.]

WAC 284-43-130 Definitions. Except as defined in other subchapters and unless the context requires otherwise, the following definitions shall apply throughout this chapter.

(1) "Adverse determination" has the same meaning as the definition of adverse benefit determination in RCW 48.43.005, and includes:

(a) The determination includes any decision by a health carrier's designee utilization review organization that a request for a benefit under the health carrier's health benefit plan does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part for the benefit;

(b) The denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit based on a determination by a health carrier or its designee utilization review organization of a covered person's eligibility to participate in the health carrier's health benefit plan;

(c) Any prospective review or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment in whole or in part for a benefit;

(d) A rescission of coverage determination; or

(e) A carrier's denial of an application for coverage.

(2) "Authorization" or "certification" means a determination by the carrier that an admission, extension of stay, or other health care service has been reviewed and, based on the information provided, meets the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness in relation to the applicable health plan.

(3) "Clinical review criteria" means the written screens, decision rules, medical protocols, or guidelines used by the carrier as an element in the evaluation of medical necessity and appropriateness of requested admissions, procedures, and services under the auspices of the applicable health plan.

(4) "Covered health condition" means any disease, illness, injury or condition of health risk covered according to the terms of any health plan.

(5) "Covered person" or "enrollee" means an individual covered by a health plan including a subscriber, policyholder, or beneficiary of a group plan.

(6) "Emergency medical condition" means the emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

(7) "Emergency services" has the meaning set forth in RCW 48.43.005.

(8) "Enrollee point-of-service cost-sharing" or "cost-sharing" means amounts paid to health carriers directly providing services, health care providers, or health care facilities by enrollees and may include copayments, coinsurance, or deductibles.

(9) "Facility" means an institution providing health care services, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory, and imaging centers, and rehabilitation and other therapeutic settings, and as defined in RCW 48.43.005.

(10) "Formulary" means a listing of drugs used within a health plan.

(11) "Grievance" has the meaning set forth in RCW 48.43.005.

(12) "Health care provider" or "provider" means:

(a) 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

(b) An employee or agent of a person described in (a) of this subsection, acting in the course and scope of his or her employment.

(13) "Health care service" or "health service" means that service offered or provided by health care facilities and health care providers relating to the prevention, cure, or treatment of illness, injury, or disease.

(14) "Health carrier" or "carrier" means a disability insurance company regulated under chapter 48.20 or 48.21 RCW, a health care service contractor as defined in RCW 48.44.010, and a health maintenance organization as defined in RCW 48.46.020, and includes "issuers" as that term is used in the Patient Protection and Affordable Care Act (P.L. 111-148, as amended (2010)).

(15) "Health plan" or "plan" means any individual or group policy, contract, or agreement offered by a health carrier to provide, arrange, reimburse, or pay for health care service except the following:

(a) Long-term care insurance governed by chapter 48.84 RCW;

(b) Medicare supplemental health insurance governed by chapter 48.66 RCW;

(c) Limited health care service offered by limited health care service contractors in accordance with RCW 48.44.035;

(d) Disability income;

(e) Coverage incidental to a property/casualty liability insurance policy such as automobile personal injury protection coverage and homeowner guest medical;

(f) Workers' compensation coverage;

(g) Accident only coverage;

(h) Specified disease and hospital confinement indemnity when marketed solely as a supplement to a health plan;

(i) Employer-sponsored self-funded health plans;

(j) Dental only and vision only coverage; and

(k) Plans deemed by the insurance commissioner to have a short-term limited purpose or duration, or to be a student-only plan that is guaranteed renewable while the covered person is enrolled as a regular full-time undergraduate or graduate student at an accredited higher education institution, after a written request for such classification by the carrier and subsequent written approval by the insurance commissioner.

(16) "Indian health care provider" means:

(a) The Indian Health Service, an agency operated by the U.S. Department of Health and Human Services established by the Indian Health Care Improvement Act, Section 601, 25 U.S.C. §1661;

(b) An Indian tribe, as defined in the Indian Health Care Improvement Act, Section 4(14), 25 U.S.C. §1603(14), that operates a health program under a contract or compact to carry out programs of the Indian Health Service pursuant to the Indian Self-Determination and Education Assistance Act (ISDEAA), 25 U.S.C. §450 et seq.;

(c) A tribal organization, as defined in the Indian Health Care Improvement Act, Section 4(26), 25 U.S.C. §1603(26), that operates a health program under a contract or compact to carry out programs of the Indian Health Service pursuant to the ISDEAA, 25 U.S.C. §450 et seq.;

(d) An Indian tribe, as defined in the Indian Health Care Improvement Act, Section 4(14), 25 U.S.C. §1603(14), or tribal organization, as defined in the Indian Health Care Improvement Act, Section 4(26), 25 U.S.C. §1603(26), that operates a health program with funding provided in whole or part pursuant to 25 U.S.C. §47 (commonly known as the Buy Indian Act); or

(e) An urban Indian organization that operates a health program with funds in whole or part provided by Indian Health Service under a grant or contract awarded pursuant to Title V of the Indian Health Care Improvement Act, Section 4(29), 25 U.S.C. §1603(29).

(17) "Managed care plan" means a health plan that coordinates the provision of covered health care services to a covered person through the use of a primary care provider and a network.

(18) "Medically necessary" or "medical necessity" in regard to mental health services and pharmacy services is a carrier determination as to whether a health service is a covered benefit because the service is consistent with generally recognized standards within a relevant health profession.

(19) "Mental health provider" means a health care provider or a health care facility authorized by state law to provide mental health services.

(20) "Mental health services" means in-patient or out-patient treatment, partial hospitalization or out-patient treatment to manage or ameliorate the effects of a mental disorder listed in the *Diagnostic and Statistical Manual (DSM) IV* published by the American Psychiatric Association, includ-

ing diagnoses and treatments for substance abuse, 291.0 through 292.9 and 303.0 through 305.9.

(21) "Network" means the group of participating providers and facilities providing health care services to a particular health plan or line of business (individual, small, or large group). A health plan network for issuers offering more than one health plan may be smaller in number than the total number of participating providers and facilities for all plans offered by the carrier.

(22) "Out-patient therapeutic visit" or "out-patient visit" means a clinical treatment session with a mental health provider of a duration consistent with relevant professional standards used by the carrier to determine medical necessity for the particular service being rendered, as defined in *Physicians Current Procedural Terminology*, published by the American Medical Association.

(23) "Participating provider" and "participating facility" means a facility or provider who, under a contract with the health carrier or with the carrier's contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, from the health carrier rather than from the covered person.

(24) "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing.

(25) "Pharmacy services" means the practice of pharmacy as defined in chapter 18.64 RCW and includes any drugs or devices as defined in chapter 18.64 RCW.

(26) "Primary care provider" means a participating provider who supervises, coordinates, or provides initial care or continuing care to a covered person, and who may be required by the health carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person.

(27) "Preexisting condition" means any medical condition, illness, or injury that existed any time prior to the effective date of coverage.

(28) "Premium" means all sums charged, received, or deposited by a health carrier as consideration for a health plan or the continuance of a health plan. Any assessment or any "membership," "policy," "contract," "service," or similar fee or charge made by a health carrier in consideration for a health plan is deemed part of the premium. "Premium" shall not include amounts paid as enrollee point-of-service cost-sharing.

(29) "Service area" means the geographic area or areas where a specific product is issued, accepts members or enrollees, and covers provided services. A service area must be defined by the county or counties included unless, for good cause, the commissioner permits limitation of a service area by zip code. Good cause includes geographic barriers within a service area, or other conditions that make offering coverage throughout an entire county unreasonable.

(30) "Small group plan" means a health plan issued to a small employer as defined under RCW 48.43.005(33) comprising from one to fifty eligible employees.

(31) "Substitute drug" means a therapeutically equivalent substance as defined in chapter 69.41 RCW.

(32) "Supplementary pharmacy services" or "other pharmacy services" means pharmacy services involving the provision of drug therapy management and other services not required under state and federal law but that may be rendered in connection with dispensing, or that may be used in disease prevention or disease management.

[Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.460, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.44.050, 48.46.200, 48.20.450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. §§ 156.230, 156.235, and 156.245. WSR 14-10-017 (Matter No. R 2013-22), § 284-43-130, filed 4/25/14, effective 5/26/14. Statutory Authority: RCW 48.02.060, 48.43.525, 48.43.530, 48.43.535, and The Patient Protection and Affordable Care Act, P.L. 111-148, as amended (2010). WSR 12-23-005 (Matter No. R 2011-11), § 284-43-130, filed 11/7/12, effective 11/20/12. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.100, 48.46.200, 48.43.505, 48.43.510, 48.43.515, 48.43.520, 48.43.525, 48.43.530, 48.43.535. WSR 01-03-033 (Matter No. R 2000-02), § 284-43-130, filed 1/9/01, effective 7/1/01. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.200, 2000 c 79 § 26, and RCW 48.30.040, 48.44.110, 48.46.400. WSR 01-03-032 (Matter No. R 2000-04), § 284-43-130, filed 1/9/01, effective 2/9/01. Statutory Authority: RCW 48.02.060, 48.30.010, 48.44.050, 48.46.200, 48.30.040, 48.44.110 and 48.46.400. WSR 99-19-032 (Matter No. R 98-7), § 284-43-130, filed 9/8/99, effective 10/9/99. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. WSR 98-04-005 (Matter No. R 97-3), § 284-43-130, filed 1/22/98, effective 2/22/98.]

SUBCHAPTER B

HEALTH CARE NETWORKS

WAC 284-43-200 Network access—General standards. (1) An issuer must maintain each provider network for each health plan in a manner that is sufficient in numbers and types of providers and facilities to assure that, to the extent feasible based on the number and type of providers and facilities in the service area, all health plan services provided to enrollees will be accessible in a timely manner appropriate for the enrollee's condition. An issuer must demonstrate that for each health plan's defined service area, a comprehensive range of primary, specialty, institutional, and ancillary services are readily available without unreasonable delay to all enrollees and that emergency services are accessible twenty-four hours per day, seven days per week without unreasonable delay.

(2) Each enrollee must have adequate choice among health care providers, including those providers which must be included in the network under WAC 284-43-205, and for qualified health plans and qualified stand-alone dental plans, under WAC 284-43-222.

(3) An issuer's service area must not be created in a manner designed to discriminate or that results in discrimination against persons because of age, gender, gender identity, sexual orientation, disability, national origin, sex, family structure, ethnicity, race, health condition, employment status, or socioeconomic status.

(4) An issuer must establish sufficiency and adequacy of choice of providers based on the number and type of providers and facilities necessary within the service area for the plan to meet the access requirements set forth in this subchapter. Where an issuer establishes medical necessity or other prior authorization procedures, the issuer must ensure sufficient qualified staff is available to provide timely prior authoriza-

tion decisions on an appropriate basis, without delays detrimental to the health of enrollees.

(5) In any case where the issuer has an absence of or an insufficient number or type of participating providers or facilities to provide a particular covered health care service, the issuer must ensure through referral by the primary care provider or otherwise that the enrollee obtains the covered service from a provider or facility within reasonable proximity of the enrollee at no greater cost to the enrollee than if the service were obtained from network providers and facilities. An issuer must satisfy this obligation even if an alternate access delivery request has been submitted and is pending commissioner approval.

An issuer may use facilities in neighboring service areas to satisfy a network access standard if one of the following types of facilities is not in the service area, or if the issuer can provide substantial evidence of good faith efforts on its part to contract with the facilities in the service area. Such evidence of good faith efforts to contract will include documentation about the efforts to contract but not the substantive contract terms offered by either the issuer or the facility. This applies to the following types of facilities:

- (a) Tertiary hospitals;
- (b) Pediatric community hospitals;
- (c) Specialty or limited hospitals, such as burn units, rehabilitative hospitals, orthopedic hospitals, and cancer care hospitals;
- (d) Neonatal intensive care units; and
- (e) Facilities providing transplant services, including those that provide solid organ, bone marrow, and stem cell transplants.

(6) An issuer must establish and maintain adequate arrangements to ensure reasonable proximity of network providers and facilities to the business or personal residence of enrollees, and located so as to not result in unreasonable barriers to accessibility. Issuers must make reasonable efforts to include providers and facilities in networks in a manner that limits the amount of travel required to obtain covered benefits.

(7) A single case provider reimbursement agreement must be used only to address unique situations that typically occur out-of-network and out of service area, where an enrollee requires services that extend beyond stabilization or one time urgent care. Single case provider reimbursement agreements must not be used to fill holes or gaps in the network and do not support a determination of network access.

(8) An issuer must disclose to enrollees that limitations or restrictions on access to participating providers and facilities may arise from the health service referral and authorization practices of the issuer. A description of the health plan's referral and authorization practices, including information about how to contact customer service for guidance, must be set forth as an introduction or preamble to the provider directory for a health plan. In the alternative, the description of referral and authorization practices may be included in the summary of benefits and explanation of coverage for the health plan.

(9) To provide adequate choice to enrollees who are American Indians/Alaska Natives, each health issuer must maintain arrangements that ensure that American Indians/Alaska Natives who are enrollees have access to covered

medical and behavioral health services provided by Indian health care providers.

Issuers must ensure that such enrollees may obtain covered medical and behavioral health services from the Indian health care provider at no greater cost to the enrollee than if the service were obtained from network providers and facilities, even if the Indian health care provider is not a contracted provider. Issuers are not responsible for credentialing providers and facilities that are part of the Indian health system. Nothing in this subsection prohibits an issuer from limiting coverage to those health services that meet issuer standards for medical necessity, care management, and claims administration or from limiting payment to that amount payable if the health service were obtained from a network provider or facility.

(10) An issuer must have a demonstrable method and contracting strategy to ensure that contracting hospitals in a plan's service area have the capacity to serve the entire enrollee population based on normal utilization.

(11) At a minimum, an issuer's provider network must adequately provide for mental health and substance use disorder treatment, including behavioral health therapy.

(a) Adequate networks include crisis intervention and stabilization, psychiatric inpatient hospital services, including voluntary psychiatric inpatient services, and services from mental health providers. There must be mental health providers of sufficient number and type to provide diagnosis and medically necessary treatment of conditions covered by the plan through providers acting within their scope of license and scope of competence established by education, training, and experience to diagnose and treat conditions found in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* or other recognized diagnostic manual or standard.

(b) An issuer must establish a reasonable standard for the number and geographic distribution of mental health providers who can treat serious mental illness of an adult and serious emotional disturbances of a child, taking into account the various types of mental health practitioners acting within the scope of their licensure.

The issuer must measure the adequacy of the mental health network against this standard at least twice a year, and submit an action plan with the commissioner if the standard is not met.

(c) Emergency mental health services, including crisis intervention and crisis stabilization services, must be included in an issuer's provider network.

(d) An issuer must include a sufficient number and type of mental health and substance use disorder treatment providers and facilities within a service area based on normal utilization patterns.

(e) An issuer must ensure that an enrollee can identify information about mental health services and substance use disorder treatment including benefits, providers, coverage, and other relevant information by calling a customer service representative during normal business hours.

(12) The provider network must include preventive and wellness services, including chronic disease management and smoking cessation services as defined in RCW 48.43.005(37) and WAC 284-43-878(9). If these services are provided through a quit-line or help-line, the issuer must ensure that

when follow-up services are medically necessary, the enrollee will have access to sufficient information to access those services within the service area. Contracts with quit-line or help-line services are subject to the same conditions and terms as other provider contracts under this section.

(13) For the essential health benefits category of ambulatory patient services, as defined in WAC 284-43-878(1), an issuer's network is adequate if:

(a) The issuer establishes a network that affords enrollee access to urgent appointments without prior authorization within forty-eight hours, or with prior authorization, within ninety-six hours of the referring provider's referral.

(b) For primary care providers the following must be demonstrated:

(i) The ratio of primary care providers to enrollees within the issuer's service area as a whole meets or exceeds the average ratio for Washington state for the prior plan year;

(ii) The network includes such numbers and distribution that eighty percent of enrollees within the service area are within thirty miles of a sufficient number of primary care providers in an urban area and within sixty miles of a sufficient number of primary care providers in a rural area from either their residence or work; and

(iii) Enrollees have access to an appointment, for other than preventive services, with a primary care provider within ten business days of requesting one.

(c) For specialists:

(i) The issuer documents the distribution of specialists in the network for the service area in relation to the population distribution within the service area; and

(ii) The issuer establishes that when an enrollee is referred to a specialist, the enrollee has access to an appointment with such a specialist within fifteen business days for nonurgent services.

(d) For preventive care services, and periodic follow-up care including, but not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological or imaging monitoring for recurrence of disease, the issuer permits scheduling such services in advance, consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice.

(14) The network access requirements in this subchapter apply to stand-alone dental plans offered through the exchange or where a stand-alone dental plan is offered outside of the exchange for the purpose of providing the essential health benefit category of pediatric oral benefits. All such stand-alone dental plans must ensure that all covered services to enrollees will be accessible in a timely manner appropriate for the enrollee's conditions.

(a) An issuer of such stand-alone dental plans must demonstrate that, for the dental plan's defined service area, all services required under WAC 284-43-879(3) are available to all enrollees without unreasonable delay.

(b) Dental networks for pediatric oral services must be sufficient for the enrollee population in the service area based on expected utilization.

(15) Issuers must meet all requirements of this subsection for all provider networks. An alternate access delivery request under WAC 284-43-201 may be proposed only if:

(a) There are sufficient numbers and types of providers or facilities in the service area to meet the standards under this subchapter but the issuer is unable to contract with sufficient providers or facilities to meet the network standards in this subchapter; or

(b) An issuer's provider network has been previously approved under this section, and a provider or facility type subsequently becomes unavailable within a health plan's service area; or

(c) A county has a population that is fifty thousand or fewer, and the county is the sole service area for the plan, and the issuer chooses to propose an alternative access delivery system for that county; or

(d) A qualified health plan issuer is unable to meet the standards for inclusion of essential community providers, as provided under WAC 284-43-222(3).

(16) This section is effective for all plans, whether new or renewed, with effective dates on or after January 1, 2015.

[Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.460, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.44.050, 48.46.200, 48.20.450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. §§ 156.230, 156.235, and 156.245. WSR 14-10-017 (Matter No. R 2013-22), § 284-43-200, filed 4/25/14, effective 5/26/14. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.100, 48.46.200, 48.43.505, 48.43.510, 48.43.515, 48.43.520, 48.43.525, 48.43.530, 48.43.535. WSR 01-03-033 (Matter No. R 2000-02), § 284-43-200, filed 1/9/01, effective 7/1/01. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.030, 48.46.200. WSR 00-04-034 (Matter No. R 99-2), § 284-43-200, filed 1/24/00, effective 3/1/00. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. WSR 98-04-005 (Matter No. R 97-3), § 284-43-200, filed 1/22/98, effective 2/22/98.]

WAC 284-43-201 Alternate access delivery request.

(1) Where an issuer's network meets one or more of the criteria in WAC 284-43-200 (15)(a) through (d), the issuer may submit an alternate access delivery request for the commissioner's review and approval. The alternate access delivery request must be made using the Alternate Access Delivery Request Form C, as provided in WAC 284-43-220 (3)(d).

(a) An alternate access delivery system must provide enrollees with access to medically necessary care on a reasonable basis without detriment to their health.

(b) The issuer must ensure that the enrollee obtains all covered services in the alternate access delivery system at no greater cost to the enrollee than if the service was obtained from network providers or facilities or must make other arrangements acceptable to the commissioner.

(i) Copayments and deductible requirements must apply to alternate access delivery systems at the same level they are applied to in-network services.

(ii) The alternate access delivery system may result in issuer payment of billed charges to ensure network access.

(c) An issuer must demonstrate in its alternate access delivery request a reasonable basis for not meeting a standard as part of its filing for approval of an alternate access delivery system, and include an explanation of why the alternate access delivery system provides a sufficient number or type

of the provider or facility to which the standard applies to enrollees.

(d) An issuer must demonstrate a plan and practice to assist enrollees to locate providers and facilities in neighboring service areas in a manner that assures both availability and accessibility. Enrollees must be able to obtain health care services from a provider or facility within the closest reasonable proximity of the enrollee in a timely manner appropriate for the enrollee's health needs.

Alternate access delivery systems include, but are not limited to, such provider network strategies as use of out-of-state and out of county or service area providers, and exceptions to network standards based on rural locations in the service area.

(2) The commissioner will not approve an alternate access delivery system unless the issuer provides substantial evidence of good faith efforts on its part to contract with providers or facilities, and can demonstrate that there is not an available provider or facility with which the issuer can contract to meet provider network standards under WAC 284-43-200.

(a) Such evidence of good faith efforts to contract, where required, will be submitted as part of the issuer's Alternate Access Delivery Request Form C submission, as described in WAC 284-43-220 (3)(d).

(b) Evidence of good faith efforts to contract will include documentation about the efforts to contract but not the substantive contract terms offered by either the issuer or the provider.

(3) The practice of entering into a single case provider reimbursement agreement with a provider or facility in relation to a specific enrollee's condition or treatment requirements is not an alternate access delivery system for purposes of establishing an adequate provider network. A single case provider reimbursement agreement must be used only to address unique situations that typically occur out of network and out of service area, where an enrollee requires services that extend beyond stabilization or one time urgent care. Single case provider reimbursement agreements must not be used to fill holes or gaps in a network for the whole population of enrollees under a plan, and do not support a determination of network access.

(4) This section is effective for all plans, whether new or renewed, with effective dates on or after January 1, 2015.

[Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.460, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.44.050, 48.46.200, 48.20.-450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. §§ 156.230, 156.235, and 156.245. WSR 14-10-017 (Matter No. R 2013-22), § 284-43-201, filed 4/25/14, effective 5/26/14.]

WAC 284-43-203 Use of subcontracted networks. (1)

The primary contractor with each provider and facility in an issuer's network must be specifically identified in network report filings with the commissioner. An issuer may use subcontracted networks as part of a provider network for a service area, subject to the following requirements:

(a) An issuer must not elect to use less than one hundred percent of the subcontracted network or networks in its service area.

(b) An issuer may use a combination of directly contracting with providers and use of a subcontracted network in the same service area.

(2) Upon request by the commissioner, an issuer must produce an executed copy of its agreement with a subcontracted network, and certify to the commissioner that there is reasonable assurance the providers listed as part of the subcontracted network are under enforceable contracts with the subcontractor. The contract with the subcontracted network's administrator must provide the issuer with the ability to require providers to conform to the requirements in chapter 284-43 WAC, subchapter B.

(3) If an issuer permits a facility or provider to delegate functions, the issuer must require the facility or provider to:

(a) Include the requirements of this subchapter in its contracting documents with the subcontractor, including providing the commissioner with access to any pertinent information related to the contract during the contract term, for up to ten years from the final date of the contract period, and in certain instances, where required by federal or state law, periods in excess of ten years;

(b) Provide the issuer with the right to approve, suspend or terminate any such arrangement.

(4) This section is effective for all plans, whether new or renewed, with effective dates on or after January 1, 2015.

[Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.460, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.44.050, 48.46.200, 48.20.-450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. §§ 156.230, 156.235, and 156.245. WSR 14-10-017 (Matter No. R 2013-22), § 284-43-203, filed 4/25/14, effective 5/26/14.]

WAC 284-43-204 Provider directories. (1) Provider directories must be updated at least monthly, and must be offered to accommodate individuals with limited-English proficiency or disabilities. An issuer must post the current provider directory for each health plan online, and must make a printed copy of the current directory available to an enrollee upon request as required under RCW 48.43.510 (1)(g).

(2) For each health plan, the associated provider directory must include the following information for each provider:

(a) The specialty area or areas for which the provider is licensed to practice and included in the network;

(b) Any in-network institutional affiliation of the provider, such as hospitals where the provider has admitting privileges or provider groups with which a provider is a member;

(c) Whether the provider may be accessed without referral;

(d) Any languages, other than English, spoken by the provider.

(3) An issuer must include in its electronic posting of a health plan's provider directory a notation of any primary care, chiropractor, women's health care provider, or pediatrician whose practice is closed to new patients.

(4) If an issuer maintains more than one provider network, its posted provider directory or directories must make it reasonably clear to an enrollee which network applies to which health plan.

(5) Information about any available telemedicine services must be included and specifically described.

(6) Information about any available interpreter services, communication and language assistance services, and accessibility of the physical facility must be identified in the directory, and the mechanism by which an enrollee may access such services.

(7) An issuer must include information about the network status of emergency providers as required by WAC 284-43-252.

(8) This section is effective for all plans, whether new or renewed, with effective dates on or after January 1, 2015.

[Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.460, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.44.050, 48.46.200, 48.20.450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. §§ 156.230, 156.235, and 156.245. WSR 14-10-017 (Matter No. R 2013-22), § 284-43-204, filed 4/25/14, effective 5/26/14.]

WAC 284-43-205 Every category of health care providers. (1) Issuers must not exclude any category of providers licensed by the state of Washington who provide health care services or care within the scope of their practice for services covered as essential health benefits, as defined in WAC 284-43-878 and RCW 48.43.715, for individual and small group plans; and as covered by the basic health plan, as defined in RCW 48.43.005(4), for plans other than individual and small group.

For individual and small group plans, the issuer must not exclude a category of provider who is licensed to provide services for a covered condition, and is acting within the scope of practice, unless such services would not meet the issuer's standards pursuant to RCW 48.43.045 (1)(a). For example, if the issuer covers outpatient treatment of lower back pain as part of the essential health benefits, any category of provider that provides cost-effective and clinically efficacious outpatient treatment for lower back pain within its scope of practice and otherwise abides by standards pursuant to RCW 48.43.045 (1)(a) must not be excluded from the network.

(2) RCW 48.43.045 (1)(a) permits issuers to require providers to abide by certain standards. These standards may not be used in a manner designed to exclude categories of providers unreasonably. For example, issuers must not decide that a particular category of provider can never render any cost-effective or clinically efficacious services and thereby exclude that category of provider completely from health plans on that basis.

(3) Health plans are not prohibited by this section from placing reasonable limits on individual services rendered by specific categories of providers based on relevant information or evidence of the type usually considered and relied upon in making determinations of cost-effectiveness or clinical efficacy. However, health plans must not contain unreasonable limits, and must not include limits on the type of provider permitted to render the covered service unless such limits comply with RCW 48.43.045 (1)(a).

(4) This section does not prohibit health plans from using restricted networks. Issuers offering plans with restricted networks may select the individual providers in any category of provider with whom they will contract or whom they will reimburse. An issuer is not required by RCW 48.43.045 or this section to accede to a request by any individual provider for inclusion in any network for any health plan.

(a) Health plan networks that use "gatekeepers" or "medical homes" for access to specialist providers may use them for access to specified categories of providers.

(b) For purposes of this section:

(i) "Gatekeeper" means requiring a referral from a primary care or direct access provider or practitioner to access specialty or in-patient services.

(ii) "Medical home" means a team based health care delivery model for patient centered primary care that provides comprehensive and continuous medical care to patients with the goal of obtaining maximized health outcomes as modified and updated by the Agency for Healthcare Research and Quality, the U.S. Department of Health and Human Services (HRSA), and other state and federal agencies.

(5) Issuers must not offer coverage for health services for certain categories of providers solely as a separately priced optional benefit.

(6) The insurance commissioner may grant reasonable temporary extensions of time for implementation of RCW 48.43.045 or this section, or any part thereof, for good cause shown.

[Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.460, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.44.050, 48.46.200, 48.20.450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. §§ 156.230, 156.235, and 156.245. WSR 14-10-017 (Matter No. R 2013-22), § 284-43-205, filed 4/25/14, effective 5/26/14. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050 and 48.46.200. WSR 99-16-036 (Matter No. R 98-20), § 284-43-205, filed 7/28/99, effective 8/28/99.]

WAC 284-43-220 Network reports—Format. (1) An issuer must submit its provider network materials to the commissioner for approval prior to or at the time it files a newly offered health plan.

(a) For individual and small groups, the submission must occur when the issuer submits its plan under WAC 284-170-870. For groups other than individual and small, the submission must occur when the issuer submits a new health plan and as required in this section.

