Chapter 48.43 RCW
INSURANCE REFORM

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CONSTRUCTION

48.43.902 Effective date—1996 c 312.
48.43.904 Construction—Chapter applicable to state registered domestic partnerships—2009 c 521.

RCW 48.43.001 Intent. It is the intent of the legislature to ensure that all enrollees in managed care settings have access to adequate information regarding health care services covered by health carriers' health plans, and provided by health care providers and health care facilities. It is only through such disclosure that Washington state citizens can be fully informed as to the extent of health insurance coverage, availability of health care service options, and necessary treatment. With such information, citizens are able to make knowledgeable decisions regarding their health care. [1996 c 312 s 1.]

RCW 48.43.005 Definitions. Unless otherwise specifically provided, the definitions in this section apply throughout this chapter.

(1) "Adjusted community rate" means the rating method used to establish the premium for health plans adjusted to reflect actuarially demonstrated differences in utilization or cost attributable to geographic region, age, family size, and use of wellness activities.

(2) "Adverse benefit determination" means a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit, including a denial, reduction, termination, or failure to provide or make payment that is based on a determination of an enrollee's or applicant's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

(3) "Air ambulance service" has the same meaning as defined in section 2799A-2 of the public health service act (42 U.S.C. Sec. 300gg-112) and implementing federal regulations in effect on March 31, 2022.

(4) "Allowed amount" means the maximum portion of a billed charge a health carrier will pay, including any applicable enrollee cost-sharing responsibility, for a covered health care service or item rendered by a participating provider or facility or by a nonparticipating provider or facility.

(5) "Applicant" means a person who applies for enrollment in an individual health plan as the subscriber or an enrollee, or the dependent or spouse of a subscriber or enrollee.

(6) "Balance bill" means a bill sent to an enrollee by a nonparticipating provider or facility for health care services provided to the enrollee after the provider or facility's billed amount is not fully reimbursed by the carrier, exclusive of permitted cost-sharing.

(7) "Basic health plan" means the plan described under chapter 70.47 RCW, as revised from time to time.

(8) "Basic health plan model plan" means a health plan as required in RCW 70.47.060(2)(e).

(9) "Basic health plan services" means that schedule of covered health services, including the description of how those benefits are to be administered, that are required to be delivered to an enrollee under the basic health plan, as revised from time to time.

(10) "Behavioral health emergency services provider" means emergency services provided in the following settings:

(a) A crisis stabilization unit as defined in RCW 71.05.020;

(b) A 23-hour crisis relief center as defined in RCW 71.24.025;

(c) An evaluation and treatment facility that can provide directly, or by direct arrangement with other public or private agencies, emergency evaluation and treatment, outpatient care, and timely and appropriate inpatient care to persons suffering from a mental disorder, and which is licensed or certified as such by the department of health;

(d) An agency certified by the department of health under chapter 71.24 RCW to provide outpatient crisis services;

(e) An agency certified by the department of health under chapter 71.24 RCW to provide medically managed or medically monitored withdrawal management services; or

(f) A mobile rapid response crisis team as defined in RCW 71.24.025 that is contracted with a behavioral health administrative services organization operating under RCW 71.24.045 to provide crisis response services in the behavioral health administrative services organization's service area.

(11) "Board" means the governing board of the Washington health benefit exchange established in chapter 43.71 RCW.

(12)(a) For grandfathered health benefit plans issued before January 1, 2014, and renewed thereafter, "catastrophic health plan" means:

(i) In the case of a contract, agreement, or policy covering a single enrollee, a health benefit plan requiring a calendar year deductible of, at a minimum, $1,750 and an annual out-of-pocket expense required to be paid under the plan (other than for premiums) for covered benefits of at least $3,500, both amounts to be adjusted annually by the insurance commissioner; and

(ii) In the case of a contract, agreement, or policy covering more than one enrollee, a health benefit plan requiring a calendar year deductible of, at a minimum, $3,500 and an annual out-of-pocket expense required to be paid under the plan (other than for premiums) for covered benefits of at least $6,000, both amounts to be adjusted annually by the insurance commissioner.

(b) In July 2008, and in each July thereafter, the insurance commissioner shall adjust the minimum deductible and out-of-pocket expense required for a plan to qualify as a catastrophic plan to reflect the percentage change in the consumer price index for medical care for a preceding 12 months, as determined by the United States department of labor. For a plan year beginning in 2014, the out-of-pocket limits must be adjusted as specified in section 1302(c)(1) of P.L. 111-148 of 2010, as amended. The adjusted amount shall apply on the following January 1st.

