WAC 284-43-5800 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 website 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 284-43-0160(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. WSR 16-14-106 (Matter No. R 2016-11), § 284-43-5800, filed 7/6/16, effective 8/6/16. WSR 16-01-081, recodified as § 284-43-5800, filed 12/14/15, effective 12/14/15. 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.]