(b) The commissioner may extend the time for filing for good cause shown.

(c) For plan year 2015 only, the commissioner will permit a safe harbor standard. An issuer who can not meet the submission requirements in (e) and (f) of this subsection will be determined to meet the requirements of those subsections even if the submissions are incomplete, provided that the issuer:

(i) Identifies specifically each map required under subsection (3)(e)(i) of this section, or Access Plan component required under subsection (3)(f) of this section, which has not been included in whole or part;

(ii) Explains the specific reason each map or component has not been included; and

(iii) Sets forth the issuer's plan to complete the submission, including the date(s) by which each incomplete map and component will be completed and submitted.

(2) Unless indicated otherwise, the issuer's reports must be submitted electronically and completed consistent with the posted submission instructions on the commissioner's web site, using the required formats.

(3) For plan years beginning January 1, 2015, an issuer must submit the following specific documents and data to the commissioner to document network access:

(a) **Provider Network Form A.** An issuer must submit a report of all participating providers by network.

(i) The Provider Network Form A must be submitted for each network being reviewed for network access. A network may be used by more than one plan.

(ii) An issuer must indicate whether a provider is an essential community provider as instructed in the commissioner's Provider Network Form A instructions.

(iii) An issuer must submit an updated, accurate Provider Network Form A on a monthly basis by the 5th of each month for each network and when a material change in the network occurs as described in subchapter B.

(iv) Filing of this data satisfies the reporting requirements of RCW 48.44.080 and the requirements of RCW 48.46.030 relating to filing of notices that describe changes in the provider network.

(b) **Provider directory certification.** An issuer must submit at the time of each Provider Network Form A submission a certification that the provider directory posted on the issuer's web site is specific to each plan, accurate as of the last date of the prior month. A certification signed by an officer of the issuer must confirm that the provider directory contains only providers and facilities with which the issuer has a signed contract that is in effect on the date of the certification.

(c) **Network Enrollment Form B.** The Network Enrollment Form B report provides the commissioner with an issuer's count of total covered lives for the prior year, during each month of the year, for each health plan by county.

(i) The report must be submitted for each network as a separate report. The report must contain all data items shown in and conform to the format of Network Enrollment Form B prescribed by and available from the commissioner.

(ii) An issuer must submit this report by March 31st of each year.

(d) **Alternate Access Delivery Request Form C.** For plan years that begin on or after January 1, 2015, alternate access delivery requests must be submitted when an issuer's network meets one or more of the criteria in WAC 284-43-200 (15)(a) through (d). Alternate access delivery requests must be submitted to the commissioner using the Alternate Access Delivery Request Form C.

(i) The Alternate Access Delivery Request Form C submission must address the following areas, and may include other additional information as requested by the commissioner:

(A) A description of the specific issues the alternate access delivery system is intended to address, accompanied by supporting data describing how the alternate access delivery system ensures that enrollees have reasonable access to sufficient providers and facilities, by number and type, for covered services;

(B) A description and schedule of cost-sharing requirements for providers that fall under the alternate access delivery system;

(C) The issuer's proposed method of noting on its provider directory how an enrollee can access provider types under the alternate access delivery system;

(D) The issuer's marketing plan to accommodate the time period that the alternate access delivery system is in effect, and specifically describe how it impacts current and future enrollment and for what period of time;

(ii) Provider Network Form A and Network Enrollment Form B submissions are required in relation to an alternate access delivery system on the basis described in subsections (1) and (2) of this section.

(iii) If a network becomes unable to meet the network access standards after approval but prior to the health product's effective date, an alternate access delivery request must include a timeline to bring the network into full compliance with this subchapter.

(e) **Geographic Network Reports.**

(i) The geographic mapping criteria outlined below are minimum requirements and will be considered in conjunction with the standards set forth in WAC 284-43-200 and 284-43-222. One map for each of the following provider types must be submitted:

(A) Hospital and emergency services. Map must identify provider locations, and demonstrate that each enrollee in the service area has access within thirty minutes in an urban area and sixty minutes in a rural area from either their residence or workplace to general hospital facilities including emergency services.

(B) Primary care providers. Map must demonstrate that eighty percent of the enrollees in the service area have access within thirty miles in an urban area and sixty miles in a rural area from either their residence or workplace to a primary care provider with an open practice. The provider type selected must have a license under Title 18 RCW that includes primary care services in the scope of license.

(C) Mental health and substance use disorder providers. For general mental health providers, such as licensed psychiatrists, psychologists, social workers, and mental health nurse practitioners, the map must demonstrate that eighty percent of the enrollees in the service area have access to a mental health provider within thirty miles in an urban area and sixty miles in a rural area from either their residence or workplace. For specialty mental health providers and substance use disorder providers, the map must demonstrate that eighty percent of the enrollees have access to the following types of service provider or facility: Evaluation and treatment, voluntary and involuntary inpatient mental health and substance use disorder treatment, outpatient mental health and substance use disorder treatment, and behavioral therapy. If one of the types of specialty providers is not available as required above, the issuer must propose an alternate access delivery system to meet this requirement.

(D) Pediatric services. For general pediatric services, the map must demonstrate that eighty percent of the covered children in the service area have access to a pediatrician or other provider whose license under Title 18 RCW includes pediatric services in the scope of license. This access must be within thirty miles in an urban area and sixty miles in a rural area of their family or placement residence. For specialty pediatric services, the map must demonstrate that eighty percent of covered children in the service area have access to pediatric specialty care within sixty miles in an urban area and ninety miles in a rural area of their family or placement residence. The pediatric specialty types include, but are not

limited to, nephrology, pulmonology, rheumatology, hematology-oncology, perinatal medicine, neurodevelopmental disabilities, cardiology, endocrinology, and gastroenterology.

(E) Specialty services. An issuer must provide one map for the service area for specialties found on the American Board of Medical Specialties list of approved medical specialty boards. The map must demonstrate that eighty percent of the enrollees in the service area have access to an adequate number of providers and facilities in each specialty. Subspecialties are subsumed on the map.

(F) Therapy services. An issuer must provide one map that demonstrates that eighty percent of the enrollees have access to the following types of providers within thirty miles in an urban area and sixty miles in a rural area of their residence or workplace: Chiropractor, rehabilitative service providers and habilitative service providers.

(G) Home health, hospice, vision, and dental providers. An issuer must provide one map that identifies each provider or facility to which an enrollee has access in the service area for home health care, hospice, vision, and pediatric oral coverage, including allied dental professionals, dental therapists, dentists, and orthodontists.

(H) Covered pharmacy dispensing services. An issuer must provide one map that demonstrates the geographic distribution of the pharmacy dispensing services within the service area. If a pharmacy benefit manager is used by the issuer, the issuer must establish that the specifically contracted pharmacy locations within the service area are available to enrollees through the pharmacy benefit manager.

(I) Essential community providers. An issuer must provide one map that demonstrates the geographic distribution of essential community providers, by type of provider or facility, within the service area. This requirement applies only to qualified health plans as certified in RCW 43.71.065.

(ii) Each report must include the provider data points on each map, title the map as to the provider type or facility type it represents, include the network identification number the map applies to, and the name of each county included on the report.

(iii) For plan years beginning January 1, 2015, and every year thereafter, an issuer must submit reports as required in subsection (1) of this section to the commissioner for review and approval, or when an alternate access delivery request is submitted.

(f) **Access Plan.** An issuer must establish an access plan specific to each product that describes the issuer's strategy, policies, and procedures necessary to establishing, maintaining, and administering an adequate network.

(i) At a minimum, the issuer's policies and procedures referenced in the access plan must address:

(A) Referral of enrollees out-of-network, including criteria for determining when an out-of-network referral is required or appropriate;

(B) Copayment and coinsurance determination standards for enrollees accessing care out-of-network;

(C) Standards of accessibility expressed in terms of objectives and minimum levels below which corrective action will be taken, including the proximity of specialists and hospitals to primary care sources, and a method and pro-

cess for documentation confirming that access will not result in delay detrimental to health of enrollees;

(D) Monitoring policies and procedures for compliance, including tracking and documenting network capacity and availability;

(E) Standard hours of operation, and after-hours, for prior authorization, consumer and provider assistance, and claims adjudication;

(F) Triage and screening arrangements for prior authorization requests;

(G) Prior authorization processes that enrollees must follow, including the responsibilities and scope of use of nonlicensed staff to handle enrollee calls about prior authorization;

(H) Specific procedures and materials used to address the needs of enrollees with limited-English proficiency and literacy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities;

(I) Assessment of the health status of the population of enrollees or prospective enrollees, including incorporation of the findings of local public health community assessments, and standardized outcome measures, and use of the assessment data and findings to develop network or networks in the service area;

(J) Notification to enrollees regarding personal health information privacy rights and restrictions, termination of a provider from the network, and maintaining continuity of care for enrollees when there is a material change in the provider network, insolvency of the issuer, or other cessation of operations;

(K) Issuer's process for corrective action for providers related to the provider's licensure, prior authorization, referral and access compliance. The process must include remedies to address insufficient access to appointments or services.

(ii) An access plan applicable to each product must be submitted with every Geographic Network Report when the issuer seeks initial certification of the network, submits its annual rate filing to the commissioner for review and approval, or when an alternative access delivery request is required due to a material change in the network.

(iii) The current access plan, with all associated data sets, policies and procedures, must be made available to the commissioner upon request, and a summary of the access plan's associated procedures must be made available to the public upon request.

(4) For purposes of this section, "urban area" means:

(a) A county with a density of ninety persons per square mile; or

(b) An area within a twenty-five mile radius around an incorporated city with a population of more than thirty thousand.

[Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.460, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.44.050, 48.46.200, 48.20.450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. §§ 156.230, 156.235, and 156.245. WSR 14-10-017 (Matter No. R 2013-22), § 284-43-220, filed 4/25/14, effective 5/26/14. Statutory Authority: RCW 48.02.060, 48.43.510 and 48.43.515. WSR 11-07-015 (Matter No. R 2011-01), § 284-43-220, filed 3/8/11, effective 4/8/11. Statutory Authority: RCW 48.02.060. WSR 08-17-037 (Matter No. R 2008-17), § 284-43-220, filed 8/13/08, effective 9/13/08. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.43.515, 48.44.050, 48.46.030, 48.46.200, 48.42.100, 48.43.515, 48.46.030. WSR 03-09-142 (Matter No. R 2003-01), § 284-43-220, filed 4/23/03, effective 5/24/03. Statutory Authority: RCW 48.02.060, 48.18.120,

48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.030, 48.46.200. WSR 00-04-034 (Matter No. R 99-2), § 284-43-220, filed 1/24/00, effective 1/1/01. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. WSR 98-04-005 (Matter No. R 97-3), § 284-43-220, filed 1/22/98, effective 2/22/98.]

WAC 284-43-221 Essential community providers for exchange plans—Definition. "Essential community provider" means providers listed on the Centers for Medicare and Medicaid Services Non-Exhaustive List of Essential Community Providers. This list includes providers and facilities that have demonstrated service to medicaid, low-income, and medically underserved populations in addition to those that meet the federal minimum standard, which includes:

- (1) Hospitals and providers who participate in the federal 340B Drug Pricing Program;
- (2) Disproportionate share hospitals, as designated annually;
- (3) Those eligible for Section 1927 Nominal Drug Pricing;
- (4) Those whose patient mix is at least thirty percent medicaid or medicaid expansion patients who have approved applications for the Electronic Medical Record Incentive Program;
- (5) State licensed community clinics or health centers or community clinics exempt from licensure;
- (6) Indian health care providers as defined in WAC 284-43-130(16);
- (7) Long-term care facilities in which the average residency rate is fifty percent or more eligible for medicaid during the preceding calendar year;
- (8) School-based health centers as referenced for funding in Sec. 4101 of Title IV of ACA;
- (9) Providers identified as essential community providers by the U.S. Department of Health and Human Services through subregulatory guidance or bulletins;
- (10) Facilities or providers who waive charges or charge for services on a sliding scale based on income and that do not restrict access or services because of a client's financial limitations;
- (11) Title X Family Planning Clinics and Title X look-alike Family Planning Clinics;
- (12) Rural based or free health centers as identified on the Rural Health Clinic and the Washington Free Clinic Association web sites; and
- (13) Federal qualified health centers (FQHC) or FQHC look-alikes.

[Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.20.450, 48.43.515, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. 156.230, 156.235, and 156.245. WSR 14-22-007, § 284-43-221, filed 10/23/14, effective 11/23/14. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.460, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.44.050, 48.46.200, 48.20.450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. §§ 156.230, 156.235, and 156.245. WSR 14-10-017 (Matter No. R 2013-22), § 284-43-221, filed 4/25/14, effective 5/26/14.]

WAC 284-43-222 Essential community providers for exchange plans—Network access. (1) An issuer must include essential community providers in its provider network for qualified health plans and qualified stand-alone den-

tal plans in compliance with this section and as defined in WAC 284-43-221.

(2) An issuer must include a sufficient number and type of essential community providers in its provider network to provide reasonable access to the medically underserved or low-income in the service area, unless the issuer can provide substantial evidence of good faith efforts on its part to contract with the providers or facilities in the service area. Such evidence of good faith efforts to contract will include documentation about the efforts to contract but not the substantive contract terms offered by either the issuer or the provider.

(3) The following minimum standards apply to establish adequate qualified health plan inclusion of essential community providers:

(a) Each issuer must demonstrate that at least thirty percent of available primary care providers, pediatricians, and hospitals that meet the definition of an essential community provider in each plan's service area participate in the provider network;

(b) The issuer's provider network must include access to one hundred percent of Indian health care providers in a service area, as defined in WAC 284-43-130(16), such that qualified enrollees obtain all covered services at no greater cost than if the service was obtained from network providers or facilities;

(c) Within a service area, fifty percent of rural health clinics located outside an area defined as urban by the 2010 Census must be included in the issuer's provider network;

(d) For essential community provider categories of which only one or two exist in the state, an issuer must demonstrate a good faith effort to contract with that provider or providers for inclusion in its network, which will include documentation about the efforts to contract but not the substantive contract terms offered by either the issuer or the provider;

(e) For qualified health plans that include pediatric oral services or qualified dental plans, thirty percent of essential community providers in the service area for pediatric oral services must be included in each issuer's provider network;

(f) Ninety percent of all federally qualified health centers and FQHC look-alike facilities in the service area must be included in each issuer's provider network;

(g) At least one essential community provider hospital per county in the service area must be included in each issuer's provider network;

(h) At least fifteen percent of all providers participating in the 340B program in the service area, balanced between hospital and nonhospital entities, must be included in the issuer's provider network;

(i) By 2016, at least seventy-five percent of all school-based health centers in the service area must be included in the issuer's network.

(4) An issuer must, at the request of a school-based health center or group of school-based health centers, offer to contract with such a center or centers to reimburse covered health care services delivered to enrollees under an issuer's health plan.

(a) If a contract is not entered into, the issuer must provide substantial evidence of good faith efforts on its part to contract with a school-based health center or group of school-based health centers. Such evidence of good faith efforts to

contract will include documentation about the efforts to contract but not the substantive contract terms offered by either the issuer or the provider.

(b) "School-based health center" means a school-based location for the delivery of health services, often operated as a partnership of schools and community health organizations, which can include issuers, which provide on-site medical and mental health services through a team of medical and mental health professionals to school-aged children and adolescents.

(5) An issuer must, at the request of an Indian health care provider, offer to contract with such a provider to reimburse covered health care services delivered to qualified enrollees under an issuer's health plan.

(a) Issuers are encouraged to use the current version of the Washington State Indian Health Care Provider Addendum, as posted on <http://www.aihc-wa.com>, to supplement the existing provider contracts when contracting with an Indian health care provider.

(b) If an Indian health care provider requests a contract and a contract is not entered into, the issuer must provide substantial evidence of good faith efforts on its part to contract with the Indian health care provider. Such evidence of good faith efforts to contract will include documentation about the efforts to contract but not the substantive contract terms offered by either the issuer or the provider.

(6) These requirements do not apply to integrated delivery systems pursuant to RCW 43.71.065.

[Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.20.450, 48.43.515, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. 156.230, 156.235, and 156.245. WSR 14-22-007, § 284-43-222, filed 10/23/14, effective 11/23/14. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.460, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.44.050, 48.46.200, 48.20.450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. §§ 156.230, 156.235, and 156.245. WSR 14-10-017 (Matter No. R 2013-22), § 284-43-222, filed 4/25/14, effective 5/26/14.]

WAC 284-43-229 Tiered provider networks. (1)

"Tiered provider network" means a network that identifies and groups providers and facilities into specific groups to which different provider reimbursement, enrollee cost-sharing, or provider access requirements, or any combination thereof, apply as a means to manage cost, utilization, quality, or to otherwise incentivize enrollee or provider behavior.

(a) An issuer may use a term other than tiered network as long as the term is not misleading or susceptible to confusion with a specific licensee designation, such as accountable care organization.

(b) An issuer must not use tiered networks to limit access to certain categories of providers or facilities.

(2) When an issuer's contracts include the placement of providers or facilities in tiers, and the network design results in cost differentials for enrollees, the issuer must disclose to enrollees at the time of enrollment the cost difference and the basis for the issuer's placement of providers or facilities in one tier or another.

(3) The lowest cost-sharing tier of a tiered network must provide enrollees with adequate access and choice among health care providers and facilities for essential health benefits as set forth in WAC 284-43-878, 284-43-879, and 284-43-880.

(4) Cost-sharing differentials between tiers must not be imposed on an enrollee if the sole provider or facility type or

category required to deliver a covered service is not available to the enrollee in the lowest cost-sharing tier of the network.

(a) All enrollees must have reasonable access to providers and facilities at the lowest cost tier of cost-sharing.

(b) Variations in cost-sharing between tiers must be reasonable in relation to the premium rate charged.

(5) An issuer must include with the Provider Compensation Agreement the metrics and methodology used to assign participating providers and facilities to tiers. An issuer must be able to demonstrate to the commissioner's satisfaction that its assignment of providers and facilities to tiers, when based on a rating system, is consistent with the issuer's placement methodology.

(a) When an issuer revises or amends a quality, cost-efficiency or tiering program related to its provider network, it must provide notice to affected providers and facilities of the proposed change sixty days before notifying the public of the program. The notice must explain the methodology and data, if any, used for particular providers and facilities and include information on provider appeal rights as stated in the provider agreement.

(b) An issuer must make its physician cost profile available to providers and facilities under a tiered network, including the written criteria by which the provider's performance is measured.

(6) An issuer's provider and facility ranking program, and the criteria used to assign providers and facilities to different tiers, must not be described in advertising or plan documents so as to deceive consumers as to issuer rating practices and their affect on available benefits. When a tiered network is used, an issuer must provide detailed information on its web site and if requested, make available in paper form information about the tiered network including, but not limited to:

(a) The providers and facilities participating in the tiered network;

(b) The selection criteria, if any, used to place the providers and facilities, but not including the results of applying those selection criteria to a particular provider or facility;

(c) The potential for providers and facilities to move from one tier to another at any time; and

(d) The tier in which each participating provider or facility is assigned.

(7) For any health plan in effect on a tiered network's reassignment date, an issuer must make a good faith effort to provide information to affected enrollees at least sixty days before the reassignment takes effect. This information includes, but is not limited to, the procedure the enrollee must follow to choose an alternate provider or facility to obtain treatment at the same cost-sharing level. The specific classes of enrollees to whom notice must be sent are:

(a) Patients of a reassigned primary care provider if their primary care provider is reassigned to a higher cost-sharing level;

(b) A patient in the second or third trimester of pregnancy if a care provider or facility in connection with her pregnancy is reassigned to a higher cost-sharing level;

(c) A terminally ill patient if a provider or facility in connection with the illness is reassigned to a higher cost-sharing level; and

(d) Patients under active treatment for cancer or hematologic disorders, if the provider or facility that is delivering the care is reassigned to a higher cost-sharing level.

[Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.460, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.44.050, 48.46.200, 48.20.450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. §§ 156.230, 156.235, and 156.245. WSR 14-10-017 (Matter No. R 2013-22), § 284-43-229, filed 4/25/14, effective 5/26/14.]

WAC 284-43-230 Assessment of access. (1) The commissioner will assess whether an issuer's provider network access meets the requirements of WAC 284-43-200, 284-43-201, and 284-43-205 such that all health plan services to enrollees will be accessible in a timely manner appropriate for the enrollee's condition. Factors considered by the commissioner will include the following:

(a) The location of the participating providers and facilities;

(b) The location of employers or enrollees in the health plan;

(c) The range of services offered by providers and facilities for the health plan;

(d) Health plan provisions that recognize and provide for extraordinary medical needs of enrollees that cannot be adequately treated by the network's participating providers and facilities;

(e) The number of enrollees within each service area living in certain types of institutions or who have chronic, severe, or disabling medical conditions, as determined by the population the issuer is covering and the benefits provided;

(f) The availability of specific types of providers who deliver medically necessary services to enrollees under the supervision of a provider licensed under Title 18 RCW;

(g) The availability within the service area of facilities under Titles 70 and 71 RCW;

(h) Accreditation as to network access by a national accreditation organization including, but not limited to, the National Committee for Quality Assurance (NCQA), the Joint Commission, Accreditation Association of Ambulatory Health Care (AAAHC), or URAC.

(2) In determining whether an issuer has complied with the provisions of WAC 284-43-200, the commissioner will give due consideration to the relative availability of health care providers or facilities in the service area under consideration and to the standards established by state agency health care purchasers. Relative availability includes the willingness of providers or facilities in the service area to contract with the issuer under reasonable terms and conditions.

(3) If the commissioner determines that an issuer's proposed or current network for a health plan is not adequate, the commissioner may, for good cause shown, permit the issuer to propose changes sufficient to make the network adequate within a sixty-day period of time. The proposal must include a mechanism to ensure that new enrollees have access to an open primary care provider within ten business days of enrolling in the plan while the proposed changes are being implemented. This requirement is in addition to such enforcement action as is otherwise permitted under Title 48 RCW.

[Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.460, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.44.050, 48.46.200, 48.20.450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. §§ 156.230, 156.235, and

156.245. WSR 14-10-017 (Matter No. R 2013-22), § 284-43-230, filed 4/25/14, effective 5/26/14.]

WAC 284-43-250 Issuer standards for women's right to directly access certain health care practitioners for women's health care services. (1)(a) "Women's health care services" means organized services to provide health care to women, inclusive of the women's preventive services required by the Health Resources and Services Administration of the U.S. Department of Health and Human Services. The services include, but are not limited to, maternity care, reproductive health services, gynecological care, general examination, and preventive care as medically appropriate, and medically appropriate follow-up visits for these services. Women's health care services also include any appropriate health care service for other health problems, discovered and treated during the course of a visit to a women's health care practitioner for a women's health care service, which is within the practitioner's scope of practice. For purposes of determining a woman's right to directly access health services covered by the plan, maternity care, reproductive health, and preventive services include: Contraceptive services, testing and treatment for sexually transmitted diseases, pregnancy termination, breast-feeding, and complications of pregnancy.

(b) An issuer must not exclude or limit access to covered women's health care services offered by a particular type of women's health care provider, practitioner, or facility in a manner that would unreasonably restrict access to that type of provider, practitioner, or facility or covered service. For example, an issuer must not impose a limitation on maternity services that would require all child birth to occur in a hospital attended by a physician, thus preventing a woman from choosing between and using the birthing services of an advanced registered nurse practitioner, a certified midwife, or a licensed midwife.

(c) An issuer must not impose notification or prior authorization requirements upon women's health care practitioners, providers, and facilities who render women's health care services or upon women who directly access such services unless such requirements are imposed upon other providers offering similar types of service. For example, an issuer must not require a directly accessed women's health care practitioner to notify the plan within seven days of providing direct women's health care services if a primary care provider would not also be required to provide seven-day notice to the issuer for the same or similar service.

(2) An issuer must not deny coverage for medically appropriate laboratory services, imaging services, diagnostic services, or prescriptions for pharmaceutical or medical supplies, which are ordered by a directly accessed women's health care practitioner, and which are within the practitioner's scope of practice, if such services would be covered when provided by another type of health care practitioner. An issuer must not require authorization by another type of health care practitioner for these services. For example, if the issuer would cover a prescription if the prescription had been written by the primary care provider, the issuer must cover the prescription written by the directly accessed women's health care practitioner.

(3)(a) All issuers must permit each female enrollee of a health plan to directly access providers or practitioners for

appropriate covered women's health care services without prior referral from another health care practitioner.

(b) An issuer may limit direct access to those women's health care practitioners who have signed participating provider agreements with the issuer for a specific health plan network. Irrespective of the financial arrangements an issuer may have with participating providers, an issuer may not limit and must not permit a network provider to limit access to a subset of participating women's health care practitioners within the network. Such an impermissible limitation might arise when a primary care provider's group practice receives a capitation payment for comprehensive care to an enrollee and then represents to the enrollee that only those gynecologists in the primary care provider's clinic are available for direct access. Nothing in this subsection must be interpreted to prohibit an issuer from contracting with a provider to render limited health care services.

(c) Every issuer must include in each provider network a sufficient number of each type of practitioner included in the definition of women's health care practitioners in RCW 48.42.100(2). A "sufficient number" means enough to reasonably ensure that enrollees can exercise their right of direct access within their service area, based on the number of providers with women's health care service in the scope of their license, and the number of enrollees. An issuer must demonstrate the basis on which it determined the sufficiency of the number and type of providers under this section.

(d) A woman's right to directly access practitioners for health care services, as provided under RCW 48.42.100, includes the right to obtain appropriate women's health care services ordered by the practitioner from a participating facility used by the practitioner.

(4) To inform enrollees of their rights under RCW 48.42.100, all issuers must include in enrollee handbooks a written explanation of a woman's right to directly access covered women's health care services. Enrollee handbooks must include information regarding any limitations to direct access, including, but not limited to:

(a) Limited direct access based on a benefit plan's closed network of practitioners, if appropriate; and

(b) The issuer's right to limit coverage to medically necessary and appropriate women's health care services.

(5) No issuer shall impose cost-sharing, such as copayments or deductibles, for directly accessed women's health care services, that are not required for access to health care practitioners acting as primary care providers.

[Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.460, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.44.050, 48.46.200, 48.20.450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. §§ 156.230, 156.235, and 156.245. WSR 14-10-017 (Matter No. R 2013-22), § 284-43-250, filed 4/25/14, effective 5/26/14. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.030, 48.46.200. WSR 00-04-034 (Matter No. R 99-2), § 284-43-250, filed 1/24/00, effective 2/24/00. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. WSR 98-04-005 (Matter No. R 97-3), § 284-43-250, filed 1/22/98, effective 2/22/98.]

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

permitted to change primary care providers at any time with the change becoming effective no later than the beginning of the month following the covered person's request for the change.

(2) Each carrier must have a process whereby a covered person with a complex or serious medical or psychiatric 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 medical 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 performance of utilization review functions.

(3) Each carrier shall provide covered persons with direct access to the participating chiropractor of the covered person's choice for covered chiropractic health care without the necessity of prior referral. Nothing in this subsection shall prevent carriers from restricting covered persons to seeing only chiropractors who have signed participating provider agreements or from utilizing other managed care and cost containment techniques and processes. 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 must provide, upon the request of a covered person, access by the covered person to a second opinion regarding any medical diagnosis or treatment plan from a qualified participating provider of the covered person's choice. The carrier may not impose any charge or cost upon the covered person for such second opinion other than a charge or cost imposed for the same service in otherwise similar circumstances.

(5) 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 for at least sixty days following notice of termination to the covered persons or, in group coverage arrangements involving periods of open enrollment, only until the end of the next open enrollment period. Notice to covered persons shall include information of the covered person's right of access to the terminating provider for an additional sixty days. 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 covered persons to the terminated provider.

(6) Each carrier shall 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 who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause.

[Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.100, 48.46.200, 48.43.505, 48.43.510, 48.43.515, 48.43.520, 48.43.525, 48.43.530, 48.43.535. WSR 01-03-033 (Matter No. R 2000-02), § 284-43-251, filed 1/9/01, effective 7/1/01.]