(c) For health benefit plans issued on or after January 1, 2014, "catastrophic health plan" means:

(i) A health benefit plan that meets the definition of catastrophic plan set forth in section 1302(e) of P.L. 111-148 of 2010, as amended; or

(ii) A health benefit plan offered outside the exchange marketplace that requires a calendar year deductible or out-of-pocket expenses under the plan, other than for premiums, for covered benefits, that meets or exceeds the commissioner's annual adjustment under (b) of this subsection.

(13) "Certification" means a determination by a review organization that an admission, extension of stay, or other health care service or procedure has been reviewed and, based on the information provided, meets the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness under the auspices of the applicable health benefit plan.

(14) "Concurrent review" means utilization review conducted during a patient's hospital stay or course of treatment.

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

(16) "Dependent" means, at a minimum, the enrollee's legal spouse and dependent children who qualify for coverage under the enrollee's health benefit plan.

(17) "Emergency medical condition" means a medical, mental health, or substance use disorder condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain or emotional distress, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical, mental health, or

substance use disorder treatment attention to result in a condition (a) 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, (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part.

(18) "Emergency services" means:

(a)(i) A medical screening examination, as required under section 1867 of the social security act (42 U.S.C. Sec. 1395dd), that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate that emergency medical condition;

(ii) Medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the social security act (42 U.S.C. Sec. 1395dd) to stabilize the patient. Stabilize, with respect to an emergency medical condition, has the meaning given in section 1867(e)(3) of the social security act (42 U.S.C. Sec. 1395dd(e)(3)); and

(iii) Covered services provided by staff or facilities of a hospital after the enrollee is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit during which screening and stabilization services have been furnished. Poststabilization services relate to medical, mental health, or substance use disorder treatment necessary in the short term to avoid 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, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part; or

(b)(i) A screening examination that is within the capability of a behavioral health emergency services provider including ancillary services routinely available to the behavioral health emergency services provider to evaluate that emergency medical condition;

(ii) Examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the behavioral health emergency services provider, as are required under section 1867 of the social security act (42 U.S.C. Sec. 1395dd) or as would be required under such section if such section applied to behavioral health emergency services providers, to stabilize the patient. Stabilize, with respect to an emergency medical condition, has the meaning given in section 1867(e)(3) of the social security act (42 U.S.C. Sec. 1395dd(e)(3)); and

(iii) Covered behavioral health services provided by staff or facilities of a behavioral health emergency services provider after the enrollee is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit during which screening and stabilization services have been furnished. Poststabilization services relate to mental health or substance use disorder treatment necessary in the short term to avoid 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, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

(19) "Employee" has the same meaning given to the term, as of January 1, 2008, under section 3(6) of the federal employee retirement income security act of 1974.

(20) "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.

(21) "Essential health benefit categories" means:

(a) Ambulatory patient services;

(b) Emergency services;

(c) Hospitalization;

(d) Maternity and newborn care;

(e) Mental health and substance use disorder services, including behavioral health treatment;

(f) Prescription drugs;

(g) Rehabilitative and habilitative services and devices;

(h) Laboratory services;

(i) Preventive and wellness services and chronic disease management; and

(j) Pediatric services, including oral and vision care.

(22) "Exchange" means the Washington health benefit exchange established under chapter 43.71 RCW.

(23) "Final external review decision" means a determination by an independent review organization at the conclusion of an external review.

(24) "Final internal adverse benefit determination" means an adverse benefit determination that has been upheld by a health plan or carrier at the completion of the internal appeals process, or an adverse benefit determination with respect to which the internal appeals process has been exhausted under the exhaustion rules described in RCW 48.43.530 and 48.43.535.

(25) "Grandfathered health plan" means a group health plan or an individual health plan that under section 1251 of the patient protection and affordable care act, P.L. 111-148 (2010) and as amended by the health care and education reconciliation act, P.L. 111-152 (2010) is not subject to subtitles A or C of the act as amended.

(26) "Grievance" means a written complaint submitted by or on behalf of a covered person regarding service delivery issues other than denial of payment for medical services or nonprovision of medical services, including dissatisfaction with medical care, waiting time for medical services, provider or staff attitude or demeanor, or dissatisfaction with service provided by the health carrier.

(27) "Ground ambulance services" means:

(a) The rendering of medical treatment and care at the scene of a medical emergency or while transporting a patient from the scene to an appropriate health care facility or behavioral health emergency services provider when the services are provided by one or more ground ambulance vehicles designed for this purpose; and

(b) Ground ambulance transport between hospitals or behavioral health emergency services providers, hospitals or behavioral health emergency services providers and other health care facilities or locations, and between health care facilities when the services are medically necessary and are provided by one or more ground ambulance vehicles designed for this purpose.

(28) "Ground ambulance services organization" means a public or private organization licensed by the department of health under chapter 18.73 RCW to provide ground ambulance services. For purposes of this chapter, ground ambulance services organizations are not considered providers.

(29) "Health care facility" or "facility" means hospices licensed under chapter 70.127 RCW, hospitals licensed under chapter 70.41 RCW, rural health care facilities as defined in RCW 70.175.020, behavioral

health hospitals licensed under chapter 71.12 RCW, nursing homes licensed under chapter 18.51 RCW, community mental health centers licensed under chapter 71.05 or 71.24 RCW, kidney disease treatment centers licensed under chapter 70.41 RCW, ambulatory diagnostic, treatment, or surgical facilities licensed under chapter 70.41 or 70.230 RCW, drug and alcohol treatment facilities licensed under chapter *70.96A RCW, and home health agencies licensed under chapter 70.127 RCW, and includes such facilities if owned and operated by a political subdivision or instrumentality of the state and such other facilities as required by federal law and implementing regulations.

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

(a) A person regulated under Title 18 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.

(31) "Health care 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.

(32) "Health carrier" or "carrier" means a disability insurer regulated under chapter 48.20 or 48.21 RCW, a health care service contractor as defined in RCW 48.44.010, or 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).

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

(a) Long-term care insurance governed by chapter 48.84 or 48.83 RCW;

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

(c) Coverage supplemental to the coverage provided under chapter 55, Title 10, United States Code;

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

(e) Disability income;

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

(g) Workers' compensation coverage;

(h) Accident only coverage;

(i) Specified disease or illness-triggered fixed payment insurance, hospital confinement fixed payment insurance, or other fixed payment insurance offered as an independent, noncoordinated benefit;

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

(k) Dental only and vision only coverage;

(l) 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;

(m) Civilian health and medical program for the veterans affairs administration (CHAMPVA);

(n) Stand-alone prescription drug coverage that exclusively supplements medicare part D coverage provided through an employer group waiver plan under federal social security act regulation 42 C.F.R. Sec. 423.458(c); and

(o) Beginning January 1, 2027, travel insurance as defined in RCW 48.216.020.

(34) "Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

(35) "In-network" or "participating" means a provider or facility that has contracted with a carrier or a carrier's contractor or subcontractor to provide health care services to enrollees and be reimbursed by the carrier at a contracted rate as payment in full for the health care services, including applicable cost-sharing obligations.

(36) "Local governmental entity" means any entity that is authorized to establish or provide ground ambulance services or set rates for ground ambulance services, including those as authorized in RCW 35.27.370, 35.23.456, 52.12.135, chapter 35.21 RCW, or as authorized under any state law.

(37) "Material modification" means a change in the actuarial value of the health plan as modified of more than five percent but less than fifteen percent.

(38) "Nonemergency health care services performed by nonparticipating providers at certain participating facilities" means covered items or services other than emergency services with respect to a visit at a participating health care facility, as provided in section 2799A-1(b) of the public health service act (42 U.S.C. Sec. 300gg-111(b)), 45 C.F.R. Sec. 149.30, and 45 C.F.R. Sec. 149.120 as in effect on March 31, 2022.

(39) "Open enrollment" means a period of time as defined in rule to be held at the same time each year, during which applicants may enroll in a carrier's individual health benefit plan without being subject to health screening or otherwise required to provide evidence of insurability as a condition for enrollment.

(40) "Out-of-network" or "nonparticipating" means a provider or facility that has not contracted with a carrier or a carrier's contractor or subcontractor to provide health care services to enrollees.

(41) "Out-of-pocket maximum" or "maximum out-of-pocket" means the maximum amount an enrollee is required to pay in the form of cost-sharing for covered benefits in a plan year, after which the carrier covers the entirety of the allowed amount of covered benefits under the contract of coverage.

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

(43) "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.

(44)(a) "Protected individual" means:

(i) An adult covered as a dependent on the enrollee's health benefit plan, including an individual enrolled on the health benefit plan of the individual's registered domestic partner; or

(ii) A minor who may obtain health care without the consent of a parent or legal guardian, pursuant to state or federal law.

(b) "Protected individual" does not include an individual deemed not competent to provide informed consent for care under **RCW 11.88.010(1)(e).