WAC 284-43-252 Hospital emergency service departments and practice groups. Enrollees must have access to emergency services twenty-four hours per day, seven days per week. An issuer must make good faith attempts to contract with provider groups offering services within hospital emergency departments, if the hospital is included in its network. Such evidence of good faith efforts to contract will include documentation about the efforts to contract but not the substantive contract terms offered by either the issuer or the provider groups. If the issuer is unsuccessful in contracting with provider groups offering services within contracted hospital emergency departments, the issuer's provider directory must prominently note that while the hospital's emergency department is contracted, the providers within the department are not.

[Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.460, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.44.050, 48.46.200, 48.20.450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. §§ 156.230, 156.235, and 156.245. WSR 14-10-017 (Matter No. R 2013-22), § 284-43-252, filed 4/25/14, effective 5/26/14.]

WAC 284-43-260 Standards for temporary substitution of contracted network providers—"Locum tenens" providers. It is a longstanding and widespread practice for contracted network providers to retain substitute providers to take over their professional practices when the contracted network providers are absent for reasons such as illness, pregnancy, vacation, or continuing medical education, and for contracted network providers to bill and receive payment for the substitute providers' services as though they were provided by the contracted network provider. The contracted network provider generally pays the substitute provider based on an agreement between the contracted network provider and the substitute provider, and the substitute provider has the status of an independent contractor rather than an employee of the contracted network provider. These substitute providers are commonly called "locum tenens" providers.

In order to protect patients and ensure that they benefit from seamless quality care when contractual network providers are away from their practices, and that patients receive quality care from qualified substitute providers, carriers may require substitute providers to provide the information required in subsection (1) of this section.

The following are minimum standards for temporary provider substitution and do not prevent a carrier from entering into other agreed arrangements with its contracted network providers for terms that are less restrictive or more favorable to providers.

Carriers must permit the following categories of contracted network provider to arrange for temporary substitution by a substitute provider: Doctor of medicine, doctor of osteopathic medicine, doctor of dental surgery or dental medicine, doctor of chiropractic, podiatric physician and surgeon, doctor of optometry, doctor of naturopathic medicine and advanced registered nurse practitioner.

(1) At the time of substitution, the substitute provider:

(a) Must have a current Washington license and be legally authorized to practice in this state;

(b) Must provide services under the same scope of practice as the contracted network provider;

(c) Must not be suspended or excluded from any state or federal health care program;

(d) Must have professional liability insurance coverage; and

(e) Must have a current drug enforcement certificate, if applicable.

(2)(a) Carriers must allow a contracted network provider to arrange for a substitute provider for at least sixty days during any calendar year.

(b) A carrier must grant an extension if a contracted network provider demonstrates that exceptional circumstances require additional time away from his or her practice.

(3) A carrier may require that the contracted network provider agree to bill for services rendered by the substitute provider using the carrier's billing guidelines, including use of HIPAA compliant code sets, commonly known as the Q-6 modifier, or any other code or modifier that the Centers for Medicare and Medicaid Services (CMS) adopts in the future.

(4) Nothing in this section is intended to prevent the carrier from requiring:

(a) That the contracted network provider require acceptance by the substitute provider of the carrier's fee schedule; or

(b) Acceptance by the substitute provider of the carrier's usual and customary charge as payment in full.

(5) This rule does not apply to Medicare Advantage or other health plans administered by the federal government that require precredentialing of all providers.

[Statutory Authority: RCW 48.02.060 and 48.43.515. WSR 08-01-025 (Matter No. R 2005-04), § 284-43-260, filed 12/10/07, effective 1/10/08.]

WAC 284-43-262 Rule concerning contracted network providers called to active duty military service. In lieu of substitution of a provider during a period of active duty military service longer than sixty continuous days, carriers must provide contracted network providers with the opportunity to return to the carrier's network after the provider's active duty military service is completed.

(1)(a) A carrier must allow the provider a period of at least one hundred twenty days to request a return to contracted network provider status after the provider returns to civilian status.

(b) The one hundred twenty-day period must begin no earlier than the date the provider's period of active duty ends.

(2)(a) As a condition for return to the carrier's network, the carrier may require that the provider provide evidence that he or she meets the carrier's then-current standards for credentialing.

(b) If the provider meets or exceeds the credentialing standards of the carrier and timely requests a return to contracted network provider status, the carrier must grant the request whether or not the carrier's network is otherwise closed.

[Statutory Authority: RCW 48.02.060 and 48.43.515. WSR 08-01-025 (Matter No. R 2005-04), § 284-43-262, filed 12/10/07, effective 1/10/08.]

SUBCHAPTER C

PROVIDER CONTRACTS AND PAYMENT

WAC 284-43-300 Provider and facility contracts with health carriers—Generally. A health carrier contracting with providers or facilities for health care service delivery to covered persons shall 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.

[Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. WSR 98-04-005 (Matter No. R 97-3), § 284-43-300, filed 1/22/98, effective 2/22/98.]

WAC 284-43-310 Selection of participating providers—Credentialing and unfair discrimination. (1) Health carrier selection standards for participating providers and facilities shall be developed by the carrier for primary care providers and each health care provider or facility license or professional specialty. The standards shall be used in determining the selection of health care providers and facilities by the health carrier. The standards shall 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 not be established in a manner:

(a) That would allow a health carrier 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.

(2) The provisions of subsection (1)(a) and (b) of this section shall not be construed to prohibit a carrier from declining to select a provider or facility who fails to meet other legitimate selection criteria of the carrier. 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.

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

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

[Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. WSR 98-04-005 (Matter No. R 97-3), § 284-43-310, filed 1/22/98, effective 2/22/98.]

WAC 284-43-320 Provider contracts—Standards—Hold harmless provisions. The execution of a contract by a health carrier shall not relieve the health carrier of its obliga-

tions to any covered person 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 be in writing and available for review upon request by the commissioner.

(1) A health carrier shall 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.

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 govern with respect to coverage provided to covered persons.

(2) Each participating provider and participating facility contract shall 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}, {name of carrier's} insolvency, or breach of this contract shall {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 or person acting on their behalf, other than {name of carrier}, for services provided pursuant to this contract. This provision shall not prohibit collection of {deductibles, copayments, coinsurance, and/or noncovered services}, which have not otherwise been paid by a primary or secondary carrier in accordance with regulatory standards for coordination of benefits, from covered persons in accordance with the terms of the covered person's health plan."

(b) "{Name of provider or facility} agrees, in the event of {name of carrier's} insolvency, to continue to provide the services promised in this contract to covered persons of {name of carrier} for the duration of the period for which premiums on behalf of the covered person were paid to {Name of carrier} or until the covered person'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 health plan."

(d) "{Name of provider or facility} may not bill the covered person for covered services (except for deductibles, copayments, or coinsurance) where {name of carrier} 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, 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 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 of {name of carrier} with the expectation of receiving payment directly or indirectly from {name of carrier}, 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) The contract shall inform participating providers and facilities that willfully collecting or attempting to collect an amount from a covered person 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 notify participating providers and facilities of their responsibilities with respect to the health carrier's applicable administrative policies and programs, including but not limited to payment terms, utilization review, quality assessment and improvement programs, credentialing, grievance procedures, data reporting requirements, confidentiality requirements and any applicable federal or state requirements.

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. Participating providers and facilities must be given reasonable notice of not less than sixty days of changes that affect provider or facility compensation and 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 be provided as soon as possible. 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. No change to the contract may be made retroactive without the express 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:

(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 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 and participating provider and facility shall provide at least sixty days' written notice to each other before terminating the contract without cause. The health carrier shall 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 who are patients seen 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 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 is responsible for ensuring that participating providers and facilities furnish covered services to covered persons without regard to the covered person'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 not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the health carrier 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) Every participating provider contract shall contain procedures for the fair resolution of disputes arising out of the contract.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.43.055, 48.44.050, 48.44.070, 48.46.030, 48.46.200 and 48.46.243. WSR 99-21-016 (Matter No. R 98-21), § 284-43-320, filed 10/11/99, effective 11/11/99. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. WSR 98-04-005 (Matter No. R 97-3), § 284-43-320, filed 1/22/98, effective 2/22/98.]

WAC 284-43-321 Provider contracts—Terms and conditions of payment.

(1) Every participating provider and facility contract shall set forth a schedule for the prompt payment of amounts owed by the carrier to the provider or facility and shall include penalties for carrier failure to abide by that schedule. At a minimum, these contract provisions shall conform to the standards of this section.

(2)(a) For health services provided to covered persons, a carrier shall pay providers and facilities as soon as practical but subject to the following minimum standards:

(i) Ninety-five percent of the monthly volume of clean claims shall be paid within thirty days of receipt by the responsible carrier or agent of the carrier; and

(ii) Ninety-five percent of the monthly volume of all claims shall be paid or denied within sixty days of receipt by

the responsible carrier or agent of the carrier, except as agreed to in writing by the parties on a claim-by-claim basis.

(b) The receipt date of a claim is the date the responsible carrier or its agent receives either written or electronic notice of the claim.

(c) The carrier shall establish a reasonable method for confirming receipt of claims and responding to provider and facility inquiries about claims.

(d) Any carrier failing to pay claims within the standard established under subsection (2) of this section shall pay interest on undenied and unpaid clean claims more than sixty-one days old until the carrier meets the standard under subsection (2) of this section. Interest shall be assessed at the rate of one percent per month, and shall be calculated monthly as simple interest prorated for any portion of a month. The carrier shall add the interest payable to the amount of the unpaid claim without the necessity of the provider or facility submitting an additional claim. Any interest paid under this section shall not be applied by the carrier to a covered person's deductible, copayment, coinsurance, or any similar obligation of the covered person.

(e) When the carrier issues payment in either the provider or facility and the covered person names, the carrier shall make claim checks payable in the name of the provider or facility first and the covered person second.

(3) For purposes of this section, "clean claim" means a claim that has no defect or impropriety, including any lack of any required substantiating documentation, or particular circumstances requiring special treatment that prevents timely payments from being made on the claim under this section.

(4) Denial of a claim must be communicated to the provider or facility and must include the specific reason why the claim was denied. If the denial is based upon medical necessity or similar grounds, then the carrier upon request of the provider or facility must also promptly disclose the supporting basis for the decision. For example, the carrier must describe how the claim failed to meet medical necessity guidelines.

(5) Every carrier shall be responsible for ensuring that any person acting on behalf of or at the direction of the carrier or acting pursuant to carrier standards or requirements complies with these billing and claim payment standards.

(6) These standards do not apply to claims about which there is substantial evidence of fraud or misrepresentation by providers, facilities or covered persons, or instances where the carrier has not been granted reasonable access to information under the provider's or facility's control.

(7) Providers, facilities, and carriers are not required to comply with these contract provisions if the failure to comply is occasioned by any act of God, bankruptcy, act of a governmental authority responding to an act of God or other emergency, or the result of a strike, lockout, or other labor dispute.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.43.055, 48.44.050, 48.44.070, 48.46.030, 48.46.200 and 48.46.243. WSR 99-21-016 (Matter No. R 98-21), § 284-43-321, filed 10/11/99, effective 11/11/99.]

WAC 284-43-322 Provider contracts—Dispute resolution process. Except as otherwise required by a specific federal or state statute or regulation governing dispute resolution, no process for the resolution of disputes arising out of a participating provider or facility contract shall be considered

fair under RCW 48.43.055 unless the process meets all the provisions of this section.

(1) A dispute resolution process may include an initial informal process but must include a formal process for resolution of all contract disputes.

(2) A carrier may have different types of dispute resolution processes as necessary for specialized concerns such as provider credentialing or as otherwise required by law. For example, disputes over health plan coverage of health care services are subject to the grievance procedures established for covered persons.

(3) Carriers must allow not less than thirty days after the action giving rise to a dispute for providers and facilities to complain and initiate the dispute resolution process.

(4) Carriers may not require alternative dispute resolution to the exclusion of judicial remedies; however, carriers may require alternative dispute resolution prior to judicial remedies.

(5) Carriers must render a decision on provider or facility complaints within a reasonable time for the type of dispute. In the case of billing disputes, the carrier must render a decision within sixty days of the complaint.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.43.055, 48.44.050, 48.44.070, 48.46.030, 48.46.200 and 48.46.243. WSR 99-21-016 (Matter No. R 98-21), § 284-43-322, filed 10/11/99, effective 11/11/99.]

WAC 284-43-323 Pharmacy identification cards. (1)

This rule outlines the minimum standards for prescription claims processing as directed by RCW 48.43.023.

(2) The pharmacy identification card or other technology must include the data element consistent with the "BIN number," "IIN/BIN number" or "RxBIN" which is the ANSI assigned international identification number, identified in the *National Council for Prescription Drug Programs (NCPDP) Pharmacy ID Card Implementation Guide*. Other data elements of the *NCPDP Guide* must be included on the card only if they are required for the processing of claims.

(3) This rule does not compel the issuance of a separate pharmacy identification card provided that the enrollee health plan identification card contains the required data elements.

(4) All plans that use a card or other technology for prescription claims processing that are delivered, issued for delivery or renewed on or after July 1, 2003, must comply with the requirements of this rule.

[Statutory Authority: RCW 48.02.060, 48.43.023, 48.44.050, 48.46.200. WSR 03-07-006 (Matter No. R 2002-04), § 284-43-323, filed 3/6/03, effective 4/6/03.]

WAC 284-43-324 Provider contracts—Audit guidelines. (1) Provider and facility contracts may not contain provisions that grant the carrier access to health information and other similar records unrelated to covered persons. This provision shall not limit the carrier's right to ask for and receive information relating to the ability of the provider or facility to deliver health care services that meet the accepted standards of medical care prevalent in the community.

(2) Provider and facility contract provisions granting the carrier access to medical records for audit purposes must be limited to only that necessary to perform the audit.

(3) Provider and facility contracts may not contain billing audit standards that are not mutual. For example, if the

carrier grants itself the right to audit hospital billing records, then the hospital has the right to audit carrier denials of the hospital's claims.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.43.055, 48.44.050, 48.44.070, 48.46.030, 48.46.200 and 48.46.243. WSR 99-21-016 (Matter No. R 98-21), § 284-43-324, filed 10/11/99, effective 11/11/99.]

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. All changes to contracts 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.

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

[Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.030, 48.46.200, and 2013 c 277 § 1. WSR 13-16-045 (Matter No. R 2012-24), § 284-43-330, filed 7/31/13, effective 8/31/13. Statutory Authority: RCW 48.02.060, 48.30.010, 48.43.055, 48.44.050, 48.44.070, 48.46.030, 48.46.200 and 48.46.243. WSR 99-21-016 (Matter No. R 98-21), § 284-43-330, filed 10/11/99, effective 11/11/99. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. WSR 98-04-005 (Matter No. R 97-3), § 284-43-330, filed 1/22/98, effective 2/22/98.]

WAC 284-43-331 Effective date. (1) All participating provider and facility contracts entered into after the effective date of these rules must comply with these rules no later than January 1, 2015.

(2) 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 January 1, 2015. The commissioner may extend the January 1, 2015, 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 January 1, 2015).

[Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.460, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.44.050, 48.46.200, 48.20.-450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. §§ 156.230, 156.235, and 156.245. WSR 14-10-017 (Matter No. R 2013-22), § 284-43-331, filed 4/25/14, effective 5/26/14. Statutory Authority: RCW 48.02.060, 48.30.010, 48.43.055, 48.44.050, 48.44.070, 48.46.030, 48.46.200 and 48.46.243. WSR 99-21-016 (Matter No. R 98-21), § 284-43-331, filed 10/11/99, effective 11/11/99.]

SUBCHAPTER D

UTILIZATION REVIEW

WAC 284-43-410 Utilization review—Generally. (1) These definitions apply to this section:

(a) "Concurrent care review request" means any request for an extension of a previously authorized inpatient stay or a previously authorized ongoing outpatient service, e.g., physical therapy, home health, etc.

(b) "Immediate review request" means any request for approval of an intervention, care or treatment where passage of time without treatment would, in the judgment of the provider, result in an imminent emergency room visit or hospital admission and deterioration of the patient's health status. Examples of situations that do not qualify under an immediate review request include, but are not limited to, situations where:

(i) The requested service was prescheduled, was not an emergency when scheduled, and there has been no change in the patient's condition;

(ii) The requested service is experimental or in a clinical trial;

(iii) The request is for the convenience of the patient's schedule or physician's schedule; and

(iv) The results of the requested service are not likely to lead to an immediate change in the patient's treatment.

(c) "Nonurgent preservice review request" means any request for approval of care or treatment where the request is made in advance of the patient obtaining medical care or services and is not an urgent care request.

(d) "Postservice review request" means any request for approval of care or treatment that has already been received by the patient.

(e) "Urgent care review request" means any request for approval of care or treatment where the passage of time could seriously jeopardize the life or health of the patient, seriously jeopardize the patient's ability to regain maximum function, or, in the opinion of a physician with knowledge of the patient's medical condition, would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

(2) Each carrier must maintain a documented utilization review program description and written clinical review criteria based on reasonable medical evidence. The program must include a method for reviewing and updating criteria. Carriers must make clinical review criteria available upon request to participating providers. A carrier need not use medical evidence or standards in its utilization review of religious non-medical treatment or religious nonmedical nursing care.

(3) The utilization review program must meet accepted national certification standards such as those used by the National Committee for Quality Assurance except as other-

wise required by this chapter and must have staff who are properly qualified, trained, supervised, and supported by explicit written clinical review criteria and review procedures.

(4) Each carrier when conducting utilization review must:

(a) Accept information from any reasonably reliable source that will assist in the certification process;

(b) Collect only the information necessary to certify the admission, procedure or treatment, length of stay, or frequency or duration of services;

(c) Not routinely require providers or facilities to numerically code diagnoses or procedures to be considered for certification, but may request such codes, if available;

(d) Not routinely request copies of medical records on all patients reviewed;

(e) Require only the section(s) of the medical record during prospective review or concurrent review necessary in that specific case to certify medical necessity or appropriateness of the admission or extension of stay, frequency or duration of service;

(f) For prospective and concurrent review, base review determinations solely on the medical information obtained by the carrier at the time of the review determination;

(g) For retrospective review, base review determinations solely on the medical information available to the attending physician or order provider at the time the health service was provided;

(h) Not retrospectively deny coverage for emergency and nonemergency care that had prior authorization under the plan's written policies at the time the care was rendered unless the prior authorization was based upon a material misrepresentation by the provider;

(i) Not retrospectively deny coverage or payment for care based upon standards or protocols not communicated to the provider or facility within a sufficient time period for the provider or facility to modify care in accordance with such standard or protocol; and

(j) Reverse its certification determination only when information provided to the carrier is materially different from that which was reasonably available at the time of the original determination.

(5) Each carrier must reimburse reasonable costs of medical record duplication for reviews.

(6) Each carrier must have written procedures to assure that reviews and second opinions are conducted in a timely manner.

(a) Review time frames must be appropriate to the severity of the patient condition and the urgency of the need for treatment, as documented in the review request.

(b) If the review request from the provider is not accompanied by all necessary information, the carrier must tell the provider what additional information is needed and the deadline for its submission. Upon the sooner of the receipt of all necessary information or the expiration of the deadline for providing information, the time frames for carrier review determination and notification must be no less favorable than federal Department of Labor standards, as follows:

(i) For immediate request situations, within one business day when the lack of treatment may result in an emergency visit or emergency admission;

(ii) For concurrent review requests that are also urgent care review requests, as soon as possible, taking into account the medical exigencies, and no later than twenty-four hours, provided that the request is made at least twenty-four hours prior to the expiration of previously approved period of time or number of treatments;

(iii) For urgent care review requests within forty-eight hours;

(iv) For nonurgent preservice review requests, including nonurgent concurrent review requests, within five calendar days; or

(v) For postservice review requests, within thirty calendar days.

(c) Notification of the determination must be provided as follows:

(i) Information about whether a request was approved or denied must be made available to the attending physician, ordering provider, facility, and covered person. Carriers must at a minimum make the information available on their web site or from their call center.

(ii) Whenever there is an adverse determination the carrier must notify the ordering provider or facility and the covered person. The carrier must inform the parties in advance whether it will provide notification by phone, mail, fax, or other means. For an adverse determination involving an urgent care review request, the carrier may initially provide notice by phone, provided that a written or electronic notification meeting United States Department of Labor standards is furnished within seventy-two hours of the oral notification.

(d) As appropriate to the type of request, notification must include the number of extended days, the next anticipated review point, the new total number of days or services approved, and the date of admission or onset of services.

(e) The frequency of reviews for the extension of initial determinations must be based on the severity or complexity of the patient's condition or on necessary treatment and discharge planning activity.

(7) No carrier may penalize or threaten a provider or facility with a reduction in future payment or termination of participating provider or participating facility status because the provider or facility disputes the carrier's determination with respect to coverage or payment for health care service.

[Statutory Authority: RCW 48.02.060, 48.43.530, P.L. 111-148 (2010, as amended) and regulations issued on June 24, 2011, amending 45 C.F.R. Part 147. WSR 11-24-004 (Matter No. R 2011-18), § 284-43-410, filed 11/28/11, effective 12/29/11. Statutory Authority: RCW 48.02.060 and 48.43.520. WSR 10-23-051 (Matter No. R 2009-19), § 284-43-410, filed 11/10/10, effective 12/11/10. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.100, 48.46.200, 48.43.-505, 48.43.510, 48.43.515, 48.43.520, 48.43.525, 48.43.530, 48.43.535. WSR 01-03-033 (Matter No. R 2000-02), § 284-43-410, filed 1/9/01, effective 7/1/01.]

SUBCHAPTER E

ADVERSE BENEFIT DETERMINATION PROCESS REQUIREMENTS FOR NONGRANDFATHERED PLANS

WAC 284-43-500 Scope and intent. Carriers and non grandfathered plans must follow the rules in this subchapter in order to comply with the adverse benefit determination

process required by RCW 48.43.530 and 48.43.535. These rules apply to any request for a review of an adverse benefit determination made by a carrier or its designee on or after January 1, 2012.

[Statutory Authority: RCW 48.02.060, 48.43.525, 48.43.530, 48.43.535, and The Patient Protection and Affordable Care Act, P.L. 111-148, as amended (2010). WSR 12-23-005 (Matter No. R 2011-11), § 284-43-500, filed 11/7/12, effective 11/20/12.]

WAC 284-43-505 Definitions. These definitions apply to the sections in this subchapter, WAC 284-43-510 through 284-43-550:

"Adverse benefit determination" has the same meaning as defined in RCW 48.43.005 and WAC 284-43-130.

"Appellant" means an applicant or a person covered as an enrollee, subscriber, policy holder, participant, or beneficiary of an individual or group health plan, and when designated, their representative. Consistent with the requirements of WAC 284-43-410, providers seeking expedited review of an adverse benefit determination on behalf of an appellant may act as the appellant's representative even if the appellant has not formally notified the health plan or carrier of the designation.

"Internal appeal or review" means an appellant's request for a carrier or health plan to review and reconsider an adverse benefit determination.

"External appeal or review" means the request by an appellant for an independent review organization to determine whether the carrier or health plan's internal appeal decisions are correct.

[Statutory Authority: RCW 48.02.060, 48.43.525, 48.43.530, 48.43.535, and The Patient Protection and Affordable Care Act, P.L. 111-148, as amended (2010). WSR 12-23-005 (Matter No. R 2011-11), § 284-43-505, filed 11/7/12, effective 11/20/12.]

WAC 284-43-510 Review of adverse benefit determinations—Generally. (1) Each carrier must establish and implement a comprehensive process for the review of adverse benefit determinations. The process must offer an appellant the opportunity for both internal review and external review of an adverse benefit determination. The process must meet accepted national certification standards such as those used by the National Committee for Quality Assurance, except as otherwise required by this chapter.

(2) Neither a carrier nor a health plan may take or threaten to take any punitive action against a provider acting on behalf of or in support of an appellant.

(3) When the appeal is related to services the appellant is currently receiving as an inpatient, or for which a continuous course of treatment is medically necessary, coverage for those services must be continued while an adverse benefit determination is reviewed. Appellants must be notified that they may be responsible for the cost of services if the adverse benefit determination is upheld.

(4) A carrier must accept a request for internal review of an adverse benefit determination if the request is received within one hundred eighty days of the appellant's receipt of a determination under the plan. A carrier must notify an appellant of its receipt of the request within seventy-two hours of receiving the request.

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(5) Each carrier and health plan must maintain a log of each adverse benefit determination review, its resolution, and the dates of receipt, notification, and determination.

(a) The carrier must make its review log available to the commissioner upon request in a form accessible by the commissioner. The log must be maintained by the carrier for a six-year period.

(b) Each carrier must identify, evaluate, and make available to the commissioner data and reports on trends in reviews for at least a six-year time frame, including the data on the number of adverse benefit determination reviews, the subject matter of the reviews and their outcome.

(c) When a carrier resolves issues related to an adverse benefit determination over the phone, without receiving a formal request for review, the carrier must include in these resolutions in its review log. A carrier's actions that are not in response to a member's call regarding an adverse benefit determination do not need to be included in the adverse benefit determination review log.

[Statutory Authority: RCW 48.02.060, 48.43.525, 48.43.530, 48.43.535, and The Patient Protection and Affordable Care Act, P.L. 111-148, as amended (2010). WSR 12-23-005 (Matter No. R 2011-11), § 284-43-510, filed 11/7/12, effective 11/20/12.]

WAC 284-43-511 Explanation of right to review. A carrier must clearly communicate in writing the right to request a review of an adverse benefit determination.

(1) At a minimum, the notice must be sent at the following times:

- (a) Upon request;
- (b) As part of the notice of adverse benefit determination;
- (c) To new enrollees at the time of enrollment; and
- (d) Annually thereafter to enrollees, group administrators, and subcontractors of the carrier.

(e) The notice requirement is satisfied if the description of the internal and external review process is included in or attached to the summary health plan descriptions, policy, certificate, membership booklet, outline of coverage or other evidence of coverage provided to participants, beneficiaries, or enrollees.

(2) Each carrier and health plan must ensure that its network providers receive a written explanation of the manner in which adverse benefit determinations may be reviewed on both an expedited and nonexpedited basis.

(3) Any written explanation of the review process must include information about the availability of Washington's designated ombudsman's office, the services it offers, and contact information. A carrier's notice must also specifically direct appellants to the office of the insurance commissioner's consumer protection division for assistance with questions and complaints.

(4) The review process must be accessible to persons who are limited-English speakers, who have literacy problems, or who have physical or mental disabilities that impede their ability to request review or participate in the review process.

(a) Carriers must conform to federal requirements to provide notice of the process in a culturally and linguistically appropriate manner to those seeking review.

(b) In counties where ten percent or more of the population is literate in a specific non-English language, carriers must include in notices a prominently displayed statement in the relevant language or languages, explaining that oral assistance and a written notice in the non-English language are available upon request. Carriers may rely on the most recent data published by the U.S. Department of Health and Human Services Office of Minority Health to determine which counties and which languages require such notices.

(c) This requirement is satisfied if the National Commission on Quality Assurance certifies the carrier is in compliance with this standard as part of the accreditation process.

(5) Each carrier must consistently assist appellants with understanding the review process. Carriers may not use and health plans may not contain procedures or practices that the commissioner determines discourage an appellant from any type of adverse benefit determination review.

(6) If a carrier reverses its initial adverse benefit determination, which it may at any time during the review process, the carrier or health plan must provide appellant with written or electronic notification of the decision immediately, but in no event more than two business days of making the decision.

[Statutory Authority: RCW 48.02.060, 48.43.525, 48.43.530, 48.43.535, and The Patient Protection and Affordable Care Act, P.L. 111-148, as amended (2010). WSR 12-23-005 (Matter No. R 2011-11), § 284-43-511, filed 11/7/12, effective 11/20/12.]

WAC 284-43-515 Notice and explanation of adverse benefit determination—General requirements. (1) A carrier must notify enrollees of an adverse benefit determination either electronically or by U.S. mail. The notification must be provided:

(a) To an appellant or their authorized representative; and

(b) To the provider if the adverse benefit determination involves the preservice denial of treatment or procedure prescribed by the provider.

(2) A carrier or health plan's notice must include the following information, worded in plain language:

(a) The specific reasons for the adverse benefit determination;

(b) The specific health plan policy or contract sections on which the determination is based, including references to the provisions;

(c) The plan's review procedures, including the appellant's right to a copy of the carrier and health plan's records related to the adverse benefit determination;

(d) The time limits applicable to the review; and

(e) The right of appellants and their providers to present evidence as part of a review of an adverse benefit determination.

(3) If an adverse benefit determination is based on medical necessity, decisions related to experimental treatment, or a similar exclusion or limit involving the exercise of professional judgment, the notification must contain either an explanation of the scientific or clinical basis for the determination, the manner in which the terms of the health plan were applied to the appellant's medical circumstances, or a statement that such explanation is available free of charge upon request.

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(4) If an internal rule, guideline, protocol, or other similar criterion was relied on in making the adverse benefit determination, the notice must contain either the specific rule, guideline, protocol, or other similar criterion; or a statement that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to the appellant on request.

(5) The notice of an adverse benefit determination must include an explanation of the right to review the records of relevant information, including evidence used by the carrier or the carrier's representative that influenced or supported the decision to make the adverse benefit determination.

(a) For purposes of this subsection, "relevant information" means information relied on in making the determination, or that was submitted, considered, or generated in the course of making the determination, regardless of whether the document, record, or information was relied on in making the determination.

(b) Relevant information includes any statement of policy, procedure, or administrative process concerning the denied treatment or benefit, regardless of whether it was relied on in making the determination.

(6) If the carrier and health plan determine that additional information is necessary to perfect the denied claim, the carrier and health plan must provide a description of the additional material or information that they require, with an explanation of why it is necessary, as soon as the need is identified.

(7) An enrollee or covered person may request that a carrier identify the medical, vocational, or other experts whose advice was obtained in connection with the adverse benefit determination, even if the advice was not relied on in making the determination. The carrier may satisfy this requirement by providing the job title, a statement as to whether the expert is affiliated with the carrier as an employee, and the expert's specialty, board certification status, or other criteria related to the expert's qualification without providing the expert's name or address. The carrier must be able to identify for the commissioner upon request the name of each expert whose advice was obtained in connection with the adverse benefit determination.

(8) The notice must include language substantially similar to the following:

"If you request a review of this adverse benefit determination, (Company name) will continue to provide coverage for the disputed benefit pending outcome of the review if you are currently receiving services or supplies under the disputed benefit. If (Company name) prevails in the appeal, you may be responsible for the cost of coverage received during the review period. The decision at the external review level is binding unless other remedies are available under state or federal law."

[Statutory Authority: RCW 48.02.060, 48.43.525, 48.43.530, 48.43.535, and The Patient Protection and Affordable Care Act, P.L. 111-148, as amended (2010). WSR 12-23-005 (Matter No. R 2011-11), § 284-43-515, filed 11/7/12, effective 11/20/12.]

WAC 284-43-520 Electronic disclosure and communication by carriers. (1) Except as otherwise provided by applicable law, rule, or regulation, a carrier furnishing documents through electronic media is deemed to satisfy the

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notice and disclosure requirements regarding adverse benefit determinations with respect to applicants, covered persons, and appellants or their representative, if the carrier takes appropriate and necessary measures reasonably calculated to ensure that the system for furnishing documents, including ensuring that its measures:

(a) Result in actual receipt of transmitted information (e.g., using return-receipt or notice of undelivered electronic mail features, conducting periodic reviews or surveys to confirm receipt of the transmitted information);

(b) Protect the confidentiality of personal information relating to the individual's accounts and benefits (e.g., incorporating into the system measures designed to preclude unauthorized receipt of or access to such information by individuals other than the individual for whom the information is intended);

(c) Provide notice in electronic or nonelectronic form, at the time a document is furnished electronically, that apprises the recipient of the significance of the document when it is not otherwise reasonably evident as transmitted (e.g., the attached document describes the internal review process used by your plan) and of the right to request and obtain a paper version of such document; and

(d) Furnish the appellant or their representative with a paper version of the electronically furnished documents if requested.

(2) Subsection (1) of this section only applies to the following individuals:

(a) An appellant who affirmatively consents, in electronic or nonelectronic form, to receiving documents through electronic media and has not withdrawn such consent.

(b) In the case of documents to be furnished through the internet or other electronic communication network, one that has affirmatively consented or confirmed consent electronically, in a manner that reasonably demonstrates the individual's ability to access information in the electronic form that will be used to provide the information that is the subject of the consent, and has provided an address for the receipt of electronically furnished documents;

(c) Prior to consenting, is provided, in electronic or nonelectronic form, a clear and conspicuous statement indicating:

(i) The types of documents to which the consent would apply;

(ii) That consent can be withdrawn at any time without charge;

(iii) The procedures for withdrawing consent and for updating the individual's electronic address for receipt of electronically furnished documents or other information;

(iv) The right to request and obtain a paper version of an electronically furnished document, including whether the paper version will be provided free of charge; and

(v) Any hardware and software requirements for accessing and retaining the documents.

(3) Following consent, if a change in hardware or software requirements needed to access or retain electronic documents creates a material risk that the individual will be unable to access or retain electronically furnished documents, the carrier must provide:

(a) A statement of the revised hardware or software requirements for access to and retention of electronically furnished documents;

(b) The individual receiving electronic communications with the right to withdraw consent without charge and without the imposition of any condition or consequence that was not disclosed at the time of the initial consent.

(c) The carrier must request and receive a new consent to the receipt of documents through electronic media, following a hardware or software requirement change as described in this subsection.

[Statutory Authority: RCW 48.02.060, 48.43.525, 48.43.530, 48.43.535, and The Patient Protection and Affordable Care Act, P.L. 111-148, as amended (2010). WSR 12-23-005 (Matter No. R 2011-11), § 284-43-520, filed 11/7/12, effective 11/20/12.]

WAC 284-43-525 Internal review of adverse benefit determinations. An appellant seeking review of an adverse benefit determination must use the carrier's review process. Each carrier must include the opportunity for internal review of an adverse benefit determination in its review process. Treating providers may seek expedited review on a patient's behalf, regardless of whether the provider is affiliated with the carrier on a contracted basis.

(1) When a carrier receives a written request for review, the carrier must reconsider the adverse benefit determination. The carrier must notify the appellant of the review decision within fourteen days of receipt of the request for review, unless the adverse benefit determination involves an experimental or investigational treatment. The carrier must notify the appellant of the review decision within twenty days of receipt of the request for review when the adverse benefit determination involves an experimental or investigational treatment.

(2) For good cause, a carrier may extend the time it takes to make a review determination by up to sixteen additional days without the appellant's written consent, and must notify appellant of the extension and the reason for the extension. The carrier may request further extension of its response time only if the appellant consents to a specific request for a further extension, the consent is reduced to writing, and includes a specific agreed-upon date for determination. In its request for the appellant's consent, the carrier must explain that waiver of the response time is not compulsory.

(3) The carrier must provide the appellant with any new or additional evidence or rationale considered, whether relied upon, generated by, or at the direction of the carrier in connection with the claim. The evidence or rationale must be provided free of charge to the appellant and sufficiently in advance of the date the notice of final internal review must be provided. The purpose of this requirement is to ensure the appellant has a reasonable opportunity to respond prior to that date. If the appellant requests an extension in order to respond to any new or additional rationale or evidence, the carrier and health plan must extend the determination date for a reasonable amount of time, which may not be less than two days.

(4) A carrier's review process must provide the appellant with the opportunity to submit information, documents, written comments, records, evidence, and testimony, including information and records obtained through a second opinion.

An appellant has the right to review the carrier and health plan's file and obtain a free copy of all documents, records, and information relevant to any claim that is the subject of the determination being appealed.

(5) The internal review process must include the requirement that the carrier affirmatively review and investigate the appealed determination, and consider all information submitted by the appellant prior to issuing a determination.

(6) Review of adverse determinations must be performed by health care providers or staff who were not involved in the initial decision, and who are not subordinates of the persons involved in the initial decision. If the determination involves, even in part, medical judgment, the reviewer must be or must consult with a health care professional who has appropriate training and experience in the field of medicine encompassing the appellant's condition or disease and make a determination that is within the clinical standard of care for an appellant's disease or condition.

(7) The internal review process for group health plans may be administered so that an appellant must file two internal requests for review prior to bringing a civil action. For individual health plans, a carrier must provide for only one level of internal review before issuing a final determination, and may not require two levels of internal review.

(8) A rescission of coverage is an adverse benefit determination for which review may be requested.

[Statutory Authority: RCW 48.02.060, 48.43.525, 48.43.530, 48.43.535, and The Patient Protection and Affordable Care Act, P.L. 111-148, as amended (2010). WSR 12-23-005 (Matter No. R 2011-11), § 284-43-525, filed 11/7/12, effective 11/20/12.]

WAC 284-43-530 Exhaustion of internal review remedies. (1) If a carrier fails to strictly adhere to its requirements with respect to the internal review, the internal review process is deemed exhausted, and the appellant may request external review without receiving an internal review determination from the carrier or the health plan.

(2) A carrier may challenge external review requested under this section on the basis that its violations are de minimis, and do not cause and are not likely to cause, prejudice or harm to the appellant. The carrier or health plan may challenge external review on this basis either in court or to the independent review organization.

(a) This exception applies only if the external reviewer or court determines that the carrier has demonstrated that the violation was for good cause or was due to matters beyond the control of the carrier, and that the violation occurred in the context of an ongoing, good faith exchange of information between the carrier or health plan and the appellant.

(b) This exception is not available, and the challenge may not be sustained, if the violation is part of a pattern or practice of violations by the carrier or health plan.

(3) The appellant may request a written explanation of the violation from the carrier and the carrier must provide such explanation within ten calendar days, including a specific description of its basis, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted.

(4) If the independent review organization or court determines that the internal review process is not exhausted, based on a carrier or health plan's challenge under this section, the

carrier or health plan must provide the appellant with notice that they may resubmit and pursue the internal appeal within a reasonable time, not to exceed ten days, of receiving the independent review organization's determination, or of the entry of the court's final order.

[Statutory Authority: RCW 48.02.060, 48.43.525, 48.43.530, 48.43.535, and The Patient Protection and Affordable Care Act, P.L. 111-148, as amended (2010). WSR 12-23-005 (Matter No. R 2011-11), § 284-43-530, filed 11/7/12, effective 11/20/12.]

WAC 284-43-535 Notice of internal review determination. Each carrier's review process must require delivery of written notification of the internal review determination to the appellant. In addition to the requirements of WAC 284-43-515, the written determination must include:

- (1) The actual reasons for the determination;
- (2) If applicable, instructions for obtaining further review of the determination, either through a second level of internal review, if applicable, or using the external review process;
- (3) The clinical rationale for the decision, which may be in summary form; and
- (4) Instructions on obtaining the clinical review criteria used to make the determination;
- (5) A statement that the appellant has up to one hundred eighty days to file a request for external review, and that if review is not requested, the internal review decision is final and binding.

[Statutory Authority: RCW 48.02.060, 48.43.525, 48.43.530, 48.43.535, and The Patient Protection and Affordable Care Act, P.L. 111-148, as amended (2010). WSR 12-23-005 (Matter No. R 2011-11), § 284-43-535, filed 11/7/12, effective 11/20/12.]

WAC 284-43-540 Expedited review. (1) A carrier's internal and external review processes must permit an expedited review of an adverse benefit determination at any time in the review process, if:

- (a) The appellant is currently receiving or is prescribed treatment or benefits that would end because of the adverse benefit determination; or
- (b) The ordering provider for the appellant, regardless of their affiliation with the carrier or health plan, believes that a delay in treatment based on the standard review time may seriously jeopardize the appellant's life, overall health or ability to regain maximum function, or would subject the appellant to severe and intolerable pain; or

(c) The determination is related to an issue related to admission, availability of care, continued stay, or emergency health care services where the appellant has not been discharged from the emergency room or transport service.

(2) An appellant is not entitled to expedited review if the treatment has already been delivered and the review involves payment for the delivered treatment, if the situation is not urgent, or if the situation does not involve the delivery of services for an existing condition, illness, or disease.

(3) An expedited review may be filed by an appellant, the appellant's authorized representative, or the appellant's provider orally, or in writing.

(4) The carrier must respond as expeditiously as possible to an expedited review request, preferably within twenty-four hours, but in no case longer than seventy-two hours.

(a) The carrier's response to an expedited review request may be delivered orally, and must be reduced to and issued in writing not later than seventy-two hours after the date of the decision. Regardless of who makes the carrier's determination, the time frame for providing a response to an expedited review request begins when the carrier first receives the request.

(b) If the carrier requires additional information to determine whether the service or treatment determination being reviewed is covered under the health plan, or eligible for benefits, they must request such information as soon as possible after receiving the request for expedited review.

(5) If the treating health care provider determines that a delay could jeopardize the covered person's health or ability to regain maximum function, the carrier must presume the need for expedited review, and treat the review request as such, including the need for an expedited determination of an external review under RCW 48.43.535.

(6) A carrier may require exhaustion of the internal appeal process before an appellant may request an external review in urgent care situations that justify expedited review as set forth in this section.

(7) An expedited review must be conducted by an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed. The clinical peer or peers must not have been involved in making the initial adverse determination.

(8) These requirements do not replace the requirements related to utilization review for the initial authorization of coverage for services set forth in WAC 284-43-410. These requirements apply when the utilization review decision results in an adverse benefit determination. In some circumstances, an urgent care review under WAC 284-43-410 may apply in an identical manner to an expedited review under this section.

[Statutory Authority: RCW 48.02.060, 48.43.525, 48.43.530, 48.43.535, and The Patient Protection and Affordable Care Act, P.L. 111-148, as amended (2010). WSR 12-23-005 (Matter No. R 2011-11), § 284-43-540, filed 11/7/12, effective 11/20/12.]

WAC 284-43-545 Concurrent expedited review of adverse benefit determinations. (1) "Concurrent expedited review" means initiation of both the internal and external expedited review simultaneously to:

(a) Review of a decision made under WAC 284-43-410; or

(b) Review conducted during a patient's stay or course of treatment in a facility, the office of a health care professional or other inpatient or outpatient health care setting so that the final adverse benefit determination is reached as expeditiously as possible.

(2) A carrier must offer the right to request concurrent expedited internal and external review of adverse benefit determinations. When a concurrent expedited review is requested, a carrier may not extend the timelines by making the determinations consecutively. The requisite timelines must be applied concurrently.

(3) A carrier may deny a request for concurrent expedited review only if the conditions for expedited review in WAC 284-43-540 are not met. A carrier may not require

exhaustion of internal review if an appellant requests concurrent expedited review.

[Statutory Authority: RCW 48.02.060, 48.43.525, 48.43.530, 48.43.535, and The Patient Protection and Affordable Care Act, P.L. 111-148, as amended (2010). WSR 12-23-005 (Matter No. R 2011-11), § 284-43-545, filed 11/7/12, effective 11/20/12.]

WAC 284-43-550 External review of adverse benefit determinations. When the internal review of an adverse benefit determination is final, or is deemed exhausted, the appellant may request an external independent review of the final internal adverse benefit determination. Carriers and health plans must inform appellants of their right to external independent review, and explain the process to exercise that right. If the appellant requests an external independent review of a final internal adverse determination, the carrier or health plan must cooperatively participate in that review.

(1) Appellants must be provided the right to external review of adverse benefit determinations based on medical necessity, appropriateness, health care setting, level of care, or that the requested service or supply is not efficacious or otherwise unjustified under evidence-based medical criteria. The carrier may not establish a minimum dollar amount restriction as a predicate for an appellant to seek external independent review.

(2) Carriers must use the rotational registry system of certified independent review organizations (IRO) established by the commissioner, and must select reviewing IROs in the rotational manner described in the rotational registry system. A carrier may not make an assignment to an IRO out of sequence for any reason other than the existence of a conflict of interest, as set forth in WAC 246-305-030.

(3) The rotational registry system, a current list of certified IROs, IRO assignment instructions, and an IRO assignment form to be used by carriers, are available on the insurance commissioner's web site (www.insurance.wa.gov).

(4) In addition to the requirements set forth in RCW 48.43.535, the carrier and health plan must:

(a) Make available to the appellant and to any provider acting on behalf of the appellant all materials provided to an IRO reviewing the carrier's determination;

(b) Provide IRO review without imposing any cost to the appellant or their provider;

(c) Provide IROs with:

(i) All relevant clinical review criteria used by the carrier and other relevant medical, scientific, and cost-effectiveness evidence;

(ii) The attending or ordering provider's recommendations; and

(iii) A copy of the terms and conditions of coverage under the relevant health plan; and

(d) Within one day of selecting the IRO, notify the appellant of the name of the IRO and its contact information. This requirement is intended to comply with the federal standard that appellants receive notice of the IRO's identity and contact information within one day of assignment. The notice from the carrier must explain that the IRO will accept additional information in writing from the appellant for up to five business days after it receives the assignment. The IRO must consider this information when conducting its review.

(5) A carrier may waive a requirement that internal appeals must be exhausted before an appellant may proceed to an independent review of an adverse determination.

(6) Upon receipt of the information provided by the appellant to the IRO pursuant to RCW 48.43.535 and this section, a carrier may reverse its final internal adverse determination. If it does so, it must immediately notify the IRO and the appellant.

(7) Carriers must report to the commissioner each assignment made to an IRO not later than one business day after an assignment is made. Information regarding the enrollee's personal health may not be provided with the report.

(8) The requirements of this section are in addition to the requirements set forth in RCW 48.43.535 and 43.70.235, and rules adopted by the department of health in chapter 246-305 WAC.

[Statutory Authority: RCW 48.02.060, 48.43.525, 48.43.530, 48.43.535, and The Patient Protection and Affordable Care Act, P.L. 111-148, as amended (2010). WSR 12-23-005 (Matter No. R 2011-11), § 284-43-550, filed 11/7/12, effective 11/20/12.]

SUBCHAPTER F

GRANDFATHERED HEALTH PLAN APPEAL PROCEDURES

WAC 284-43-611 Application of subchapter F. Subchapter F applies to grandfathered health plans. For any grandfathered health plan as defined in RCW 48.43.005, a carrier may comply with RCW 48.43.530 and 48.43.535 by using an appeal process that conforms to the procedures and standards set forth in WAC 284-43-615 through 284-43-630.

[Statutory Authority: RCW 48.02.060, 48.43.525, 48.43.530, 48.43.535, and The Patient Protection and Affordable Care Act, P.L. 111-148, as amended (2010). WSR 12-23-005 (Matter No. R 2011-11), § 284-43-611, filed 11/7/12, effective 11/20/12.]

WAC 284-43-615 Grievance and complaint procedures—Generally. (1) Each carrier must adopt and implement a comprehensive process for the resolution of appeals of adverse determinations. This process shall meet accepted national certification standards such as those used by the National Committee for Quality Assurance except as otherwise required by this chapter.

(2) This process must conform to the provisions of this chapter and each carrier must:

(a) Provide a clear explanation of the appeal process upon request, upon enrollment to new enrollees, and annually to enrollees and subcontractors of the carrier.

(b) Ensure that the appeal process is accessible to enrollees who are limited-English speakers, who have literacy problems, or who have physical or mental disabilities that impede their ability to file an appeal.

(c) Implement procedures for registering and responding to oral and written appeals in a timely and thorough manner including the notification of an enrollee that an appeal has been received.

(d) Assist the enrollee with all appeal processes.

(e) Cooperate with any representative authorized in writing by the enrollee.

(11/19/14)

(f) Consider all information submitted by the enrollee or representative.

(g) Investigate and resolve all appeals.

(h) Provide information on the enrollee's right to obtain second opinions.

(i) Track each appeal until final resolution; maintain, and make accessible to the commissioner for a period of three years, a written log of all appeals; and identify and evaluate trends in appeals. The written log may be maintained electronically.

[Statutory Authority: RCW 48.02.060, 48.43.525, 48.43.530, 48.43.535, and The Patient Protection and Affordable Care Act, P.L. 111-148, as amended (2010). WSR 12-23-005 (Matter No. R 2011-11), § 284-43-615, filed 11/7/12, effective 11/20/12. Statutory Authority: RCW 48.02.060, 48.18.-120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.100, 48.46.200, 48.43.505, 48.43.510, 48.43.515, 48.43.520, 48.43.525, 48.43.530, 48.43.-535. WSR 01-03-033 (Matter No. R 2000-02), § 284-43-615, filed 1/9/01, effective 7/1/01.]

WAC 284-43-620 Procedures for review and appeal

of adverse determinations. (1) An enrollee or the enrollee's representative, including the treating provider (regardless of whether the provider is affiliated with the carrier) acting on behalf of the enrollee may appeal an adverse determination in writing. The carrier must reconsider the adverse determination and notify the enrollee of its decision within fourteen days of receipt of the appeal unless the carrier notifies the enrollee that an extension is necessary to complete the appeal; however, the extension cannot delay the decision beyond thirty days of the request for appeal, without the informed, written consent of the enrollee.

(2) Whenever a health carrier makes an adverse determination and delay would jeopardize the enrollee's life or materially jeopardize the enrollee's health, the carrier shall expedite and process either a written or an oral appeal and issue a decision no later than seventy-two hours after receipt of the appeal. If the treating health care provider determines that delay could jeopardize the enrollee's health or ability to regain maximum function, the carrier shall presume the need for expeditious review, including the need for an expeditious determination in any independent review under WAC 284-43-630.

(3) A carrier may not take or threaten to take any punitive action against a provider acting on behalf or in support of an enrollee appealing an adverse determination.

(4) Appeals of adverse determinations shall be evaluated by health care providers who were not involved in the initial decision and who have appropriate expertise in the field of medicine that encompasses the enrollee's condition or disease.

(5) All appeals must include a review of all relevant information submitted by the enrollee or a provider acting on behalf of the enrollee.

(6) The carrier shall issue to affected parties and to any provider acting on behalf of the enrollee a written notification of the adverse determination that includes the actual reasons for the determination, the instructions for obtaining an appeal of the carrier's decision, a written statement of the clinical rationale for the decision, and instructions for obtaining the clinical review criteria used to make the determination.

[Statutory Authority: RCW 48.02.060, 48.43.525, 48.43.530, 48.43.535, and The Patient Protection and Affordable Care Act, P.L. 111-148, as amended

(2010). WSR 12-23-005 (Matter No. R 2011-11), § 284-43-620, filed 11/7/12, effective 11/20/12. Statutory Authority: RCW 48.02.060, 48.18-120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.100, 48.46.200, 48.43.505, 48.43.510, 48.43.515, 48.43.520, 48.43.525, 48.43.530, 48.43-535. WSR 01-03-033 (Matter No. R 2000-02), § 284-43-620, filed 1/9/01, effective 7/1/01. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.43.055, 48.44.050, 48.46.100 and 48.46.200. WSR 99-24-075 (Matter No. R 98-17), § 284-43-620, filed 11/29/99, effective 12/30/99.]

WAC 284-43-630 Independent review of adverse determinations. Carriers must use the rotational registry system of certified independent review organizations (IRO) established by the commissioner.

(1) Carriers must select reviewing IROs in the rotational manner described in the rotational registry system. A carrier may not make an assignment to an IRO out of sequence for any reason other than the existence of a conflict of interest, as set forth in WAC 246-305-030.

(2) The rotational registry system, a current list of certified IROs, IRO assignment instructions, and an IRO assignment form to be used by carriers are set forth on the insurance commissioner's web site (www.insurance.wa.gov).

(3) In addition to the requirements set forth in RCW 48.43.535(4), carriers must:

(a) Make available to the covered person and to any provider acting on behalf of the covered person all materials provided to an independent review organization reviewing the carrier's determination; and

(b) Provide IROs with:

(i) All relevant clinical review criteria used by the carrier and other relevant medical, scientific, and cost-effectiveness evidence;

(ii) The attending or ordering provider's recommendations; and

(iii) A copy of the terms and conditions of coverage under the relevant health plan.

(4) Carriers must report to the commissioner each assignment made to an IRO not later than three business days after an assignment is made. Information regarding the enrollee's personal health should not be provided with the report.

(5) The requirements of this section are in addition to the requirements set forth in RCW 48.43.535 and 43.70.235, and rules adopted by the department of health in chapter 246-305 WAC.

[Statutory Authority: RCW 48.02.060 and 48.53.535(10). WSR 08-07-101 (Matter R 2006-11), § 284-43-630, filed 3/19/08, effective 4/19/08. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.100, 48.46.200, 48.43.505, 48.43.510, 48.43.515, 48.43-520, 48.43.525, 48.43.530, 48.43.535. WSR 01-03-033 (Matter No. R 2000-02), § 284-43-630, filed 1/9/01, effective 7/1/01.]

SUBCHAPTER G

GRIEVANCES

WAC 284-43-711 Definition. This definition applies to subchapter G. "Grievant" means a person filing a grievance as defined in WAC 284-43-130, and who is not an appellant under either subchapter E or F of this chapter.

[Statutory Authority: RCW 48.02.060, 48.43.525, 48.43.530, 48.43.535, and The Patient Protection and Affordable Care Act, P.L. 111-148, as amended

(2010). WSR 12-23-005 (Matter No. R 2011-11), § 284-43-711, filed 11/7/12, effective 11/20/12.]

WAC 284-43-721 Grievance process—Generally. This section applies to a health benefit plan regardless of its status as grandfathered or nongrandfathered.

(1) Each carrier and health plan must offer applicants, covered persons, and providers a way to resolve grievances.

(2) Each carrier must maintain a log or otherwise register grievances, and retain the log or record for three years. It must be available for review by the commissioner upon request. The log must provide sufficient detail to permit the commissioner to determine whether the carrier is administering its grievance process in accordance with the law, and in good faith, and to identify whether and in what manner the carrier adjusted practices or requirements in response to a grievance.

(3) Grievances are not adverse benefit determinations and do not establish the right to internal or external review of a carrier or health plan's resolution of the grievance.

(4) Nothing in this section prohibits a carrier from creating or using its own system to categorize the nature of grievances in order to collect data, if the system permits reporting of the data specified in subsection (2) of this section.

[Statutory Authority: RCW 48.02.060, 48.43.525, 48.43.530, 48.43.535, and The Patient Protection and Affordable Care Act, P.L. 111-148, as amended (2010). WSR 12-23-005 (Matter No. R 2011-11), § 284-43-721, filed 11/7/12, effective 11/20/12.]

SUBCHAPTER H

HEALTH PLAN BENEFITS

WAC 284-43-800 Recognizing the exercise of conscience by purchasers of basic health plan services and ensuring access for all enrollees to such services. (1) All carriers required pursuant to law to offer and file with the commissioner a plan providing benefits identical to the basic health plan services (the model plan) shall file for such plan a full description of the process it will use to recognize an organization or individual's exercise of conscience based on a religious belief or conscientious objection to the purchase of coverage for a specific service. This process may not affect a nonobjecting enrollee's access to coverage for those services.

(2) A religiously sponsored carrier who elects, for reasons of religious belief, not to participate in the provision of certain services otherwise included in the model plan, shall file for such plan a description of the process by which enrollees will have timely access to all services in the model plan.

(3) The commissioner will not disapprove processes that meet the following criteria:

(a) Enrollee access to all basic health plan services is not impaired in any way;

(b) The process meets notification requirements specified in RCW 48.43.065; and

(c) The process relies on sound actuarial principles to distribute risk.

[Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. WSR 98-04-005 (Matter No. R 97-3), § 284-43-800, filed 1/22/98, effective 2/22/98.]

WAC 284-43-815 Coverage for pharmacy services.