(45) "Review organization" means a disability insurer regulated under chapter 48.20 or 48.21 RCW, health care service contractor as defined in RCW 48.44.010, or health maintenance organization as defined in RCW 48.46.020, and entities affiliated with, under contract with, or acting on behalf of a health carrier to perform a utilization review.

(46) "Sensitive health care services" means health services related to reproductive health, sexually transmitted diseases, substance use disorder, gender dysphoria, gender-affirming care, domestic violence, and mental health.

(47) "Small employer" or "small group" means any person, firm, corporation, partnership, association, political subdivision, sole proprietor, or self-employed individual that is actively engaged in business that employed an average of at least one but no more than 50 employees, during the previous calendar year and employed at least one employee on the first day of the plan year, is not formed primarily for purposes of buying health insurance, and in which a bona fide employer-employee relationship exists. In determining the number of employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation by this state, shall be considered an employer. Subsequent to the issuance of a health plan to a small employer and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, a small employer shall continue to be considered a small employer until the plan anniversary following the date the small employer no longer meets the requirements of this definition. A self-employed individual or sole proprietor who is covered as a group of one must also: (a) Have been employed by the same small employer or small group for at least twelve months prior to application for small group coverage, and (b) verify that he or she derived at least 75 percent of his or her income from a trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040, schedule C or F, for the previous taxable year, except a self-employed individual or sole proprietor in an agricultural trade or business, must have derived at least 51 percent of his or her income from the trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040, for the previous taxable year.

(48) "Special enrollment" means a defined period of time of not less than thirty-one days, triggered by a specific qualifying event experienced by the applicant, during which applicants may enroll in the carrier's individual health benefit plan without being subject to health screening or otherwise required to provide evidence of insurability as a condition for enrollment.

(49) "Standard health questionnaire" means the standard health questionnaire designated under chapter 48.41 RCW.

(50) "Utilization review" means the prospective, concurrent, or retrospective assessment of the necessity and appropriateness of the allocation of health care resources and services of a provider or facility, given or proposed to be given to an enrollee or group of enrollees.

(51) "Wellness activity" means an explicit program of an activity consistent with department of health guidelines, such as, smoking cessation, injury and accident prevention, reduction of alcohol misuse, appropriate weight reduction, exercise, automobile and motorcycle safety, blood cholesterol reduction, and nutrition education for the purpose of improving enrollee health status and reducing health service costs. [2026 c 165 s 14; 2024 c 218 s 1; 2023 c 433 s 20. Prior: 2022 c 263 s 2; 2020 c 196 s 1; prior: 2019 c 427 s 2; 2019 c 56 s 2; 2019 c 33 s 1; 2016 c 65 s 2; prior: 2012 c 211 s 17; 2012 c 87 s 1; prior: 2011 c 315 s 2; 2011 c 314 s 3; prior: 2010 c 292 s 1; prior: 2008 c 145 s 20; 2008 c 144 s 1; prior: 2007 c 296 s 1; 2007 c 259 s 32; 2006 c 25 s 16; 2004 c 244 s 2; prior: 2001 c 196 s 5; 2001 c 147 s 1; 2000 c 79 s 18; prior: 1997 c 231 s 202; 1997 c 55 s 1; 1995 c 265 s 4.]

Reviser's note: *(1) Chapter 70.96A RCW was repealed and/or recodified in its entirety pursuant to 2016 sp.s. c 29 ss 301, 601, and 701.

**(2) RCW 11.88.010 was repealed by 2020 c 312 s 904, effective January 1, 2022.

Effective date—2022 c 263: See note following RCW 43.371.100.

Effective date—2020 c 196: "This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately [March 27, 2020]." [2020 c 196 s 2.]

Findings—Intent—Effective date—2019 c 427: See RCW 48.49.003 and 48.49.900.

Findings—Declarations—Effective date—2019 c 56: See notes following RCW 48.43.5051.

Effective date—2019 c 33: "This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately [April 17, 2019]." [2019 c 33 s 17.]

Spiritual care services—2012 c 87: See RCW 43.71.901.

Intent—2011 c 315: "The federal patient protection and affordable care act (P.L. 111-148) prohibits insurance carriers from applying preexisting condition limitations for persons under age nineteen, beginning on or after September 23, 2010. The guidance from the United States department of health and human services provides some direction for the implementation of the new policy requirement, and the office of the insurance commissioner further clarified open enrollment requirements to help prevent disruption in the individual health insurance marketplace. It is the intent of this act to:

(1) Maintain access to individual plan options for persons under age nineteen; and

(2) Provide clarity for the establishment of open enrollment and special open enrollment periods that balance access to guaranteed issue coverage with efforts that protect market stability." [2011 c 315 s 1.]