(1) The commissioner may disapprove any contract issued or renewed after July 1, 2001, that includes coverage for pharmacy services if the following statement is not provided to covered persons at the time of enrollment:

YOUR RIGHT TO SAFE AND EFFECTIVE PHARMACY SERVICES

State and federal laws establish standards to assure safe and effective pharmacy services, and to guarantee your right to know what drugs are covered under this plan and what coverage limitations are in your contract. If you would like more information about the drug coverage policies under this plan, or if you have a question or a concern about your pharmacy benefit, please contact us (the health carrier) at 1-800-???-????.

If you would like to know more about your rights under the law, or if you think anything you received from this plan may not conform to the terms of your contract, you may contact the Washington State Office of Insurance Commissioner at 1-800-562-6900. If you have a concern about the pharmacists or pharmacies serving you, please call the State Department of Health at 360-236-4825.

(2) The commissioner may disapprove any contract issued or renewed after July 1, 2001, that includes coverage for pharmacy services if the carrier does not: Pose and respond in writing to the following questions in language that complies with WAC 284-50-010 through 284-50-230; offers to provide and provide upon request this information prior to enrollment; and ensures that this information is provided to covered persons at the time of enrollment:

(a) **"Does this plan limit or exclude certain drugs my health care provider may prescribe, or encourage substitutions for some drugs?"** The response must describe the process for developing coverage standards and formularies, including the principal criteria by which drugs are selected for inclusion, exclusion, restriction or limitation. If a determination of medical necessity is used, that term must be briefly defined here. Coverage standards involving the use of substitute drugs, whether generic or therapeutic, are either an exception, reduction or limitation and must be discussed here. Major categories of drugs excluded, limited or reduced from coverage may be included in this response.

(b) **"When can my plan change the approved drug list (formulary)? If a change occurs, will I have to pay more to use a drug I had been using?"** The response must identify the process of changing formularies and coverage standards, including changes in the use of substitute drugs. If the plan gives prior notice of these changes or has provisions for "grandfathering" certain ongoing prescriptions, these practices may be discussed here.

(c) **"What should I do if I want a change from limitations, exclusions, substitutions or cost increases for drugs specified in this plan?"** The response must include a phone number to call with a request for a change in coverage decisions, and must discuss the process and criteria by which such a change may be granted. The response may refer to the appeals or grievance process without describing that process in detail here. The response must state the time within which requests for changes will be acted upon in normal circum-

stances and in circumstances where an emergency medical condition exists.

(d) **"How much do I have to pay to get a prescription filled?"** The response must list enrollee point-of-service cost-sharing dollar amounts or percentages for all coverage categories including at least name brand drugs, substitute drugs and any drugs which may be available, but which are not on the health plan's formulary.

(e) **"Do I have to use certain pharmacies to pay the least out of my own pocket under this health plan?"** If the answer to this question is "yes," the plan must state the approximate number of pharmacies in Washington at which the most favorable enrollee cost sharing will be provided, and some means by which the enrollee can learn which ones they are.

(f) **"How many days' supply of most medications can I get without paying another co-pay or other repeating charge?"** The response should discuss normal and exceptional supply limits, mail order arrangements and travel supply and refill requirements or guidelines.

(g) **"What other pharmacy services does my health plan cover?"** The response should include any "intellectual services," or disease management services reimbursed by the plan in addition to those required under state and federal law in connection with dispensing, such as disease management services for migraine, diabetes, smoking cessation, asthma, or lipid management.

(3) The commissioner may disapprove any contract issued or renewed after July 1, 2001, that includes coverage for pharmacy services if the general categories of drugs excluded from coverage are not provided to covered persons at the time of enrollment. Such categories may include items such as appetite suppressants, dental prescriptions, cosmetic agents or most over-the-counter medications. This subsection intends only to promote clearer enrollee understanding of the exclusions, reductions and limitations contained in a health plan, and not to suggest that any particular categories of coverage for drugs or pharmacy services should be excluded, reduced, or limited by a health plan.

(4) In complying with these requirements, a carrier may, where appropriate and consistent with the provisions of these rules, consolidate the information with other material required by disclosure provisions set forth in RCW 48.43.510 and WAC 284-43-820.

(5) This information may be provided in a narrative form to the extent that the content of both questions and answers is included.

(6) The commissioner may grant an extension or waive these requirements for good cause and if there is assurance that the information, required herein, is distributed in a timely manner consistent with the purpose and intent of these rules.

[Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.200, 2000 c 79 § 26, and RCW 48.30.040, 48.44.110, 48.46.400. WSR 01-03-032 (Matter No. R 2000-04), § 284-43-815, filed 1/9/01, effective 2/9/01.]

WAC 284-43-816 General prescription drug benefit requirements. A health carrier must not offer, renew, or issue a health benefit plan providing a prescription drug benefit, which the commissioner determines results or can reasonably be expected to result in an unreasonable restriction

on the treatment of patients. A carrier may restrict prescription drug coverage based on contract or plan terms and conditions that otherwise limit coverage, such as a preexisting condition waiting period, or medical necessity.

(1) A carrier must ensure that a prescription drug benefit covers Federal Drug Administration approved prescribed drugs, medications or drug therapies that are the sole prescription drug available for a covered medical condition.

(2) A prescription drug benefit that only covers generic drugs constitutes an unreasonable restriction on the treatment of patients.

(3) A prescription drug benefit or formulary must not exclude coverage for a nonformulary drug or medication if the only formulary drug available for an enrollee's covered condition is one that the enrollee cannot tolerate or that is not clinically efficacious for the enrollee.

(4) Nothing in this chapter is intended to limit or deter the use of "Dispense as Written" prescriptions, subject to the terms and conditions of the health plan.

[Statutory Authority: RCW 48.02.060, 48.02.062, 48.18.140, 48.43.525, 48.44.050, 48.44.440(2), 48.44.460(2), 48.46.200, and 48.46.510. WSR 12-21-019 (Matter No. R 2012-03), § 284-43-816, filed 10/8/12, effective 11/8/12.]

WAC 284-43-817 Prescription drug benefit design.

(1) A carrier may design its prescription drug benefit to include cost control measures, including requiring preferred drug substitution in a given therapeutic class, if the restriction is for a less expensive, equally therapeutic alternative product available to treat the condition.

(2) A carrier may include elements in its prescription drug benefit design that, where clinically feasible, create incentives for the use of generic drugs. Examples of permitted incentives include, but are not limited to, refusal to pay for higher cost drugs until it can be shown that a lower cost drug or medication is not effective (also known as step therapy protocols or fail-first policies), establishing a preferred brand and nonpreferred brand formulary, or otherwise limiting the benefit to the use of a generic drug in lieu of brand name drugs, subject to a substitution process as set forth in subsection (3) of this section.

(3) A carrier must establish a process that a provider and enrollee may use to request a substitution for a covered prescribed therapy, drug or medication.

(a) The process must not unreasonably restrict an enrollee's access to nonformulary or alternate medications for refractory conditions. Used in this context, "refractory" means "not responsive to treatment."

(b) A carrier's substitution process must not result in delay in treating an enrollee's emergency fill or urgent care needs, or expedited requests for authorization. Subject to the terms and conditions of the policy that otherwise limit or exclude coverage, the carrier must permit substitution of a covered generic drug or formulary drug if:

(i) An enrollee does not tolerate the covered generic or formulary drug; or

(ii) An enrollee's provider determines that the covered generic or formulary drug is not therapeutically efficacious for an enrollee. A carrier may require the provider to submit specific clinical documentation as part of the substitution request; or

(iii) The provider determines that a dosage is required for clinically efficacious treatment that differs from a carrier's formulary dosage limitation for the covered drug. A carrier may require the provider to submit specific clinical documentation as part of the substitution request and must review that documentation prior to making a decision.

(4) A carrier may include a preauthorization requirement for its prescription drug benefit and its substitution process, based on accepted peer reviewed clinical studies, Federal Drug Administration black box warnings, the fact that the drug is available over-the-counter, objective and relevant clinical information about the enrollee's condition, specific medical necessity criteria, patient safety, or other criteria that meet an accepted, medically applicable standard of care.

(a) Neither the substitution process criteria nor the type or volume of documentation required to support a substitution request may be unreasonably burdensome to the enrollee or their provider.

(b) The substitution process must be administered consistently, and include a documented consultation with the prescribing provider prior to denial of a substitution request.

(5) Use of a carrier's substitution process is not a grievance or appeal pursuant to RCW 48.43.530 and 48.43.535. Denial of a substitution request is an adverse benefit determination, and an enrollee, their representative provider or facility, or representative may request review of that decision using the carrier's appeal or adverse benefit determination review process.

[Statutory Authority: RCW 48.02.060, 48.02.062, 48.18.140, 48.43.525, 48.44.050, 48.44.440(2), 48.44.460(2), 48.46.200, and 48.46.510. WSR 12-21-019 (Matter No. R 2012-03), § 284-43-817, filed 10/8/12, effective 11/8/12.]

WAC 284-43-818 Formulary changes. A carrier is not required to use a formulary as part of its prescription drug benefit design. If a formulary is used, a carrier must, at a minimum, comply with these requirements when a formulary change occurs.

(1) In addition to the requirements set forth in WAC 284-30-450, a carrier must not exclude or remove a medication from its formulary if the medication is the sole prescription medication option available to treat a disease or condition for which the health benefit plan, policy or agreement otherwise provides coverage, unless the medication or drug is removed because the drug or medication becomes available over-the-counter, is proven to be medically inefficacious, or for documented medical risk to patient health.

(2) If a drug is removed from a carrier's formulary for a reason other than withdrawal of the drug from the market, availability of the drug over-the-counter, or the issue of black box warnings by the Federal Drug Administration, a carrier must continue to cover a drug that is removed from the carrier's formulary for the time period required for an enrollee who is taking the medication at the time of the formulary change to use a carrier's substitution process to request continuation of coverage for the removed medication, and receive a decision through that process, unless patient safety requires swifter replacement.

(3) Formularies posted on a carrier or a carrier's contracted pharmacy benefit manager web site must be current. Unless the removal is done on an immediate or emergency

basis or because a generic equivalent becomes available without prior notice, formulary changes must be posted thirty days before the effective date of the change. In the case of an emergency removal, the change must be posted as soon as practicable, without unreasonable delay.

[Statutory Authority: RCW 48.02.060, 48.02.062, 48.18.140, 48.43.525, 48.44.050, 48.44.440(2), 48.44.460(2), 48.46.200, and 48.46.510. WSR 12-21-019 (Matter No. R 2012-03), § 284-43-818, filed 10/8/12, effective 11/8/12.]

WAC 284-43-819 Cost-sharing for prescription drugs. (1) A carrier and health plan unreasonably restrict the treatment of patients if an ancillary charge, in addition to the plan's normal copayment or coinsurance requirements, is imposed for a drug that is covered because of one of the circumstances set forth in either WAC 284-43-817 or 284-43-818. An ancillary charge means any payment required by a carrier that is in addition to or excess of cost-sharing explained in the policy or contract form as approved by the commissioner. Cost-sharing means amounts paid directly to a provider or pharmacy by an enrollee for services received under the health benefit plan, and includes copayment, coinsurance, or deductible amounts.

(2) When an enrollee requests a brand name drug from the formulary in lieu of a therapeutically equivalent generic drug or a drug from a higher tier within a tiered formulary, and there is not a documented clinical basis for the substitution, a carrier may require the enrollee to pay for the difference in price between the drug that the formulary would have required, and the covered drug, in addition to the copayment. This charge must reflect the actual cost difference.

(3) When a carrier approves a substitution drug, whether or not the drug is in the carrier's formulary, the enrollee's cost-sharing for the substitution drug must be adjusted to reflect any discount agreements or other pricing adjustments for the drug that are available to a carrier. Any charge to the enrollee for a substitution drug must not increase the carrier's underwriting gain for the plan beyond the gain contribution calculated for the original formulary drug that is replaced by the substitution.

(4) If a carrier uses a tiered formulary in its prescription drug benefit design, and a substitute drug that is in the formulary is required based on one of the circumstances in either WAC 284-43-817 or 284-43-818, the enrollee's cost sharing may be based on the tier in which the carrier has placed the substitute drug.

[Statutory Authority: RCW 48.02.060, 48.02.062, 48.18.140, 48.43.525, 48.44.050, 48.44.440(2), 48.44.460(2), 48.46.200, and 48.46.510. WSR 12-21-019 (Matter No. R 2012-03), § 284-43-819, filed 10/8/12, effective 11/8/12.]

WAC 284-43-820 Health plan disclosure requirements. (1) Health plan disclosure information must comply with and include each requirement listed in RCW 48.43.510.

(2) Health plan disclosures must be current and:

- (a) Provided by paper copy upon request;
- (b) Provided by electronic communication upon request;
- (c) Clearly identified as health plan disclosures; and
- (d) Prominently displayed and accessible on the carrier's web site.

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(3) Each disclosure must be written in a manner that is easily understood by the average plan participant.

(4) Each carrier must provide to all enrollees and prospective enrollees a list of available disclosure items, including instructions on how to access and request copies of health disclosure information in paper and electronic forms, and web site links to the entire health plan disclosure information.

[Statutory Authority: RCW 48.02.060 and 48.43.510. WSR 10-02-068 (Matter No. R 2008-16), § 284-43-820, filed 1/4/10, effective 2/4/10. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.100, 48.46.200, 48.43.505, 48.43.510, 48.43.515, 48.43.520, 48.43.525, 48.43.530, 48.43.535. WSR 01-03-033 (Matter No. R 2000-02), § 284-43-820, filed 1/9/01, effective 7/1/01.]

WAC 284-43-822 Unfair practice relating to health coverage. (1) It is an unfair practice for any health carrier to restrict, exclude, or reduce coverage or benefits under any health plan on the basis of sex. By way of example, a health plan providing generally comprehensive coverage of prescription drugs and prescription devices restricts, excludes, or reduces coverage or benefits on the basis of sex if it fails to provide prescription contraceptive coverage that complies with this regulation.

An example of a plan that provides generally comprehensive coverage of prescription drugs is a plan that covers prescription drugs but excludes some categories such as weight reduction or smoking cessation.

(2)(a) Health plans providing generally comprehensive coverage of prescription drugs and/or prescription devices shall not exclude prescription contraceptives or cover prescription contraceptives on a less favorable basis than other covered prescription drugs and prescription devices. Coverage of prescription contraceptives includes coverage for medical services associated with the prescribing, dispensing, delivery, distribution, administration and removal of a prescription contraceptive to the same extent, and on the same terms, as other outpatient services.

(b) Health plans may not impose benefit waiting periods, limitations, or restrictions on prescription contraceptives that are not required or imposed on other covered prescription drugs and prescription devices.

(c) Health plans may require cost sharing, such as copayments or deductibles, for prescription contraceptives and for services associated with the prescribing, dispensing, delivery, distribution, administration, and removal of the prescription contraceptives, to the same extent that such cost sharing is required for other covered prescription drugs, devices or services.

(d) Health carriers may use, and health plans may limit coverage to, a closed formulary for prescription contraceptives if they otherwise use a closed formulary, but the formulary shall cover each of the types of prescription contraception as defined in (f) of this subsection.

(e) If a health plan excludes coverage for nonprescription drugs and devices except for those required by law, it may also exclude coverage for nonprescription contraceptive drugs and devices.

(f) For purposes of subsections (1) and (2) of this section, "prescription contraceptives" include United States Food and Drug Administration (FDA) approved contraceptive drugs, devices, and prescription barrier methods, including contra-

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ceptive products declared safe and effective for use as emergency contraception by the FDA.

(g) This section applies prospectively to health plans offered, issued, or renewed by a health carrier on or after January 1, 2002.

[Statutory Authority: RCW 48.02.060, 48.18.480, 48.20.450, 48.20.460, 48.21.045, 48.30.010, 48.30.300, 48.41.110, 48.41.170, 48.42.010, 48.42.040, 48.42.100, 48.43.012, 48.43.025, 48.43.035, 48.43.041, 48.43.115, 48.43.520, 48.44.020, 48.44.023, 48.44.050, 48.44.220, 48.46.060, 48.46.066, 48.46.110, 48.46.200, 49.60.010, 49.60.030, 49.60.120, 49.60.178, 49.60.220. WSR 01-19-001 (Matter No. R 2001-02), § 284-43-822, filed 9/5/01, effective 10/6/01.]

WAC 284-43-825 Prescription drug benefit disclosures. (1) A carrier must include the following information in the certificate of coverage issued for a health benefit plan, policy or agreement that includes a prescription drug benefit:

(a) A clear statement explaining that the health benefit plan, policy or agreement may cover brand name drugs or medication under the circumstances set forth in WAC 284-43-817 or 284-43-818, including, if a formulary is part of the benefit design, brand name drugs or other medication not in the formulary.

(b) A clear explanation of the substitution process that the enrollee or their provider must use to seek coverage of a prescription drug or medication that is not in the formulary or is not the carrier's preferred drug or medication for the covered medical condition.

(2) When a carrier eliminates a previously covered drug from its formulary, or establishes new limitations on coverage of the drug or medication, at a minimum a carrier must ensure that prior notice of the change will be provided as soon as is practicable, to enrollees who filled a prescription for the drug within the prior three months.

(a) Provided the enrollee agrees to receive electronic notice and such agreement has not been withdrawn, either electronic mail notice, or written notice by first class mail at the last known address of the enrollee, are acceptable methods of notice.

(b) If neither of these notice methods is available because the carrier lacks contact information for enrollees, a carrier may post notice on its web site or at another location that may be appropriate, so long as the posting is done in a manner that is reasonably calculated to reach and be noticed by affected enrollees.

(3) A carrier and health plan may use provider and enrollee education to promote the use of therapeutically equivalent generic drugs. The materials must not mislead an enrollee about the difference between biosimilar or bioequivalent, and therapeutically equivalent, generic medications.

[Statutory Authority: RCW 48.02.060, 48.02.062, 48.18.140, 48.43.525, 48.44.050, 48.44.440(2), 48.44.460(2), 48.46.200, and 48.46.510. WSR 12-21-019 (Matter No. R 2012-03), § 284-43-825, filed 10/8/12, effective 11/8/12.]

WAC 284-43-840 Anticancer medication. A carrier and health plan must cover prescribed, self-administered anticancer medication that is used to kill or slow the growth of cancerous cells on at least a comparable basis to the plan's coverage for the delivery of cancer chemotherapy medications administered in a clinical or medical setting.

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(1) A carrier may not impose dollar limits, copayments, deductibles or coinsurance requirements on coverage for orally administered anticancer drugs or chemotherapy that are less favorable to an insured or enrollee than the dollar limits, copayments, deductibles or coinsurance requirements that apply to coverage for anticancer medication or chemotherapy that is administered intravenously or by injection.

(2) A carrier may not reclassify an anticancer medication or increase an enrollee's out-of-pocket costs as a method of compliance with the requirements of this section.

[Statutory Authority: RCW 48.02.060, 48.02.062, 48.18.140, 48.43.525, 48.44.050, 48.44.440(2), 48.44.460(2), 48.46.200, and 48.46.510. WSR 12-21-019 (Matter No. R 2012-03), § 284-43-840, filed 10/8/12, effective 11/8/12.]

WAC 284-43-849 Purpose and scope. For plan years beginning on or after January 1, 2014, each nongrandfathered health benefit plan offered, issued, or renewed to small employers or individuals, both inside and outside the Washington health benefit exchange, must provide coverage for a package of essential health benefits, pursuant to RCW 48.43.715. WAC 284-43-849 through 284-43-885 explains the regulatory standards defining this coverage, and establishes supplementation of the base-benchmark plan consistent with PPACA and RCW 48.43.715, and the parameters of the state EHB-benchmark plan.

(1) WAC 284-43-849 through 284-43-885 do not apply to a health benefit plan that provides excepted benefits as described in section 2722 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-21), nor to a health benefit plan that qualifies as a grandfathered health plan as defined in RCW 48.43.005.

(2) WAC 284-43-849 through 284-43-885 do not require provider reimbursement at the same levels negotiated by the base-benchmark plan's issuer for their plan.

(3) WAC 284-43-849 through 284-43-885 do not require a health benefit plan to exclude the services or treatments from coverage that are excluded in the base-benchmark plan.

[Statutory Authority: RCW 48.02.060, 48.21.241, 48.21.320, 48.44.050, 48.44.341, 48.44.460, 48.46.200, 48.46.291, 48.46.530, 48.43.715, and Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010) (PPACA), as amended by the Health Care and Education Reconciliation Act (HCERA), Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010), in particular § 1302 of PPACA, § 10104 (b)(1) (HCERA). WSR 13-15-025 (Matter No. R 2012-17), § 284-43-849, filed 7/9/13, effective 7/10/13.]

WAC 284-43-850 Clinical trials. A carrier must not restrict coverage of routine patient costs for enrollees who participate in a clinical trial. "Routine costs" means items and services delivered to the enrollee that are consistent with and typically covered by the plan or coverage for an enrollee who is not enrolled in a clinical trial. A carrier may continue to apply its limitations and requirements related to use of network services.

(1) A carrier may require enrollees to meet the eligibility requirements of the clinical trial according to the trial protocol. While not required to impose such a condition, a carrier may refuse coverage under this section if the enrollee does not provide medical and scientific information establishing that the individual's participation in such trial would be appropriate based on the individual meeting the eligibility requirements for the clinical trial, unless the enrollee is

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referred to the clinical trial by a health care provider participating in the carrier's network.

(2) This includes the cost of prescription medication used for the direct clinical management of the enrollee, unless the trial is for the investigation of the prescription medication or the medication is typically provided by the research sponsors free of charge for any enrollee in the trial.

(3) The requirement does not apply to:

(a) A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;

(b) For items and services provided solely to satisfy data collection and analysis needs;

(c) Items and services that are not used in the direct clinical management of the enrollee; or

(d) The investigational item, device, or service itself.

(4) Clinical trial means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, funded or approved by:

(a) One of the National Institutes of Health (NIH);

(b) An NIH cooperative group or center which is a formal network of facilities that collaborate on research projects and have an established NIH-approved peer review program operating within the group including, but not limited to, the NCI Clinical Cooperative Group and the NCI Community Clinical Oncology Program;

(c) The federal Departments of Veterans Affairs or Defense;

(d) An institutional review board of an institution in this state that has a multiple project assurance contract approval by the Office of Protection for the Research Risks of the NIH; or

(e) A qualified research entity that meets the criteria for NIH Center Support Grant eligibility.

"Life threatening condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

[Statutory Authority: RCW 48.02.060, WSR 13-03-038 (Matter No. R 2012-25), § 284-43-850, filed 1/9/13, effective 2/9/13. Statutory Authority: RCW 48.02.060, 48.02.062, 48.18.140, 48.43.525, 48.44.050, 48.44.440(2), 48.44.460(2), 48.46.200, and 48.46.510. WSR 12-21-019 (Matter No. R 2012-03), § 284-43-850, filed 10/8/12, effective 11/8/12.]

WAC 284-43-852 Definitions. The following definitions apply to WAC 284-43-849 through 284-43-885 unless the context indicates otherwise.

"Base-benchmark plan" means the small group plan with the largest enrollment, as designated in WAC 284-43-865(1), prior to any supplementation or adjustments made pursuant to RCW 48.43.715.

"EHB-benchmark plan" means the set of benefits that an issuer must include in nongrandfathered plans offered in the individual or small group market in Washington state.

"Health benefit," unless defined differently pursuant to federal rules, regulations, or guidance issued pursuant to section 1302(b) of PPACA, means health care items or services for injury, disease, or a health condition, including a behavioral health condition.

"Individual plan" includes any nongrandfathered health benefit plan offered, issued, or renewed by an admitted issuer

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in the state of Washington for the individual health benefit plan market, unless the certificate of coverage is issued to an individual pursuant to or issued through an organization meeting the definition established pursuant to 29 U.S.C. 1002(5).

"Mandated benefit" or "required benefit" means a health plan benefit for a specific type of service, device or medical equipment, or treatment for a specified condition or conditions that a health plan is required to cover by either state or federal law. Required benefits do not include provider, delivery method, or health status based requirements.

"Meaningful health benefit" means a benefit that must be included in an essential health benefit category, without which the coverage for the category does not reasonably provide medically necessary services for an individual patient's condition on a nondiscriminatory basis.

"Medical necessity determination process" means the process used by a health issuer to make a coverage determination about whether a health benefit is medically necessary for an individual patient.

"PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

"Scope or limitation requirement" means a requirement applicable to a benefit that limits its duration, the number of times coverage is available for the benefit, or imposes a legally permitted eligibility or reference-based limitation on a specific benefit.

"Small group plan" includes any nongrandfathered health benefit plan offered, issued, or renewed by an admitted issuer in the state of Washington for the small group health benefit plan market to a small group, as defined in RCW 48.43.005, and 45 C.F.R. 144.102(c), unless the certificate of coverage is issued to a small group pursuant to a master contract held by or issued through an organization meeting the definition established pursuant to 29 U.S.C. 1002(5).

"Stand-alone dental plan" means coverage for a set of benefits limited to oral care including, but not necessarily limited to, pediatric oral care, as referenced in RCW 43.71.-065.

[Statutory Authority: RCW 48.02.060, 48.21.241, 48.21.320, 48.44.050, 48.44.341, 48.44.460, 48.46.200, 48.46.291, 48.46.530, 48.43.715, and Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010) (PPACA), as amended by the Health Care and Education Reconciliation Act (HCERA), Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010), in particular § 1302 of PPACA, § 10104 (b)(1) (HCERA). WSR 13-15-025 (Matter No. R 2012-17), § 284-43-852, filed 7/9/13, effective 7/10/13.]

WAC 284-43-860 Medical necessity determination.

(1) An issuer's certificate of coverage and the summary of coverage for the health benefit plan must specifically explain any uniformly applied limitation on the scope, visit number or duration of a benefit, and state whether the uniform limitation is subject to adjustment based on the specific treatment requirements of the patient.

(2) An issuer's medical necessity determination process must:

(a) Be clearly explained in the certificate of coverage, plan document, or contract for health benefit coverage;

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(b) Be conducted fairly, and with transparency to enrollees and providers, at a minimum when an enrollee or their representative appeals or seeks review of an adverse benefit determination;

(c) Include consideration of services that are a logical next step in reasonable care if they are appropriate for the patient;

(d) Identify the information needed in the decision-making process and incorporate appropriate outcomes within a developmental framework;

(e) Ensure that when the interpretation of the medical purpose of interventions is part of the medical necessity decision making, the interpretation standard can be explained in writing to an enrollee and providers, and is broad enough to address any of the services encompassed in the ten essential health benefits categories of care;

(f) Comply with inclusion of the ten essential health benefits categories;

(g) Not discriminate based on age, present or predicted disability, expected length of life, degree of medical dependency, quality of life or other health conditions, race, gender, national origin, sexual orientation and gender identity;

(h) Include consideration of the treating provider's clinical judgment and recommendations regarding the medical purpose of the requested service, and the extent to which the service is likely to produce incremental health benefits for the enrollee;

(i) Identify by role who will participate in the issuer's medical necessity decision-making process; and

(j) Ensure that where medically appropriate, and consistent with the health benefit plan's contract terms, an enrollee is not unreasonably restricted as to the site of service delivery.

(3) An issuer's medical necessity determination process may include, but is not limited to, evaluation of the effectiveness and benefit of a service for the individual patient based on scientific evidence considerations, up-to-date and consistent professional standards of care, convincing expert opinion and a comparison to alternative interventions, including no interventions. Cost effectiveness may be one of but not the sole criteria for determining medical necessity.

(4) Within thirty days of receiving a request, an issuer must furnish its medical necessity criteria for medical/surgical benefits and mental health/substance use disorder benefits or for other essential health benefit categories to an enrollee or provider.

[Statutory Authority: RCW 48.02.060, 48.21.241, 48.21.320, 48.44.050, 48.44.341, 48.44.460, 48.46.200, 48.46.291, 48.46.530, 48.43.715, and Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010) (PPACA), as amended by the Health Care and Education Reconciliation Act (HCERA), Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010), in particular § 1302 of PPACA, § 10104 (b)(1) (HCERA). WSR 13-15-025 (Matter No. R 2012-17), § 284-43-860, filed 7/9/13, effective 7/10/13.]

WAC 284-43-865 Essential health benefits package benchmark reference plan. A not grandfathered individual or small group health benefit plan offered, issued, amended or renewed on or after January 1, 2014, must, at a minimum, include coverage for essential health benefits. "Essential health benefits" means all of the following:

(1) The benefits and services covered by health care service contractor Regence Blue Shield as the *Innova* small

group plan policy form, policy form number WW0711CCO-NMS, and certificate form number WW0112BINNS, offered during the first quarter of 2012. The SERFF filing number is RGWA-127372701.

(2) The services and items covered by a health benefit plan that are within the categories identified in Section 1302(b) of PPACA including, but not limited to, ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care, and as supplemented by the commissioner or required by the secretary of the U.S. Department of Health and Human Services.

(3) Mandated benefits pursuant to Title 48 RCW enacted before December 31, 2011.

[Statutory Authority: 2012 c 87 and RCW 48.02.060. WSR 12-19-099 (Matter No. R 2012-19), § 284-43-865, filed 9/19/12, effective 10/20/12.]

WAC 284-43-877 Plan design. (1) A nongrandfathered individual or small group health benefit plan offered, issued, or renewed, on or after January 1, 2014, must provide coverage that is substantially equal to the EHB-benchmark plan, as described in WAC 284-43-878, 284-43-879, and 284-43-880.

(a) For plans offered, issued, or renewed for a plan or policy year beginning on or after January 1, 2014, until December 31, 2016, an issuer must offer the EHB-benchmark plan without substituting benefits for the benefits specifically identified in the EHB-benchmark plan.

(b) For plan or policy years beginning on or after January 1, 2017, an issuer may substitute benefits to the extent that the actuarial value of the benefits in the category to which the substituted benefit is classified remains substantially equal to the EHB-benchmark plan.

(c) "Substantially equal" means that:

(i) The scope and level of benefits offered within each essential health benefit category supports a determination by the commissioner that the benefit is a meaningful health benefit;

(ii) The aggregate actuarial value of the benefits across all essential health benefit categories does not vary more than a de minimis amount from the aggregate actuarial value of the EHB-benchmark base plan; and

(iii) Within each essential health benefit category, the actuarial value of the category must not vary more than a de minimis amount from the actuarial value of the category for the EHB-benchmark plan.

(2) An issuer must classify covered services to an essential health benefits category consistent with WAC 284-43-878, 284-43-879, and 284-43-880 for purposes of determining actuarial value. An issuer may not use classification of services to an essential health benefits category for purposes of determining actuarial value as the basis for denying coverage under a health benefit plan.

(3) The base-benchmark plan does not specifically list all types of services, settings and supplies that can be classified to each essential health benefits category. The base-benchmark plan design does not specifically list each covered service, supply or treatment. Coverage for benefits not speci-

cally identified as covered or excluded is determined based on medical necessity. An issuer may use this plan design, provided that each of the essential health benefit categories is specifically covered in a manner substantially equal to the EHB-benchmark plan.

(4) An issuer is not required to exclude services that are specifically excluded by the base-benchmark plan. If an issuer elects to cover a benefit excluded in the base-benchmark plan, the issuer must not include the benefit in its essential health benefits package for purposes of determining actuarial value. A health benefit plan must not exclude a benefit that is specifically included in the base-benchmark plan.

(5) An issuer must not apply visit limitations or limit the scope of the benefit category based on the type of provider delivering the service, other than requiring that the service must be within the provider's scope of license for purposes of coverage. This obligation does not require an issuer to contract with any willing provider, nor is an issuer restricted from establishing reasonable requirements for credentialing of and access to providers within its network.

(6) Telemedicine or telehealth services are considered provider-type services, and not a benefit for purposes of the essential health benefits package.

(7) Consistent with state and federal law, a health benefit plan must not contain an exclusion that unreasonably restricts access to medically necessary services for populations with special needs including, but not limited to, a chronic condition caused by illness or injury, either acquired or congenital.

(8) Unless an age based reference limitation is specifically included in the base-benchmark plan or a supplemental base-benchmark plan for a category set forth in WAC 284-43-878, 284-43-879, or 284-443-880, an issuer's scope of coverage for those categories of benefits must cover both pediatric and adult populations.

(9) A health benefit plan must not be offered if the commissioner determines that:

(a) It creates a risk of biased selection based on health status;

(b) The benefits within an essential health benefit category are limited so that the coverage for the category is not a meaningful health benefit; or

(c) The benefit has a discriminatory effect in practice, outcome or purpose in relation to age, present or predicted disability, and expected length of life, degree of medical dependency, quality of life or other health conditions, race, gender, national origin, sexual orientation and gender identity or in the application of Section 511 of Public Law 110-343 (the federal Mental Health Parity and Addiction Equity Act of 2008).

(10) An issuer must not impose annual or lifetime dollar limits on an essential health benefit, other than those permitted as reference based limitations pursuant to WAC 284-43-878, 284-43-879, and 284-43-880.

[Statutory Authority: RCW 48.02.060 and 48.43.715. WSR 14-06-069 (Matter No. R 2013-28), § 284-43-877, filed 3/3/14, effective 4/3/14. Statutory Authority: RCW 48.02.060, 48.21.241, 48.21.320, 48.44.050, 48.44.341, 48.44.460, 48.46.200, 48.46.291, 48.46.530, 48.43.715, and Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010) (PPACA), as amended by the Health Care and Education Reconciliation Act (HCERA), Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010), in particular § 1302 of PPACA, § 10104 (b)(1) (HCERA). WSR 13-15-025 (Matter No. R 2012-17), § 284-43-877, filed 7/9/13, effective 7/10/13.]

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WAC 284-43-878 Essential health benefit categories.

(1) A health benefit plan must cover "ambulatory patient services." For purposes of determining a plan's actuarial value, an issuer must classify as ambulatory patient services medically necessary services delivered to enrollees in settings other than a hospital or skilled nursing facility, which are generally recognized and accepted for diagnostic or therapeutic purposes to treat illness or injury, in a substantially equal manner to the base-benchmark plan.

(a) A health benefit plan must include the following services, which are specifically covered by the base-benchmark plan, and classify them as ambulatory patient services:

(i) Home and out-patient dialysis services;

(ii) Hospice and home health care, including skilled nursing care as an alternative to hospitalization consistent with WAC 284-44-500, 284-46-500, and 284-96-500;

(iii) Provider office visits and treatments, and associated supplies and services, including therapeutic injections and related supplies;

(iv) Urgent care center visits, including provider services, facility costs and supplies;

(v) Ambulatory surgical center professional services, including anesthesiology, professional surgical services, and surgical supplies and facility costs;

(vi) Diagnostic procedures including colonoscopies, cardiovascular testing, pulmonary function studies and neurology/neuromuscular procedures; and

(vii) Provider contraceptive services and supplies including, but not limited to, vasectomy, tubal ligation and insertion or extraction of FDA-approved contraceptive devices.

(b) A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. These services are specifically excluded by the base-benchmark plan, and should not be included in establishing actuarial value for this category.

(i) Infertility treatment and reversal of voluntary sterilization;

(ii) Routine foot care for those that are not diabetic;

(iii) Coverage of dental services following injury to sound natural teeth, but not excluding services or appliances necessary for or resulting from medical treatment if the service is:

(A) Emergency in nature; or

(B) Requires extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease. Oral surgery related to trauma and injury must be covered.

(iv) Private duty nursing for hospice care and home health care, to the extent consistent with state and federal law;

(v) Adult dental care and orthodontia delivered by a dentist or in a dentist's office;

(vi) Non-skilled care and help with activities of daily living;

(vii) Hearing care, routine hearing examinations, programs or treatment for hearing loss including, but not limited to, externally worn or surgically implanted hearing aids, and the surgery and services necessary to implant them, other than for cochlear implants, which are covered, and for hearing screening tests required under the preventive services category, unless coverage for these services and devices are

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required as part of and classified to another essential health benefits category;

(viii) Obesity or weight reduction or control other than covered nutritional counseling.

(c) The base-benchmark plan establishes specific limitations on services classified to the ambulatory patient services category that conflict with state or federal law as of January 1, 2014. The base-benchmark plan limits nutritional counseling to three visits per lifetime, if the benefit is not associated with diabetes management. This lifetime limitation for nutritional counseling is not part of the state EHB-benchmark plan. An issuer may limit this service based on medical necessity, and may establish an additional reasonable visit limitation requirement for nutritional counseling for medical conditions when supported by evidence based medical criteria.

(d) The base-benchmark plan's visit limitations on services in this category include:

(i) Ten spinal manipulation services per calendar year without referral;

(ii) Twelve acupuncture services per calendar year without referral;

(iii) Fourteen days respite care on either an inpatient or outpatient basis for hospice patients, per lifetime;

(iv) One hundred thirty visits per calendar year for home health care.

(e) State benefit requirements classified to this category are:

(i) Chiropractic care (RCW 48.44.310);

(ii) TMJ disorder treatment (RCW 48.21.320, 48.44.460, and 48.46.530);

(iii) Diabetes-related care and supplies (RCW 48.20.391, 48.21.143, 48.44.315, and 48.46.272).

(2) A health benefit plan must cover "emergency medical services." For purposes of determining a plan's actuarial value, an issuer must classify care and services related to an emergency medical condition to the emergency medical services category, in a substantially equal manner to the base-benchmark plan.

(a) A health benefit plan must include the following services which are specifically covered by the base-benchmark plan and classify them as emergency services:

(i) Ambulance transportation to an emergency room and treatment provided as part of the ambulance service;

(ii) Emergency room and department based services, supplies and treatment, including professional charges, facility costs, and outpatient charges for patient observation and medical screening exams required to stabilize a patient experiencing an emergency medical condition;

(iii) Prescription medications associated with an emergency medical condition, including those purchased in a foreign country.

(b) The base-benchmark plan does not specifically exclude services classified to the emergency medical care category.

(c) The base-benchmark base plan does not establish specific limitations on services classified to the emergency medical services category that conflict with state or federal law as of January 1, 2014.

(d) The base-benchmark plan does not establish visit limitations on services in this category.

(e) State benefit requirements classified to this category include services necessary to screen and stabilize a covered person (RCW 48.43.093).

(3) A health benefit plan must cover "hospitalization." For purposes of determining a plan's actuarial value, an issuer must classify as hospitalization services the medically necessary services delivered in a hospital or skilled nursing setting including, but not limited to, professional services, facility fees, supplies, laboratory, therapy or other types of services delivered on an inpatient basis, in a substantially equal manner to the base-benchmark plan.

(a) A health benefit plan must include the following services which are specifically covered by the base-benchmark plan and classify them as hospitalization services:

(i) Hospital visits, facility costs, provider and staff services and treatments delivered during an inpatient hospital stay, including inpatient pharmacy services;

(ii) Skilled nursing facility costs, including professional services and pharmacy services and prescriptions filled in the skilled nursing facility pharmacy;

(iii) Transplant services, supplies and treatment for donors and recipients, including the transplant or donor facility fees performed in either a hospital setting or outpatient setting;

(iv) Dialysis services delivered in a hospital;

(v) Artificial organ transplants based on an issuer's medical guidelines and manufacturer recommendations;

(vi) Respite care services delivered on an inpatient basis in a hospital or skilled nursing facility.

(b) A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. These services are specifically excluded by the base-benchmark plan, and should not be included in establishing actuarial value:

(i) Hospitalization where mental illness is the primary diagnosis to the extent that it is classified under the mental health and substance use disorder benefits category;

(ii) Cosmetic or reconstructive services and supplies except in the treatment of a congenital anomaly, to restore a physical bodily function lost as a result of injury or illness, or related to breast reconstruction following a medically necessary mastectomy;

(iii) The following types of surgery:

(A) Bariatric surgery and supplies;

(B) Orthognathic surgery and supplies unless due to temporomandibular joint disorder or injury, sleep apnea or congenital anomaly; and

(C) Sexual reassignment treatment and surgery;

(iv) Reversal of sterilizations;

(v) Surgical procedures to correct refractive errors, astigmatism or reversals or revisions of surgical procedures which alter the refractive character of the eye.

(c) The base-benchmark plan establishes specific limitations on services classified to the hospitalization category that conflict with state or federal law as of January 1, 2014. The base-benchmark plan allows for a transplant waiting period. This waiting period is not part of the state EHB-benchmark plan.

(d) The base-benchmark plan's visit limitations on services in this category include:

(i) Sixty inpatient days per calendar year for illness, injury or physical disability in a skilled nursing facility;

(ii) Thirty inpatient rehabilitation service days per calendar year. This benefit may be classified to this category for determining actuarial value or to the rehabilitation services category, but not to both.

(e) State benefit requirements classified to this category are:

(i) General anesthesia and facility charges for dental procedures for those who would be at risk if the service were performed elsewhere and without anesthesia (RCW 48.43.185);

(ii) Reconstructive breast surgery resulting from a mastectomy which resulted from disease, illness or injury (RCW 48.20.395, 48.21.230, 48.44.330, and 48.46.280);

(iii) Coverage for treatment of temporomandibular joint disorder (RCW 48.21.320, 48.44.460, and 48.46.530);

(iv) Coverage at a long-term care facility following hospitalization (RCW 48.43.125).

(4) A health benefit plan must cover "maternity and newborn" services. For purposes of determining a plan's actuarial value, an issuer must classify as maternity and newborn services the medically necessary care and services delivered to women during pregnancy and in relation to delivery and recovery from delivery, and to newborn children, in a substantially equal manner to the base-benchmark plan.

(a) A health benefit plan must cover the following services which are specifically covered by the base-benchmark plan and classify them as maternity and newborn services:

(i) In utero treatment for the fetus;

(ii) Vaginal or cesarean childbirth delivery in a hospital or birthing center, including facility fees;

(iii) Nursery services and supplies for newborns, including newly adopted children;

(iv) Infertility diagnosis;

(v) Prenatal and postnatal care and services, including screening;

(vi) Complications of pregnancy such as, but not limited to, fetal distress, gestational diabetes, and toxemia; and

(vii) Termination of pregnancy. Termination of pregnancy may be included in an issuer's essential health benefits package, but nothing in this section requires an issuer to offer the benefit, consistent with 42 U.S.C. 18023 (b)(a)(A)(i) and 45 C.F.R. 156.115.

(b) A health benefit plan may, but is not required to, include the following service as part of the EHB-benchmark package. Genetic testing of the child's father is specifically excluded by the base-benchmark plan, and should not be included in determining actuarial value.

(c) The base-benchmark plan establishes specific limitations on services classified to the maternity and newborn category that conflict with state or federal law as of January 1, 2014. The state EHB-benchmark plan requirements for these services are:

(i) Maternity coverage for dependent daughters must be included in the EHB-benchmark plan on the same basis that the coverage is included for other enrollees;

(ii) Newborns delivered of dependent daughters must be covered to the same extent, and on the same basis, as newborns delivered to the other enrollees under the plan.

(d) The base-benchmark plan's limitations on services in this category include coverage of home birth by a midwife or nurse midwife only for low risk pregnancy.

(e) State benefit requirements classified to this category include:

(i) Maternity services that include diagnosis of pregnancy, prenatal care, delivery, care for complications of pregnancy, physician services, and hospital services (RCW 48.43.041);

(ii) Newborn coverage that is not less than the post-natal coverage for the mother, for no less than three weeks (RCW 48.43.115);

(iii) Prenatal diagnosis of congenital disorders by screening/diagnostic procedures if medically necessary (RCW 48.20.430, 48.21.244, 48.44.344, and 48.46.375).

(5) A health benefit plan must cover "mental health and substance use disorder services, including behavioral health treatment." For purposes of determining a plan's actuarial value, an issuer must classify as mental health and substance use disorder services, including behavioral health treatment, the medically necessary care, treatment and services for mental health conditions and substance use disorders categorized in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, including behavioral health treatment for those conditions, in a substantially equal manner to the base-benchmark plan.

(a) A health benefit plan must include the following services, which are specifically covered by the base-benchmark plan, and classify them as mental health and substance use disorder services, including behavioral health treatment:

(i) Inpatient, residential and outpatient mental health and substance use disorder treatment, including partial hospital programs or inpatient services;

(ii) Chemical dependency detoxification;

(iii) Behavioral treatment for a DSM category diagnosis;

(iv) Services provided by a licensed behavioral health provider for a covered diagnosis in a skilled nursing facility;

(v) Prescription medication prescribed during an inpatient and residential course of treatment;

(vi) Acupuncture treatment visits without application of the visit limitation requirements, when provided for chemical dependency.

(b) A health benefit plan may, but is not required to include, the following services as part of the EHB-benchmark package. These services are specifically excluded by the base-benchmark plan, and should not be included in establishing actuarial value.

(i) Counseling in the absence of illness, other than family counseling when the patient is a child or adolescent with a covered diagnosis and the family counseling is part of the treatment for mental health services;

(ii) Mental health treatment for diagnostic codes 302 through 302.9 in the DSM-IV, or for "V code" diagnoses except for medically necessary services for parent-child relational problems for children five years of age or younger, neglect or abuse of a child for children five years of age or younger, and bereavement for children five years of age or younger, unless this exclusion is preempted by federal law;

(iii) Not medically necessary court-ordered mental health treatment.

(c) The base-benchmark plan establishes specific limitations on services classified to the mental health and substance abuse disorder services category that conflict with state or federal law as of January 1, 2014. The state EHB-benchmark plan requirements for these services are:

(i) Coverage for eating disorder treatment must be covered when associated with a diagnosis of a DSM categorized mental health condition;

(ii) Chemical detoxification coverage must not be uniformly limited to thirty days. Medical necessity, utilization review and criteria consistent with federal law may be applied by an issuer in designing coverage for this benefit;

(iii) Mental health services and substance use disorder treatment must be delivered in a home health setting on parity with medical surgical benefits, consistent with state and federal law.

(d) The base-benchmark plan's visit limitations on services in this category include: Court ordered treatment only when medically necessary.

(e) State benefit requirements classified to this category include:

(i) Mental health services (RCW 48.20.580, 48.21.241, 48.44.341, and 48.46.285);

(ii) Chemical dependency detoxification services (RCW 48.21.180, 48.44.240, 48.44.245, 48.46.350, and 48.46.355);

(iii) Services delivered pursuant to involuntary commitment proceedings (RCW 48.21.242, 48.44.342, and 48.46.-292).

(f) The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343) (MHPAEA) applies to a health benefit plan subject to this section. Coverage of mental health and substance use disorder services, along with any scope and duration limits imposed on the benefits, must comply with the MHPAEA, and all rules, regulations and guidance issued pursuant to Section 2726 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26) where state law is silent, or where federal law preempts state law.

(6) A health benefit plan must cover "prescription drug services." For purposes of determining a plan's actuarial value, an issuer must classify as prescription drug services the medically necessary prescribed drugs, medication and drug therapies, in a manner substantially equal to the base-benchmark plan.

(a) A health benefit plan must include the following services, which are specifically covered by the base-benchmark plan and classify them as prescription drug services:

(i) Drugs and medications both generic and brand name, including self-administrable prescription medications, consistent with the requirements of (b) through (f) of this subsection;

(ii) Prescribed medical supplies, including diabetic supplies that are not otherwise covered as durable medical equipment under the rehabilitative and habilitative services category, including test strips, glucagon emergency kits, insulin and insulin syringes;

(iii) All FDA approved contraceptive methods, and prescription based sterilization procedures for women with reproductive capacity;

(iv) Certain preventive medications including, but not limited to, aspirin, fluoride, and iron, and medications for

tobacco use cessation, according to, and as recommended by, the United States Preventive Services Task Force, when obtained with a prescription order;

(v) Medical foods to treat inborn errors of metabolism.

(b) A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. These services are specifically excluded by the base-benchmark plan, and should not be included in establishing actuarial value for this category:

(i) Insulin pumps and their supplies, which are classified to and covered under the rehabilitation and habilitation services category; and

(ii) Weight loss drugs.

(c) The base-benchmark plan establishes specific limitations on services classified to the prescription drug services category that conflict with state or federal law as of January 1, 2014. The EHB-benchmark plan requirements for these services are:

(i) Preauthorized tobacco cessation products must be covered consistent with state and federal law;

(ii) Medication prescribed as part of a clinical trial, which is not the subject of the trial, must be covered in a manner consistent with state and federal law.

(d) The base-benchmark plan's visit limitations on services in this category include:

(i) Prescriptions for self-administrable injectable medication are limited to thirty day supplies at a time, other than insulin, which may be offered with more than a thirty day supply. This limitation is a floor, and an issuer may permit supplies greater than thirty days as part of its health benefit plan;

(ii) Teaching doses of self-administrable injectable medications are limited to three doses per medication per lifetime.

(e) State benefit requirements classified to this category include:

(i) Medical foods to treat phenylketonuria (RCW 48.44.-440, 48.46.510, 48.20.520, and 48.21.300);

(ii) Diabetes supplies ordered by the physician (RCW 48.44.315, 48.46.272, 48.20.391, and 48.21.143). Inclusion of this benefit requirement does not bar issuer variation in diabetic supply manufacturers under its drug formulary;

(iii) Mental health prescription drugs to the extent not covered under the hospitalization or skilled nursing facility services, or mental health and substance use disorders categories (RCW 48.44.341, 48.46.291, 48.20.580, and 48.21.241).

(f) An issuer's formulary is part of the prescription drug services category. The formulary filed with the commissioner must be substantially equal to the base-benchmark plan formulary, both as to U.S. Pharmacopoeia therapeutic category and classes covered and number of drugs in each class. If the base-benchmark formulary does not cover at least one drug in a category or class, an issuer must include at least one drug in the uncovered category or class.

(i) An issuer must file its formulary quarterly, following the filing instructions defined by the insurance commissioner in WAC 284-44A-040, 284-46A-050, and 284-58-025.

(ii) An issuer's formulary does not have to be substantially equal to the base-benchmark plan formulary in terms of formulary placement.

(7) A health benefit plan must cover "rehabilitative and habilitative services."

(a) For purposes of determining a plan's actuarial value, an issuer must classify as rehabilitative services the medically necessary services that help a person keep, restore or improve skills and function for daily living that have been lost or impaired because a person was sick, hurt or disabled, in a manner substantially equal to the base-benchmark plan.

(b) A health benefit plan must include the following services, which are specifically covered by the base-benchmark plan, and classify them as rehabilitative services:

- (i) Cochlear implants;
- (ii) In-patient rehabilitation facility and professional services delivered in those facilities;
- (iii) Outpatient physical therapy, occupational therapy and speech therapy for rehabilitative purposes;
- (iv) Braces, splints, prostheses, orthopedic appliances and orthotic devices, supplies or apparatuses used to support, align or correct deformities or to improve the function of moving parts;
- (v) Durable medical equipment and mobility enhancing equipment used to serve a medical purpose, including sales tax.

(c) A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. These services are specifically excluded by the base-benchmark plan, and should not be included in establishing actuarial value:

- (i) Off the shelf shoe inserts and orthopedic shoes;
- (ii) Exercise equipment for medically necessary conditions;
- (iii) Durable medical equipment that serves solely as a comfort or convenience item; and
- (iv) Hearing aids other than cochlear implants.

(d) **Supplementation:** The base-benchmark plan does not cover certain federally required services under this category. A health benefit plan must cover habilitative services, but these services are not specifically covered in the base-benchmark plan. Therefore, this category is supplemented. The state EHB-benchmark plan requirements for habilitative services are:

(i) For purposes of determining actuarial value and complying with the requirements of this section, the issuer must classify as habilitative services and provide coverage for the range of medically necessary health care services and health care devices designed to assist an individual in partially or fully developing, keeping or learning age appropriate skills and functioning within the individual's environment, or to compensate for a person's progressive physical, cognitive, and emotional illness.

(ii) As a minimum level of coverage, an issuer must establish limitations on habilitative services on parity with those for rehabilitative services. A health benefit plan may include reference based limitations only if the limitations take into account the unique needs of the individual and target measurable, and specific treatment goals appropriate for the person's age, and physical and mental condition. When habilitative services are delivered to treat a mental health diagnosis categorized in the most recent version of the DSM, the mental health parity requirements apply and supersede any rehabilitative services parity limitations permitted by this subsection.

(iii) A health benefit plan must not limit an enrollee's access to covered services on the basis that some, but not all of the services in a plan of treatment are provided by a public or government program.

(iv) An issuer may establish utilization review guidelines and practice guidelines for habilitative services that are recognized by the medical community as efficacious. The guidelines must not require a return to a prior level of function.

(v) Habilitative health care devices may be limited to those that require FDA approval and a prescription to dispense the device.

(vi) Consistent with the standards in this subsection, speech therapy, occupational therapy, physical therapy, and aural therapy are habilitative services. Day habilitation services designed to provide training, structured activities and specialized assistance to adults, chore services to assist with basic needs, vocational or custodial services are not classified as habilitative services.

(vii) An issuer must not exclude coverage for habilitative services received at a school-based health care center unless the habilitative services and devices are delivered pursuant to federal Individuals with Disabilities Education Act of 2004 (IDEA) requirements and included in an individual educational plan (IEP).

(e) The base-benchmark plan's visit limitations on services in this category include:

- (i) In-patient rehabilitation facility and professional services delivered in those facilities are limited to thirty service days per calendar year; and
- (ii) Outpatient physical therapy, occupational therapy and speech therapy are limited to twenty-five outpatient visits per calendar year, on a combined basis, for rehabilitative purposes.

(f) State benefit requirements classified to this category include:

- (i) State sales tax for durable medical equipment; and
- (ii) Coverage of diabetic supplies and equipment (RCW 48.44.315, 48.46.272, 48.20.391, and 48.21.143).

(g) An issuer must not classify services to the rehabilitative services category if the classification results in a limitation of coverage for therapy that is medically necessary for an enrollee's treatment for cancer, chronic pulmonary or respiratory disease, cardiac disease or other similar chronic conditions or diseases. For purposes of this subsection, an issuer must establish limitations on the number of visits and coverage of the rehabilitation therapy consistent with its medical necessity and utilization review guidelines for medical/surgical benefits. Examples of these are, but are not limited to, breast cancer rehabilitation therapy, respiratory therapy, and cardiac rehabilitation therapy. Such services may be classified to the ambulatory patient or hospitalization services categories for purposes of determining actuarial value.

(8) A health plan must cover "laboratory services." For purposes of determining actuarial value, an issuer must classify as laboratory services the medically necessary laboratory services and testing, including those performed by a licensed provider to determine differential diagnoses, conditions, outcomes and treatment, and including blood and blood services, storage and procurement, and ultrasound, X ray, MRI, CAT scan and PET scans, in a manner substantially equal to the base-benchmark plan.

(a) A health benefit plan must include the following services, which are specifically covered by the base-benchmark plan, and classify them as laboratory services:

- (i) Laboratory services, supplies and tests, including genetic testing;
- (ii) Radiology services, including X ray, MRI, CAT scan, PET scan, and ultrasound imaging;
- (iii) Blood, blood products, and blood storage, including the services and supplies of a blood bank.

(b) A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. An enrollee's not medically indicated procurement and storage of personal blood supplies provided by a member of the enrollee's family is specifically excluded by the base-benchmark plan, and should not be included by an issuer in establishing a health benefit plan's actuarial value.

(9) A health plan must cover "preventive and wellness services, including chronic disease management." For purposes of determining a plan's actuarial value, an issuer must classify as preventative and wellness services, including chronic disease management, the services that identify or prevent the onset or worsening of disease or disease conditions, illness or injury, often asymptomatic, services that assist in the multidisciplinary management and treatment of chronic diseases, services of particular preventive or early identification of disease or illness of value to specific populations, such as women, children and seniors, in a manner substantially equal to the base-benchmark plan.

(a) A health benefit plan must include the following services as preventive and wellness services:

(i) Immunizations recommended by the Centers for Disease Control's Advisory Committee on Immunization Practices;

(ii) Screening and tests with A and B recommendations by the U.S. Preventive Services Task Force for prevention and chronic care, for recommendations issued on or before the applicable plan year;

(iii) Services, tests and screening contained in the U.S. Health Resources and Services Administration Bright Futures guidelines as set forth by the American Academy of Pediatricians;

(iv) Services, tests, screening and supplies recommended in the U.S. Health Resources and Services Administration women's preventive and wellness services guidelines;

(v) Chronic disease management services, which typically include, but are not limited to, a treatment plan with regular monitoring, coordination of care between multiple providers and settings, medication management, evidence-based care, measuring care quality and outcomes, and support for patient self-management through education or tools; and

(vi) Wellness services.

(b) The base-benchmark plan does not exclude any services that could reasonably be classified to this category.

(c) The base-benchmark plan does not apply any limitations or scope restrictions that conflict with state or federal law as of January 1, 2014.

(d) The base-benchmark plan does not establish visit limitations on services in this category.

(e) State benefit requirements classified in this category are:

(i) Colorectal cancer screening as set forth in RCW 48.43.043;

(ii) Mammogram services, both diagnostic and screening (RCW 48.21.225, 48.44.325, and 48.46.275);

(iii) Prostate cancer screening (RCW 48.20.392, 48.21.-227, 48.44.327, and 48.46.277).

(10) State benefit requirements that are limited to those receiving pediatric services, but that are classified to other categories for purposes of determining actuarial value, are:

(a) Neurodevelopmental therapy to age six, consisting of physical, occupational and speech therapy and maintenance to restore or improve function based on developmental delay, which cannot be combined with rehabilitative services for the same condition (RCW 48.44.450, 48.46.520, and 48.21.310). This state benefit requirement may be classified to ambulatory patient services or mental health and substance abuse disorder including behavioral health categories;

(b) Congenital anomalies in newborn and dependent children (RCW 48.20.430, 48.21.155, 48.44.212, and 48.46.-250). This state benefit requirement may be classified to hospitalization, ambulatory patient services or maternity and newborn categories.

[Statutory Authority: RCW 48.02.060 and 48.43.715. WSR 14-15-012 (Matter No. R 2014-03), § 284-43-878, filed 7/3/14, effective 7/3/14. Statutory Authority: RCW 48.02.060, 48.21.241, 48.21.320, 48.44.050, 48.44.341, 48.44.460, 48.46.200, 48.46.291, 48.46.530, 48.43.715, and Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010) (PPACA), as amended by the Health Care and Education Reconciliation Act (HCERA), Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010), in particular § 1302 of PPACA, § 10104 (b)(1) (HCERA). WSR 13-15-025 (Matter No. R 2012-17), § 284-43-878, filed 7/9/13, effective 7/10/13.]

WAC 284-43-879 Essential health benefit category—Pediatric oral services. A health benefit plan must include "pediatric dental benefits" in its essential health benefits package. Pediatric dental benefits means coverage for the oral services listed in subsection (3) of this section, delivered to those under age nineteen.

(1) For benefit years beginning January 1, 2015, a health benefit plan must include pediatric dental benefits as an embedded set of benefits, or through a combination of a health benefit plan and a stand-alone dental plan that includes pediatric dental benefits certified as a qualified dental plan. For a health benefit plan certified by the health benefit exchange as a qualified health plan, this requirement is met if a stand-alone dental plan meeting the requirements of subsection (3) of this section is offered in the health benefit exchange for that benefit year.

(2) The requirements of WAC 284-43-878 and 284-43-880 are not applicable to the stand-alone dental plan. A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. The supplemental base-benchmark plan specifically excludes oral implants, and an issuer should not include benefits for oral implants in establishing a plan's actuarial value.

(3) **Supplementation:** The base-benchmark plan covers pediatric services for the categories set forth in WAC 284-43-878, but does not cover pediatric oral services. Because the base-benchmark plan does not cover pediatric oral benefits, the state EHB-benchmark plan requirements are supplemented for pediatric oral benefits. The Washington state CHIP plan is designated as the supplemental base-benchmark

plan for pediatric dental benefits. A health plan issuer must offer coverage for and classify the following pediatric oral services as pediatric dental benefits in a manner substantially equal to the supplemental base-benchmark plan:

- (a) Diagnostic services;
 - (b) Preventive care;
 - (c) Restorative care;
 - (d) Oral surgery and reconstruction to the extent not covered under the hospitalization benefit;
 - (e) Endodontic treatment;
 - (f) Periodontics;
 - (g) Crown and fixed bridge;
 - (h) Removable prosthetics; and
 - (i) Medically necessary orthodontia.
- (4) The supplemental base-benchmark plan's visit limitations on services in this category are:
- (a) Diagnostic exams once every six months, beginning before one year of age;
 - (b) Bitewing X ray once a year;
 - (c) Panoramic X rays once every three years;
 - (d) Prophylaxis every six months beginning at age six months;
 - (e) Fluoride three times in a twelve-month period for ages six and under; two times in a twelve-month period for ages seven and older; three times in a twelve-month period during orthodontic treatment; sealant once every three years for occlusal surfaces only; oral hygiene instruction two times in twelve months for ages eight and under if not billed on the same day as a prophylaxis treatment;
 - (f) Every two years for the same restoration (fillings);
 - (g) Frenulectomy or frenuloplasty covered for ages six and under without prior authorization;
 - (h) Root canals on baby primary posterior teeth only;
 - (i) Root canals on permanent anterior, bicuspid and molar teeth, excluding teeth 1, 16, 17 and 32;
 - (j) Periodontal scaling and root planing once per quadrant in a two-year period for ages thirteen and older, with prior authorization;
 - (k) Periodontal maintenance once per quadrant in a twelve-month period for ages thirteen and older, with prior authorization;
 - (l) Stainless steel crowns for primary anterior teeth once every three years; if age thirteen and older with prior authorization;
 - (m) Stainless steel crowns for permanent posterior teeth once every three years;
 - (n) Metal/porcelain crowns and porcelain crowns on anterior teeth only, with prior authorization;
 - (o) Space maintainers for missing primary molars A, B, I, J, K, L, S, and T;
 - (p) One resin based partial denture, if provided at least three years after the seat date;
 - (q) One complete denture upper and lower, and one replacement denture per lifetime after at least five years from the seat date;
 - (r) Rebasement and relining of complete or partial dentures once in a three-year period, if performed at least six months from the seat date.

[Statutory Authority: RCW 48.02.060 and 48.43.715, WSR 14-09-080 (Matter No. R 2013-19), § 284-43-879, filed 4/18/14, effective 5/19/14. Statutory Authority: RCW 48.02.060, 48.21.241, 48.21.320, 48.44.050, 48.44.341,

(11/19/14)

48.44.460, 48.46.200, 48.46.291, 48.46.530, 48.43.715, and Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010) (PPACA), as amended by the Health Care and Education Reconciliation Act (HCERA), Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010), in particular § 1302 of PPACA, § 10104 (b)(1) (HCERA). WSR 13-15-025 (Matter No. R 2012-17), § 284-43-879, filed 7/9/13, effective 7/10/13.]

WAC 284-43-880 Pediatric vision services. A health benefit plan must include "pediatric vision services" in its essential health benefits package. The base-benchmark plan covers pediatric services for the categories set forth in WAC 284-43-878 (1) through (9), but does not include pediatric vision services. Pediatric vision services are vision services delivered to enrollees under age nineteen.

(1) A health benefit plan must cover pediatric vision services as an embedded set of services.

(2) **Supplementation:** The state EHB-benchmark plan requirements for pediatric vision benefits must be offered at a substantially equal level and classified consistent with the designated supplemental base-benchmark plan for pediatric vision services, the Federal Employees Vision Plan with the largest enrollment and published by the U.S. Department of Health and Human Services at www.cciioo.cms.gov on July 2, 2012.

(a) The vision services included in the pediatric vision services category are:

(i) Routine vision screening; and

(ii) A comprehensive eye exam for children, including dilation as professionally indicated and with refraction every calendar year;

(iii) One pair of prescription lenses or contacts every calendar year, including polycarbonate lenses and scratch resistant coating. Lenses may include single vision, conventional lined bifocal or conventional lined trifocal, or lenticular lenses;

(iv) One pair of frames every calendar year. An issuer may establish networks or tiers of frames within their plan design as long as there is a base set of frames to choose from available without cost sharing;

(v) Contact lenses covered once every calendar year in lieu of the lenses and frame benefits. Issuers must apply this limitation based on the manner in which the lenses must be dispensed. If disposable lenses are prescribed, a sufficient number and amount for one calendar year's equivalent must be covered. The benefit includes the evaluation, fitting and follow-up care relating to contact lenses. If determined to be medically necessary, contact lenses must be covered in lieu of eyeglasses at a minimum for the treatment of the following conditions: Keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, and irregular astigmatism;

(vi) Low vision optical devices including low vision services, training and instruction to maximize remaining usable vision as follows:

(A) One comprehensive low vision evaluation every five years;

(B) High power spectacles, magnifiers and telescopes as medically necessary, with reasonable limitations permitted; and

(C) Follow-up care of four visits in any five year period, with prior approval.

(b) The pediatric vision supplemental base-benchmark specifically excludes, and issuer must not include in its actuarial value for the category:

- (i) Visual therapy, which is otherwise covered under the medical/surgical benefits of the plan;
- (ii) Two pairs of glasses may not be ordered in lieu of bifocals;
- (iii) Medical treatment of eye disease or injury, which is otherwise covered under the medical/surgical benefits of the plan;
- (iv) Nonprescription (Plano) lenses; and
- (v) Prosthetic devices and services, which are otherwise covered under the rehabilitative and habilitative benefit category.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. WSR 14-23-092 (Matter No. R 2014-04), § 284-43-880, filed 11/19/14, effective 12/20/14. Statutory Authority: RCW 48.02.060, 48.21.241, 48.21.320, 48.44.050, 48.44.341, 48.44.460, 48.46.200, 48.46.291, 48.46.530, 48.43-715, and Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010) (PPACA), as amended by the Health Care and Education Reconciliation Act (HCERA), Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010), in particular § 1302 of PPACA, § 10104 (b)(1) (HCERA). WSR 13-15-025 (Matter No. R 2012-17), § 284-43-880, filed 7/9/13, effective 7/10/13.]

WAC 284-43-882 Plan cost-sharing and benefit substitutions and limitations. (1) A health benefit plan must not apply cost-sharing requirements to Native Americans purchasing a health benefit plan through the exchange, whose incomes are at or below three hundred percent of federal poverty level.

(2) A small group health benefit plan that includes the essential health benefits package may not impose annual cost-sharing or deductibles that exceed the maximum annual amounts that apply to high deductible plans linked to health savings accounts, as set forth in the most recent version of IRS Publication 969, pursuant to Section 106(c)(2) of the Internal Revenue Code of 1986, and Section 1302(c)(2) of PPACA.

(3) An issuer may use reasonable medical management techniques to control costs, including promoting the use of appropriate, high value preventive services, providers and settings. An issuer's policies must permit waiver of an otherwise applicable copayment for a service that is tied to one setting but not the preferred high-value setting, if the enrollee's provider determines that it would be medically inappropriate to have the service provided in the lower-value setting. An issuer may still apply applicable in-network requirements.

(4) An issuer may not require cost-sharing for preventive services delivered by network providers, specifically related to those with an A or B rating in the most recent recommendations of the United States Preventive Services Task Force, women's preventive health care services recommended by the U.S. Health Resources and Services Administration (HRSA) and HRSA Bright Futures guideline designated pediatric services. An issuer must post on its web site a list of the specific preventive and wellness services mandated by PPACA that it covers.

(5) If an issuer establishes cost-sharing levels, structures or tiers for specific essential health benefit categories, the cost-sharing levels, structures or tiers must not be discriminatory. "Cost-sharing" has the same meaning as set forth in RCW 48.43.005 and WAC 284-43-130(8).

(a) An issuer must not apply cost-sharing or coverage limitations differently to enrollees with chronic disease or complex underlying medical conditions than to other enrollees, unless the difference provides the enrollee with access to care and treatment commensurate with the enrollee's specific medical needs, without imposing a surcharge or other additional cost to the enrollee beyond normal cost-sharing requirements under the plan.

(b) An issuer must not establish a different cost-sharing structure for a specific benefit or tier for a benefit than is applied to the plan in general if the sole type of enrollee who would access that benefit or benefit tier is one with a chronic illness or medical condition.

[Statutory Authority: RCW 48.02.060, 48.21.241, 48.21.320, 48.44.050, 48.44.341, 48.44.460, 48.46.200, 48.46.291, 48.46.530, 48.43.715, and Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010) (PPACA), as amended by the Health Care and Education Reconciliation Act (HCERA), Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010), in particular § 1302 of PPACA, § 10104 (b)(1) (HCERA). WSR 13-15-025 (Matter No. R 2012-17), § 284-43-882, filed 7/9/13, effective 7/10/13.]

WAC 284-43-885 Representations regarding coverage. A health benefit plan issuer must not indicate or imply that a health benefit plan covers essential health benefits unless the plan, policy, or contract covers the essential health benefits in compliance with WAC 284-43-849 through 284-43-882. This requirement applies to any health benefit plan offered on or off the Washington health benefit exchange.

[Statutory Authority: RCW 48.02.060, 48.21.241, 48.21.320, 48.44.050, 48.44.341, 48.44.460, 48.46.200, 48.46.291, 48.46.530, 48.43.715, and Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010) (PPACA), as amended by the Health Care and Education Reconciliation Act (HCERA), Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010), in particular § 1302 of PPACA, § 10104 (b)(1) (HCERA). WSR 13-15-025 (Matter No. R 2012-17), § 284-43-885, filed 7/9/13, effective 7/10/13.]

WAC 284-43-899 Effective date. The effective date of WAC 284-43-130, 284-43-200, 284-43-251, 284-43-400, 284-43-410, 284-43-610, 284-43-615, 284-43-620, 284-43-630, and 284-43-820 is July 1, 2001.

[Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.100, 48.46.200, 48.43.505, 48.43.510, 48.43-515, 48.43.520, 48.43.525, 48.43.530, 48.43.535. WSR 01-03-033 (Matter No. R 2000-02), § 284-43-899, filed 1/9/01, effective 2/9/01.]

SUBCHAPTER I—HEALTH PLAN RATES

WAC 284-43-901 Authority and purpose. This subchapter is adopted under the general authority of RCW 48.02.060, 48.44.017, 48.44.020, 48.44.050, 48.46.060, 48.46.062, and 48.46.200. Its purpose is to provide guidelines for the implementation of RCW 48.44.017(2), 48.44.020(3), 48.44.022, 48.44.023, 48.44.040, 48.46.060 (4) and (6), 48.46.062(2), 48.46.064, and 48.46.066 as to the filing of contract forms by health care service contractors and health maintenance organizations and the calculations and evaluations of premium rates for these contracts.

[Statutory Authority: RCW 48.02.060, 48.18.110, 48.44.020, 48.44.050, 48.46.060, 48.46.200. WSR 08-20-071 (Matter No. R 2008-08), § 284-43-901, filed 9/25/08, effective 10/26/08.]

WAC 284-43-905 Applicability and scope. This subchapter applies to health benefit plans as defined in RCW 48.43.005, and contracts for limited health care services as defined in RCW 48.44.035, offered by health care service contractors and health maintenance organizations transacting business in this state under chapter 48.44 or 48.46 RCW. It applies to such plans purchased directly by individuals, small employers, large employers and other organizations.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. WSR 05-07-006 (Matter No. R 2004-05), § 284-43-905, filed 3/3/05, effective 4/3/05. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066. WSR 98-04-011 (Matter No. R 97-2), § 284-43-905, filed 1/23/98, effective 3/1/98.]

WAC 284-43-910 Definitions. For the purpose of this subchapter:

(1) "Adjusted earned premium" means the amount of "earned premium" the "carrier" would have earned had the "carrier" charged current "premium rates" for all applicable "plans."

(2) "Annualized earned premium" means the "earned premium" that would be earned in a twelve-month period if earned at the same rate as during the applicable period.

(3) "Anticipated loss ratio" means the "projected incurred claims" divided by the "projected earned premium."

(4) "Base rate" means the "premium" for a specific "plan," expressed as a monthly amount per "covered person or subscriber," prior to any adjustments for geographic area, age, family size, wellness activities, tenure, or any other factors as may be allowed.

(5) "Capitation expenses" means the amount paid to a provider or facility on a per "covered person" basis, or as part of risk-sharing provisions, for the coverage of specified health care services.

(6) "Carrier" means a health care service contractor or health maintenance organization.

(7) "Certificate" means the statement of coverage document furnished "subscribers" covered under a "group contract."

(8) "Claim reserves" means the "claims" that have been reported but not paid plus the "claims" that have not been reported but may be reasonably expected.

(9) "Claims" means the cost to the "carrier" of health care services provided to a "covered person" or paid to or on behalf of the "covered person" in accordance with the terms of a "plan." This includes "capitation payments" or other similar payments made to providers or facilities for the purpose of paying for health care services for a "covered person."

(10) "Community rate" means the weighted average of all "premium rates" within a filing with the weights determined according to current enrollment.

(11) "Contract" means an agreement to provide health care services or pay health care costs for or on behalf of a "subscriber" or group of "subscribers" and such eligible dependents as may be included therein.

(12) "Contract form" means the prototype of a "contract" and any associated riders and endorsements filed with the commissioner by a health care service contractor or health maintenance organization.

(13) "Contribution to surplus, contingency charges, or risk charges" means the portion of the "projected earned premium" not associated directly with "claims" or "expenses."

(14) "Covered person" or "enrollee" has the same meaning as that contained in RCW 48.43.005.

(15) "Current community rate" means the weighted average of the "community rates" at the renewal or initial effective dates of each plan for the year immediately preceding the renewal period, with weights determined according to current enrollment.

(16) "Current enrollment" means the monthly average number and demographic makeup of the "covered persons" for the applicable contracts during the most recent twelve months for which information is available to the carrier.

(17) "Earned premium" means the "premium" plus any rate credits or recoupments, applicable to an accounting period whether received before, during, or after such period.

(18) "Expenses" means costs that include but are not limited to the following:

(a) Claim adjudication costs;

(b) Utilization management costs if distinguishable from "claims";

(c) Home office and field overhead;

(d) Acquisition and selling costs;

(e) Taxes; and

(f) All other costs except "claims."

(19) "Experience period" means the most recent twelve-month period from which the carrier accumulates the data to support a filing.

(20) "Extraordinary expenses" means "expenses" resulting from occurrences atypical of the normal business activities of the "carrier" that are not expected to recur regularly in the near future.

(21) "Group contract" or "group plan" means an agreement issued to an employer, corporation, labor union, association, trust, or other organization to provide health care services to employees or members of such entities and the dependents of such employees or members.

(22) "Incurred claims" means "claims" paid during the applicable period plus the "claim reserves" as of the end of the applicable period minus the "claim reserves" as of the beginning of the applicable period. Alternatively, for the purpose of providing monthly data or trend analysis, "incurred claims" may be defined as the current best estimate of the "claims" for services provided during the applicable period.

(23) "Individual contract" means a "contract" issued to and covering an individual. An "individual contract" may include dependents.

(24) "Investment earnings" means the income, dividends, and realized capital gains earned on an asset.

(25) "Loss ratio" means "incurred claims" as a percentage of "earned premiums" before any deductions.

(26) "Medical care component of the consumer price index for all urban consumers" means the similarly named figure published monthly by the United States Bureau of Labor Statistics.

(27) "Net worth or reserves and unassigned funds" means the excess of assets over liabilities on a statutory basis.

(28) "Plan" means a "contract" that is a health benefit plan as defined in RCW 48.43.005 or a "contract" for limited health care services as defined in RCW 48.44.035.

(29) "Premium" has the same meaning as that contained in RCW 48.43.005.

(30) "Premium rate" means the "premium" per "subscriber" or "covered person" obtained by adjusting the "base rate" for geographic area, family size, age, wellness activities, or any other factors as may be allowed.

(31) "Projected earned premium" means the "earned premium" that would be derived from applying the proposed "premium rates" to the current enrollment.

(32) "Projected incurred claims" means the estimate of "incurred claims" for the rate renewal period based on the current enrollment.

(33) "Proposed community rate" means the weighted average of the "community rates" at the renewal dates of each plan for the renewal period, with weights determined according to current enrollment.

(34) "Provider" has the same meaning as that contained in RCW 48.43.005.

(35) "Rate renewal period" means the period for which the proposed "premium rates" are intended to remain in effect.

(36) "Rate schedule" means the schedule of all "base rates" for "plans" included in the filing.

(37) "Requested increase in the community rate" means the amount, expressed as a percentage, by which the "proposed community rate" exceeds the "current community rate."

(38) "Service type" means the category of service for which "claims" are paid, such as hospital, professional, dental, prescription drug, or other.

(39) "Small group contracts" or "small group plans" means the class of "group contracts" issued to "small employers," as that term is defined in RCW 48.43.005.

(40) "Staffing data" means statistics on the number of providers and associated compensation required to provide a fixed number of services or provide services to a fixed number of "covered persons."

(41) "Subscriber" means a person on whose behalf a "contract" or "certificate" is issued.

(42) "Unit cost data" means statistics on the cost per health care service provided to a "covered person."

(43) "Utilization data" means statistics on the number of services used by a fixed number of "covered persons" over a fixed length of time.

[Statutory Authority: RCW 48.02.060, 48.18.110, 48.44.020, 48.44.050, 48.46.060, 48.46.200. WSR 08-20-071 (Matter No. R 2008-08), § 284-43-910, filed 9/25/08, effective 10/26/08. Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. WSR 05-07-006 (Matter No. R 2004-05), § 284-43-910, filed 3/3/05, effective 4/3/05. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066. WSR 98-04-011 (Matter No. R 97-2), § 284-43-910, filed 1/23/98, effective 3/1/98.]

WAC 284-43-915 Demonstration that benefits provided are not reasonable in relation to the amount charged for a contract per RCW 48.44.020 and 48.46.060.

(1) The provisions of this section are in addition to the requirements set forth in RCW 48.44.022, 48.44.023, 48.46.064, and 48.46.066.

(2) Benefits will be found not to be unreasonable if the projected earned premium for the rate renewal period is equal to the following:

(a) An actuarially sound estimate of incurred claims associated with the filing for the rate renewal period, where the actuarial estimate of claims recognizes, as applicable, the savings and costs associated with managed care provisions of the plans included in the filing; plus

(b) An actuarially sound estimate of prudently incurred expenses associated with the plans included in the filing for the rate renewal period, where the estimate is based on an equitable and consistent expense allocation or assignment methodology; plus

(c) An actuarially sound provision for contribution to surplus, contingency charges, or risk charges, where the justification recognizes the carrier's investment earnings on assets other than those related to claim reserves or other similar liabilities; minus

(d) An actuarially sound estimate of the forecasted investment earnings on assets related to claim reserves or other similar liabilities for the plans included in the filing for the rate renewal period.

(3) The contribution to surplus, contingency charges, or risk charges in subsection (2)(c) of this section, will not be required to be less than zero.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. WSR 05-07-006 (Matter No. R 2004-05), § 284-43-915, filed 3/3/05, effective 4/3/05. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066. WSR 98-04-011 (Matter No. R 97-2), § 284-43-915, filed 1/23/98, effective 3/1/98.]

WAC 284-43-920 When a carrier is required to file.

(1) Carriers must file with the commissioner every contract form and rate schedule and modification of a contract form and rate schedule:

(a) Before the contract form is offered for sale to the public and before the rate schedule is used; and

(b) Within thirty days after the end of an eighteen-month period during which a previous filing has remained unchanged for such period, including contract forms filed prior to the effective date of this regulation.

(2) Filings of negotiated contract forms, and applicable rate schedules, that are placed into effect at time of negotiation or that have a retroactive effective date are not required to be filed in accordance with subsection (1)(a) and (b) of this section, but must be filed within thirty working days after the earlier of:

(a) The date group contract negotiations are completed; or

(b) The date renewal premiums are implemented.

(3) An explanation for any filing delayed beyond the thirty-day period as described in subsection (2) of this section must be given on the filing document as set forth in WAC 284-43-950.

(4) If written confirmation of the commissioner's final action is desired, the carrier must submit with the filing duplicate copies of the filing transmittal and cover letter, along with a return self-addressed, stamped envelope. The duplicate transmittal will note the commissioner's final action and will be returned to the sender in the return envelope enclosed with the filing.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. WSR 05-07-006 (Matter No. R 2004-05), § 284-43-920, filed 3/3/05, effective 4/3/05. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020

(2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066. WSR 98-04-011 (Matter No. R 97-2), § 284-43-920, filed 1/23/98, effective 3/1/98.]

WAC 284-43-925 General contents of all filings. Each filing required by WAC 284-43-920 must be submitted with the filing transmittal form prescribed by and available from the commissioner. The form must include the name of the filing entity, its address, identification number, the type of filing being submitted, the form name or group name and number, and other relevant information. Filings also must include the information required on the filing summary set forth in WAC 284-43-945 for individual and small group plans and rate schedules or as set forth in WAC 284-43-950 for group plans and rate schedules other than those for small groups.

[Statutory Authority: RCW 48.02.060, 48.18.110, 48.44.020, 48.44.050, 48.46.060, 48.46.200. WSR 08-20-071 (Matter No. R 2008-08), § 284-43-925, filed 9/25/08, effective 10/26/08. Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. WSR 05-07-006 (Matter No. R 2004-05), § 284-43-925, filed 3/3/05, effective 4/3/05. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066. WSR 98-04-011 (Matter No. R 97-2), § 284-43-925, filed 1/23/98, effective 3/1/98.]

WAC 284-43-930 Contents of individual and small group filings. Under RCW 48.44.022 and 48.46.064 the experience of all individual plans must be pooled. Under RCW 48.44.023 and 48.46.066 the experience of all small group plans must be pooled. Filings for individual plans must include each individual plan rate schedule. Filings for small group plans must include base rates and annual base rate changes in dollar and percentage amounts for each small group plan. Each individual and small group filing must include the following information and documents:

(1) An actuarially sound estimate of incurred claims. Experience data, assumptions, and justifications of the carrier's projected incurred claims must be provided in a manner consistent with the carrier's rate-making methodology and incorporate the following elements:

(a) A brief description of the carrier's rate-making methodology, including identification of the data used and the kinds of assumptions and projections made.

(b) The number of subscribers by family size, or covered persons for the plans included in the filing. These figures must be shown for each month or quarter of the experience period and the prior two periods if not included in previous filings. This data must be presented in aggregate for the plans included in the filing and in aggregate for all of the carrier's plans.

(c) Earned premium for each month or quarter of the experience period and the prior two periods if not included in previous filings, for the plans included in the filing.

(d) An estimate of the adjusted earned premium for each month or quarter of the experience period and prior two periods for the plans included in the filing.

(e) Claims data for each month or quarter of the experience period and the prior two periods. Examples of claims data are incurred claims, capitation payments, utilization data, unit cost data, and staffing data. The specific data elements included in the filing must be consistent with the carrier's rate-making methodology.

(f) Documentation and justification of any adjustments made to the experience data.

(g) Documentation and justification of the factors and methods used to forecast incurred claims.

(2) An actuarially sound estimate of prudently incurred expenses. Experience data, assumptions, and justifications must be provided by the carrier as follows:

(a) A breakdown of the carrier's expenses allocated or assigned to the plans included in the filing for the experience period or for the period corresponding to the most recent "annual statement";

(i) An expense breakdown at least as detailed as the annual statement schedule "Underwriting and Investment Exhibit, Part 3, Analysis of Expenses" as revised from time to time;

(ii) The allocation and assignment methodology used in (a)(i) of this subsection may be based on readily available data and easily applied calculations;

(b) Identification of any extraordinary experience period expenses; and

(c) Documentation and justification of the assignment or allocation of expenses to the plans included in the filing; and

(d) Documentation and justification of forecasted changes in expenses.

(3) An actuarially sound provision for contribution to surplus, contingency charges, or risk charges. Assumptions and justifications must be provided by the carrier as follows:

(a) The methodology, justification, and calculations used to determine the contribution to surplus, contingency charges, or risk charges included in the proposed base rates; and

(b) The carrier's net worth or reserves and unassigned surplus at the beginning and end of the experience period.

(4) An actuarially sound estimate of forecasted investment earnings on assets related to claim reserves or other similar liabilities. The carrier must include documentation and justification of forecasted investment earnings identified in dollars, and as a percentage of total premiums and the amount credited to the plans included in the filing.

(5) Adjustment of the base rate. Experience data, assumptions, justifications, and methodology descriptions must be provided and must include:

(a) Justifications for adjustments to the base rate, supported by data if appropriate, attributable to geographic region, age, family size, tenure discounts, and wellness activities;

(b) Justifications, supported by data if appropriate, of any other factors or circumstances used to adjust the base rates; and

(c) Description of the methodology used to adjust the base rate to obtain the premium rate for a specific individual or group, which is detailed enough to allow the commissioner to replicate the calculation of premium rates if given the necessary data.

(6) Actuarial certification. Certification by an actuary, as required by RCW 48.44.017(2), 48.44.023(3), 48.46.062(2) and 48.46.066(3).

(7) The requirements of subsections (1) through (6) of this section may be waived or modified upon the finding by the commissioner that a plan contains or involves unique pro-

visions or circumstances and that the requirements represent an extraordinary administrative burden on the carrier.

[Statutory Authority: RCW 48.02.060, 48.18.110, 48.44.020, 48.44.050, 48.46.060, 48.46.200. WSR 08-20-071 (Matter No. R 2008-08), § 284-43-930, filed 9/25/08, effective 10/26/08. Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. WSR 05-07-006 (Matter No. R 2004-05), § 284-43-930, filed 3/3/05, effective 4/3/05. Statutory Authority: RCW 48.02.060 and 48.92.140. WSR 98-11-089 (Matter No. R 98-8), § 284-43-930, filed 5/20/98, effective 6/20/98. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066. WSR 98-04-011 (Matter No. R 97-2), § 284-43-930, filed 1/23/98, effective 3/1/98.]

WAC 284-43-935 Experience records. (1) For each plan, carriers must maintain the following records for five years:

- (a) Incurred claims;
- (b) Earned premiums; and
- (c) Expenses.

(2) Such records must include data for rider and endorsement forms that are used with the contract forms. Separate data may be maintained for each rider or endorsement form as appropriate. For recordkeeping purposes, carriers may combine experience under contract forms that provide substantially similar coverage.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. WSR 05-07-006 (Matter No. R 2004-05), § 284-43-935, filed 3/3/05, effective 4/3/05. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066. WSR 98-04-011 (Matter No. R 97-2), § 284-43-935, filed 1/23/98, effective 3/1/98.]

WAC 284-43-940 Evaluating experience data. In determining the credibility and appropriateness of experience data, consideration will be given to all relevant factors, including:

- (1) Statistical credibility of the amount charged and services and benefits paid, such as low exposure, low loss frequency, and recoupment;
- (2) Actual and projected trends relative to changes in medical costs and changes in utilization;
- (3) The mix of business by risk classification; and
- (4) Adverse selection or lapse factors reasonably expected in connection with revisions to plan provisions, services, benefits, and amount charged.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. WSR 05-07-006 (Matter No. R 2004-05), § 284-43-940, filed 3/3/05, effective 4/3/05. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066. WSR 98-04-011 (Matter No. R 97-2), § 284-43-940, filed 1/23/98, effective 3/1/98.]

WAC 284-43-945 Summary for individual and small group contract filings.

INDIVIDUAL AND SMALL GROUP FILING SUMMARY

Carrier Name _____
Address _____

Carrier Identification Number _____

Rate Renewal Period:	From _____	To _____
Date Submitted:	_____	

Proposed Rate Summary

Current community rate	per month
Proposed community rate	per month
Percentage change	%
Portion of carrier's total enrollment affected	%
Portion of carrier's total premium revenue affected	%

Components of Proposed Community Rate

	Dollars Per Month	% of Total
a) Claims		
b) Expenses		
c) Contribution to surplus, contingency charges, or risk charges		
d) Investment earnings		
e) Total (a + b + c - d)		

Summary of Pooled Experience

	Experience Period	First Prior Period	Second Prior Period
	From To	From To	From To
Member Months			
Earned Premium			
Paid Claims			
Beginning Claim Reserve			
Ending Claim Reserve			
Incurred Claims			
Expenses			
Gain/Loss			
Loss Ratio Percentage			

General Information

1. Trend Factor Summary

Type of Service	Annual Trend Assumed	Portion of Claim Dollars
Hospital	%	%
Professional	%	%
Prescription Drugs	%	%
Dental	%	%
Other	%	%

2. List the effective date and the rate of increase for all rate changes in the past three rate periods.

1) _____ 2) _____ 3) _____
 Date % Date % Date %

3. Since the previous filing, have any changes been made to the factors or methodology for adjusting base rates?

- Geographic Area Yes No
- Family Size Yes No
- Age Yes No
- Wellness Activities Yes No
- Other (specify) Yes No

4. Attach a table showing the base rate for each plan affected by this filing.

5. Attach comments or additional information.

6. Preparer's Information

Name: _____

Title: _____

Telephone Number: _____

[Statutory Authority: RCW 48.02.060, 48.18.110, 48.44.020, 48.44.050, 48.46.060, 48.46.200. WSR 08-20-071 (Matter No. R 2008-08), § 284-43-945, filed 9/25/08, effective 10/26/08. Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. WSR 05-07-006 (Matter No. R 2004-05), § 284-43-945, filed 3/3/05, effective 4/3/05. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066. WSR 98-04-011 (Matter No. R 97-2), § 284-43-945, filed 1/23/98, effective 3/1/98.]

WAC 284-43-950 Summary for group contract filings other than small group contract filings.

GROUPS OTHER THAN SMALL GROUPS FILING SUMMARY

Carrier Name	_____
Address	_____
Contract Holder/Pool Category and Name (Check One Box)	<input type="checkbox"/> Single Employer Group:
	Employer Name: _____
	<input type="checkbox"/> Multiemployer other than Association/Trust Groups
	Group Pool Name: _____
	<input type="checkbox"/> Association/Trust Groups
	Association/Trust Group Name: _____
Contract Form Number	_____
Rate Form Number (if different from Contract Form Number)	_____
Product Name	_____

If additional space is required to list the contract/rate form number and product name, attach a separate sheet.

Rate Renewal Period:	From: _____	To: _____
Date Submitted:	_____	
Type of Filing (Check One Box)	<input type="checkbox"/> New Group Contract	<input type="checkbox"/> Revision of Existing Group Contract

Proposed Rate Schedules: Attach a separate sheet to list all proposed tier rates.

Rate Summary

Current Rate (Composite per employee or per member)	\$ _____ per member per month
Percentage Rate Change	_____ %

New Rate	\$ _____ per member per month
Average Number of Enrollees Each Month During the Experience Period (If the average number of enrollees is equal to or less than fifty, explain why this is not a small group, as defined in RCW 48.43.005.)	_____
Anticipated Loss Ratio	_____ %
Portion of carrier's total enrollment affected	_____ %
Portion of carrier's total premium revenue affected	_____ %

Summary of Contract Experience

	Experience Period	First Prior Period	Second Prior Period
	From To	From To	From To
Member Months			
Billed Premium			
Incurred Claims			
Expenses			
Gain/Loss			
Experience Refund/Credit or Recoupment			
Earned Premium (Billed Premium - /+ Refund/Credit or Recoupment)			
Loss Ratio Percentage			

Attach comments or additional information.
Preparer's Information
Name: _____
Title: _____
Telephone Number: _____

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. WSR 05-07-006 (Matter No. R 2004-05), § 284-43-950, filed 3/3/05, effective 4/3/05. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066. WSR 98-04-011 (Matter No. R 97-2), § 284-43-950, filed 1/23/98, effective 3/1/98.]

SUBCHAPTER K

MENTAL HEALTH AND SUBSTANCE USE DISORDER

WAC 284-43-990 Scope and intent—Parity in mental health and substance use disorder benefits. This subchapter applies to all health plans and issuers. The purpose of this rule is to consolidate existing state mental health and chemical dependency regulation with federal mental health and substance use disorder parity requirements into state regulation. This rule also provides health plans and issuers with the method of demonstrating compliance with these requirements.

[Statutory Authority: RCW 48.02.060, 48.43.715, 48.44.050, 48.46.200 and Paul Wellstone and Pete Domenici Mental Health Parity and Addiction

Equity Act of 2008, Pub. L. 110-343, WSR 14-23-057 (Matter No. R 2012-29), § 284-43-990, filed 11/17/14, effective 12/18/14.]

WAC 284-43-991 Definitions. Aggregate lifetime limit means a dollar limitation on the total amount of specified benefits that may be paid under a health plan (or health insurance coverage offered in connection with a plan) for any coverage unit.

Annual dollar limit means a dollar limitation on the total amount of specified benefits that may be paid in a twelve-month period under a health plan (or health insurance coverage offered in connection with a plan) for any coverage unit.

Approved treatment program means a discrete program of chemical dependency treatment provided by a treatment program certified by the department of social and health services as meeting standards adopted under chapter 70.96A RCW.

Chemical dependency professional means a person certified as a chemical dependency professional by the Washington state department of health under chapter 18.205 RCW.

Classification of benefits means a group into which all medical/surgical benefits and mental health or substance use disorder benefits offered by a health plan must fall. For the purposes of this rule, the only classifications that may be used are: Inpatient, in-network; inpatient, out-of-network; outpatient, in-network; outpatient, out-of-network; emergency care; and prescription drugs.

Coverage unit means the way in which a health plan or issuer groups individuals for purposes of determining benefits, or premiums or contributions. For example, different coverage units include self-only, family, and employee-plus-spouse.

Cumulative financial requirements means financial requirements that determine whether or to what extent benefits are provided based on accumulated amounts and include deductibles and out-of-pocket maximums. Financial requirements do not include aggregate lifetime or annual dollar limits.

Cumulative quantitative treatment limitations means treatment limitations that determine whether or to what extent benefits are provided based on accumulated amounts, such as annual or lifetime day or visit limits.

Emergency condition, for the purpose of this subchapter, means a condition manifesting itself by acute symptoms of sufficient severity, including severe emotional or physical distress or a combination of severe emotional and physical distress, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical or mental health attention to result in a condition 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.

Essential health benefits (EHBs). EHBs have the same definition as found in WAC 284-43-865. The definition of EHBs includes mental health and substance use disorder services, including behavioral health treatment. For EHBs, including mental health and substance use disorder benefits, federal and state law prohibit limitations or age, condition, lifetime and annual dollar amounts.

Financial requirements means cost sharing measures such as deductibles, copayments, coinsurance, and out-of-pocket maximums. Financial requirements do not include aggregate lifetime or annual dollar limits.

Health carrier or issuer has the same meaning as RCW 48.43.005(25).

Health plan has the same meaning as RCW 48.43.005(26).

Medical/surgical benefits means benefits with respect to items or services for medical conditions or surgical procedures, as defined under the terms of the plan or health insurance coverage and in accordance with applicable federal and state law, but does not include mental health or substance use disorder benefits. Any condition defined by the plan or coverage as being or as not being a medical/surgical condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the *International Classification of Diseases* (ICD) or state guidelines).

Medically necessary or medical necessity:

(a) With regard to chemical dependency and substance use disorder is defined by the most recent version of *The ASAM Criteria, Treatment Criteria for Addictive, Substance Related, and Co-Occurring Conditions* as published by the American Society of Addiction Medicine (ASAM).

(b) With regard to mental health services, pharmacy services, and any substance use disorder benefits not governed by ASAM, is a carrier determination as to whether a health service is a covered benefit because the service is consistent with generally recognized standards within a relevant health profession.

Mental health benefits means benefits with respect to items or services for mental health conditions, as defined under the terms of the plan or health insurance coverage and in accordance with applicable federal and state law. Any condition defined by the plan or coverage as being or as not being a mental health condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), the most current version of the *International Classification of Diseases* (ICD), or state guidelines).

Nonquantitative treatment limitations (NQTL) means processes, strategies, or evidentiary standards, or other factors that are not expressed numerically, but otherwise limit the scope or duration of benefits for treatment. NQTLs include, but are not limited to:

(a) Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;

(b) Formulary design for prescription drugs;

(c) For plans with multiple network tiers (such as preferred providers and participating providers), network tier design;

(d) Standards for provider admission to participate in a network, including reimbursement rates;

(e) Plan methods for determining usual, customary, and reasonable charges;

(f) Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols);

(g) Exclusions based on failure to complete a course of treatment; and

(h) Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage.

Predominant level: If a type of financial requirement or quantitative treatment limitation applies to substantially all medical surgical benefits in a classification, the predominant level is the level that applies to more than one-half of the medical/surgical benefits in that classification subject to the financial requirement or quantitative treatment limitation.

Quantitative parity analysis means a mathematical test by which plans and issuers determine what level of a financial requirement or quantitative treatment limitation, if any, is the most restrictive level that could be imposed on mental health or substance use disorder benefits within a classification.

Quantitative treatment limitations means types of objectively quantifiable treatment limitations such as frequency of treatments, number of visits, days of coverage, days in a waiting period or other similar limits on the scope or duration of treatment.

Substance use disorder includes illness characterized by a physiological or psychological dependency, or both, on a controlled substance regulated under chapter 69.50 RCW and/or alcoholic beverages. It is further characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially impaired or endangered or his or her social or economic function is substantially disrupted. Any disorder defined by the plan as being or as not being a substance use disorder must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the DSM, the most current version of the ICD, or state guidelines).

Substance use disorder benefits means benefits with respect to items or services for substance use disorders, as defined under the terms of the plan or health insurance coverage and in accordance with applicable federal and state law. Substance use disorder benefits must include payment for reasonable charges for medically necessary treatment and supporting service rendered to an enrollee either within an approved treatment program or by a health care professional that meets the requirements of RCW 18.205.040(2), as part of the approved treatment plan.

Substantially all: A type of financial requirement or quantitative treatment limitation considered to apply to substantially all medical/surgical benefits in a classification of benefits if it applies to at least two-thirds of all medical/surgical benefits in that classification as determined by WAC 284-43-993 (2)(a).

Treatment limitations means limits on benefits based on the frequency of treatment, number of visits, days of cov-

erage, days in a waiting period, or other similar limits on the scope or duration of treatment. Treatment limitations include both quantitative treatment limitations, which are expressed numerically (such as fifty outpatient visits per year), and non-quantitative treatment limitations, which otherwise limit the scope or duration of benefits for treatment under a plan or coverage. A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation for purposes of this section.

[Statutory Authority: RCW 48.02.060, 48.43.715, 48.44.050, 48.46.200 and Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. 110-343, WSR 14-23-057 (Matter No. R 2012-29), § 284-43-991, filed 11/17/14, effective 12/18/14.]

WAC 284-43-992 Classification of benefits. (1) A health plan providing mental health or substance use disorder benefits, must provide mental health or substance use disorder benefits in every classification in which medical/surgical benefits are provided.

(2) Parity requirements must be applied to the following six classifications of benefits: Inpatient, in-network; inpatient, out-of-network; outpatient, in-network; outpatient, out-of-network; emergency care; and prescription drugs. These are the only classifications of benefits that can be used.

(a) **Inpatient, in-network.** Benefits furnished on an inpatient basis and within a network of providers established or recognized under a plan or health insurance coverage.

(b) **Inpatient, out-of-network.** Benefits furnished on an inpatient basis and outside any network of providers established or recognized under a plan or health insurance coverage. This classification includes inpatient benefits under a plan (or health insurance coverage) that has no network of providers.

(c) **Outpatient, in-network.** Benefits furnished on an outpatient basis and within a network of providers established or recognized under a plan or health insurance coverage.

(d) **Outpatient, out-of-network.** Benefits furnished on an outpatient basis and outside any network of providers established or recognized under a plan or health insurance coverage. This classification includes outpatient benefits under a plan (or health insurance coverage) that has no network of providers.

(e) **Emergency care.** Benefits for treatment of an emergency condition related to a mental health or substance use disorder. Such benefits must comply with the requirements for emergency medical services in RCW 48.43.093. Medically necessary detoxification must be covered as an emergency medical condition according to RCW 48.43.093, and may be provided in hospitals licensed under chapter 70.41 RCW. Medically necessary detoxification services must not require prenotification.

(f) **Prescription drugs.** Benefits for prescription drugs.

(3) In determining the classification in which a particular benefit belongs, a plan must apply the same standards to medical/surgical benefits as applied to mental health or substance use disorder benefits.

An issuer or health plan must assign covered intermediate mental health/substance use disorder benefits such as residential treatment, partial hospitalization, and intensive outpatient treatment, to the existing six classifications in the

same way that they assign comparable intermediate medical/surgical benefits to these classifications. For example, if a health plan classifies medical care in skilled nursing facilities as inpatient benefits, then it must also treat covered mental health care in residential treatment facilities as inpatient benefits. If a health plan or issuer treats home health care as an outpatient benefit, then any covered intensive outpatient mental health or substance use disorder services and partial hospitalization must be considered outpatient benefits as well.

(4) A health plan or issuer may not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits that is more restrictive than the predominant financial requirement or treatment limitation applied to medical/surgical benefits. This parity analysis must be done on a classification-by-classification basis.

(5) Medical/surgical benefits and mental health or substance use disorder benefits cannot be categorized as being offered outside of these six classifications and therefore not subject to the parity analysis.

(a) A health plan or issuer must treat the least restrictive level of the financial requirement or quantitative treatment limitation that applies to at least two-thirds of medical/surgical benefits across all provider tiers in a classification as the predominant level that it may apply to mental health or substance use disorder benefits in the same classification.

(b) If a health plan or issuer classifies providers into tiers, and varies cost-sharing based on the different tiers, the criteria for classification must be applied to generalists and specialists providing mental health or substance use disorder services no more restrictively than such criteria are applied to medical/surgical benefit providers.

(6) Permitted subclassifications:

(a) A health plan or issuer is permitted to divide benefits furnished on an outpatient basis into two subclassifications:

- (i) Office visits; and
- (ii) All other outpatient items and services.

(b) A health plan or issuer may divide its benefits furnished on an in-network basis into subclassifications that reflect network tiers, if the tiering is based on reasonable factors and without regard to whether a provider is a mental health or substance use disorder provider or a medical/surgical provider.

(c) After network tiers are established, the health plan or issuer may not impose any financial requirement or treatment limitation on mental health or substance use disorder benefits in any tier that is more restrictive than the predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in that tier.

(d) If a health plan applies different levels of financial requirements to different tiers of prescription drug benefits based on reasonable factors and without regard to whether a drug is generally prescribed with respect to medical/surgical benefits or with respect to mental health/substance use disorder benefits, the health plan satisfies the parity requirements with respect to prescription drug benefits. Reasonable factors include: Cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up.

(e) A parity analysis applying the financial requirement and treatment rules found in WAC 284-43-993 and 284-43-994 must be performed within each subclassification.

(7) **Prohibited subclassifications:** All subclassifications other than the permitted subclassification listed in subsection (6) of this section are specifically prohibited. For example, a plan is prohibited from basing a subclassification on generalists and specialists.

[Statutory Authority: RCW 48.02.060, 48.43.715, 48.44.050, 48.46.200 and Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. 110-343, WSR 14-23-057 (Matter No. R 2012-29), § 284-43-992, filed 11/17/14, effective 12/18/14.]

WAC 284-43-993 Measuring health plan benefits—Financial requirements and quantitative treatment limitations. (1) Classification of benefits must be measured as follows:

(a) By type and level of financial requirement or treatment limitation.

(i) A financial requirement or treatment limitation type includes deductibles, copayments, coinsurance, and out-of-pocket maximums. Types of quantitative treatment limitations include annual, episode, and lifetime day and visit limits.

(ii) A financial requirement or treatment limitation level includes the amount of the financial requirement or treatment limitation type. For example, different levels of coinsurance include twenty percent and thirty percent; different levels of a copayment include fifteen dollars and twenty dollars; different levels of a deductible include two hundred fifty dollars and five hundred dollars; and different levels of an episode limit include twenty-one inpatient days per episode and thirty inpatient days per episode.

(b) A health plan or issuer may not apply any financial requirement or quantitative treatment limitation to mental health/substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or quantitative treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification. Whether a financial requirement or treatment limitation is a predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in a classification is determined separately for each type of financial requirement or treatment limitation.

(c) The determination of the portion of medical/surgical benefits in a classification of benefits subject to a financial requirement or quantitative treatment limitation (or subject to any level of a financial requirement or quantitative treatment limitation) is based on the dollar amount of all plan payments for medical/surgical benefits in the classification expected to be paid under the health plan for the plan year.

(i) The dollar amount of plan payments is based on the amount the plan allows (before enrollee cost sharing) rather than the amount the plan pays (after enrollee cost sharing) because payment based on the allowed amount covers the full scope of the benefits being provided.

(ii) A reasonable actuarial method must be used to determine the dollar amount expected to be paid under a plan for medical/surgical benefits subject to a financial requirement or quantitative treatment limitation.

(d) Clarifications for certain threshold requirements when performing "substantially all" and "predominant" tests.

(i) For any deductible, the dollar amount of plan payments includes all plan payments with respect to claims that would be subject to the deductible if it had not been satisfied.

(ii) For any out-of-pocket maximum, the dollar amount of plan payments includes all plan payments associated with out-of-pocket payments that are taken into account towards the out-of-pocket maximum as well as all plan payments associated with out-of-pocket payments that would have been made towards the out-of-pocket maximum if it had not been satisfied.

(iii) Similar rules apply for any other thresholds at which the rate of plan payment changes.

(2) Application to different coverage units. If a health plan or insurer applies different levels of a financial requirement or quantitative treatment limitation to different coverage units in a classification of medical/surgical benefits, the "predominant" level that applies to "substantially all" medical/surgical benefits in the classification is determined separately for each coverage unit.

(a) Determining "substantially all": A type of financial requirement or quantitative treatment limitation is considered to apply to substantially all medical/surgical benefits in a classification of benefits if it applies to at least two-thirds of all medical/surgical benefits in that classification.

(i) Benefits subject to a zero level for a type of financial requirement are treated as benefits not subject to that type of financial requirement. Benefits with no quantitative treatment limitations are treated as benefits not subject to that type of quantitative treatment limitation.

(ii) If a type of financial requirement or quantitative treatment limitation does not apply to at least two-thirds of all medical/surgical benefits in a classification, the financial requirement or quantitative treatment limitation of that type cannot be applied to mental health or substance use disorder benefits in that classification.

(b) Determining "predominant":

(i) If a type of financial requirement or quantitative treatment limitation applies to at least two-thirds of all medical/surgical benefits in a classification as determined under (a) of this subsection, the level of the financial requirement or quantitative treatment limitation that applies to more than one-half of medical/surgical benefits in that classification subject to the financial requirement or quantitative treatment limitation is the predominant level of that type in a classification of benefits.

(ii) If a type of financial requirement or quantitative treatment limitation applies to at least two-thirds of all medical/surgical benefits in a classification and there is no single level that applies to more than one-half of medical/surgical benefits in the classification subject to the financial requirement or quantitative treatment limitation, the health plan or issuer must combine levels until the combination of levels applies to more than one-half of medical/surgical benefits subject to the financial requirement or quantitative treatment limitation in the classification.

(iii) The least restrictive level within the combination is considered the predominant level of that type in the classification. (For this purpose, a health plan must combine the most restrictive levels first, with each less restrictive level added to the combination until the combination applies to

more than one-half of the benefits subject to the financial requirement or treatment limitation.)

(3) Cumulative financial requirements and cumulative quantitative treatment limitations.

(a) A health plan or issuer may not apply cumulative financial requirements (such as deductibles and out-of-pocket maximums) or cumulative quantitative treatment limitations (such as annual or lifetime day or visit limits) for mental health or substance use disorder benefits in a classification that accumulate separately from any cumulative requirement or limitation established for medical/surgical benefits in the same classification.

(b) Cumulative requirements and limitation must also satisfy the quantitative parity analysis.

[Statutory Authority: RCW 48.02.060, 48.43.715, 48.44.050, 48.46.200 and Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. 110-343. WSR 14-23-057 (Matter No. R 2012-29), § 284-43-993, filed 11/17/14, effective 12/18/14.]

WAC 284-43-994 Measuring health plan benefits—Nonquantitative treatment limitations. (1) A health plan or issuer may not impose an NQTL with respect to mental health or substance use disorder in any classification unless, under the terms of the health plan as written and in operation, any processes, strategies, evidentiary standards or other factors used in applying the NQTL to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the same classification.

(2) All health plan standards, such as in-and-out-of-network geographic limitations, limitations on inpatient services for situations where the participant is a threat to self or others, exclusions for court-ordered and involuntary holds, experimental treatment limitations, service coding, exclusions for services provided by clinical social workers, and network adequacy, while not specifically enumerated in the illustrative list of NQTLs must be applied in a manner that complies with this subsection.

[Statutory Authority: RCW 48.02.060, 48.43.715, 48.44.050, 48.46.200 and Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. 110-343. WSR 14-23-057 (Matter No. R 2012-29), § 284-43-994, filed 11/17/14, effective 12/18/14.]

WAC 284-43-995 Prohibited exclusions. (1) Benefits for actual treatment and services rendered may not be denied solely because a course of treatment was interrupted or was not completed.

(2) If a service is prescribed for a mental health condition and is medically necessary, it may not be denied solely on the basis that it is part of a category of services or benefits that is excluded by the terms of the contract.

(3) Benefits for mental health services and substance use disorder may not be limited or denied based solely on age or condition.

(4) Nothing in this section relieves a health plan or an issuer from its obligations to pay for a court ordered substance use disorder benefit or mental health benefit when it is medically necessary.

[Statutory Authority: RCW 48.02.060, 48.43.715, 48.44.050, 48.46.200 and Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. 110-343. WSR 14-23-057 (Matter No. R 2012-29), § 284-43-995, filed 11/17/14, effective 12/18/14.]

WAC 284-43-996 Required disclosures. (1) Health plans and issuers must provide reasonable access to and copies of all documents, records, and other information relevant to an individual's claim. Health plans and issuers must provide disclosures consistent with WAC 284-43-620, 284-43-515, 284-43-525, and 284-43-410, within a reasonable time.

(2) Health plans and issuers must provide the criteria, processes, strategies, evidentiary standards and other factors used to make medical necessity determinations of mental health or substance use disorder benefits. These must be made available free of charge by the health plan issuer to any current or potential participant, beneficiary, or contracting provider upon request, within a reasonable time in compliance with WAC 284-43-410, and in a manner that provides reasonable access to the requestor. This requirement includes information on the processes, strategies, evidentiary standards, and other factors used to apply an NQTL with respect to medical/surgical and mental health or substance use disorder benefits under the health plan.

(3) The reason for any adverse benefit decision for mental health or substance use disorder benefits must be provided with the notification of the adverse benefit decision.

(4) Compliance with these disclosure requirements is not determinative of compliance with any other provisions of applicable federal or state law.

(5) If a health plan is subject to ERISA, it must provide the reason for the claim denial in a form and manner consistent with the requirements of 29 C.F.R. 2560.503-1.

[Statutory Authority: RCW 48.02.060, 48.43.715, 48.44.050, 48.46.200 and Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. 110-343. WSR 14-23-057 (Matter No. R 2012-29), § 284-43-996, filed 11/17/14, effective 12/18/14.]

WAC 284-43-997 Compliance and reporting of quantitative parity analysis. (1) Health plans and issuers must file a justification demonstrating the analysis of each plan's financial requirements and quantitative treatment limitations as required under WAC 284-43-993.

(2) Filing of this justification is subject to the requirements of chapters 284-44A, 284-46A, and 284-58 WAC and may be rejected and closed if it does not comply.

[Statutory Authority: RCW 48.02.060, 48.43.715, 48.44.050, 48.46.200 and Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. 110-343. WSR 14-23-057 (Matter No. R 2012-29), § 284-43-997, filed 11/17/14, effective 12/18/14.]