Application—2010 c 292: "This act applies to policies issued or renewed on or after January 1, 2011." [2010 c 292 s 9.]

Contingent effective date—2010 c 292 ss 1 and 2: "Sections 1 and 2 of this act take effect one hundred eighty days [September 29, 2010] after the date the insurance commissioner certifies to the secretary of the senate, the chief clerk of the house of representatives, and the code reviser's office that federal legislation has been signed into law by the President of the United States that includes guaranteed issue for individuals who purchase health coverage through the individual or small group markets." [2010 c 292 s 11.]

Effective date—2008 c 145: See RCW 48.83.901.

Subheadings not law—2007 c 259: See note following RCW 7.70.060.

Application—2004 c 244: See note following RCW 48.21.045.

Effective date—2001 c 196: See note following RCW 48.20.025.

Effective date—Severability—2000 c 79: See notes following RCW 48.04.010.

Short title—1997 c 231: "This act shall be known as the consumer assistance and insurance market stabilization act." [1997 c 231 s 402.]

Part headings and captions not law—1997 c 231: "Part headings and section captions used in this act are not part of the law." [1997 c 231 s 403.]

Severability—1997 c 231: "If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected." [1997 c 231 s 404.]

Effective dates—1997 c 231: "(1) Sections 104 through 108 and 301 of this act take effect January 1, 1998.

(2) Section 111 of this act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect July 1, 1997.

(3) Section 205 of this act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately." [1997 c 231 s 405.]

Effective date—1997 c 55: "This act is necessary for the immediate preservation of the public peace, health, or safety, or

support of the state government and its existing public institutions, and takes effect immediately [April 16, 1997]." [1997 c 55 s 2.]

Captions not law—Effective dates—Savings—Severability—1995 c 265: See notes following RCW 70.47.015.

RCW 48.43.007 Availability of price and quality information—Transparency tools for members—Requirements. (1) Each carrier offering or renewing a health benefit plan on or after January 1, 2016, must offer member transparency tools with certain price and quality information to enable the member to make treatment decisions based on cost, quality, and patient experience. The transparency tools must aim for best practices and, at a minimum:

(a) Must display cost data for common treatments within the following categories:

(i) Inpatient treatments;

(ii) Outpatient treatments;

(iii) Diagnostic tests; and

(iv) Office visits;

(b) Recognizing integrated health care delivery systems focus on total cost of care, carrier's operating integrated care delivery systems may meet the requirement of (a) of this subsection by providing meaningful consumer data based on the total cost of care. This subsection applies only to the portion of enrollment a carrier offers pursuant to chapter 48.46 RCW and as part of an integrated delivery system, and does not exempt from (a) of this subsection coverage offered pursuant to chapter 48.21, 48.44, or 48.46 RCW if not part of an integrated delivery system;

(c) Are encouraged to display the cost for prescription medications on their member website or through a link to a third party that manages the prescription benefits;

(d) Must include a patient review option or method for members to provide a rating or feedback on their experience with the medical provider that allows other members to see the patient review, the feedback must be monitored for appropriateness and validity, and the site may include independently compiled quality of care ratings of providers and facilities;

(e) Must allow members to access the estimated cost of the treatment, or the total cost of care, as set forth in (a) and (b) of this subsection on a portable electronic device;

(f) Must display options based on the selected search criteria for members to compare;

(g) Must display the estimated cost of the treatment, or total cost of the care episode, and the estimated out-of-pocket costs of the treatment for the member and display the application of personalized benefits such as deductibles and cost-sharing;

(h) Must display quality information on providers when available; and

(i) Are encouraged to display alternatives that are more cost-effective when there are alternatives available, such as the use of an ambulatory surgical center when one is available or medical versus surgical alternatives as appropriate.

(2) In addition to the required features on cost and quality information, the member transparency tools must include information to allow a provider and hospital search of in-network providers and

hospitals with provider information including specialists, distance from patient, the provider's contact information, the provider's education, board certification and other credentials, where to find information on malpractice history and disciplinary actions, affiliated hospitals and other providers in a clinic, and directions to provider offices and hospitals.

(3) Each carrier offering or renewing a health benefit plan on or after January 1, 2016, must provide enrollees with the performance information required by section 2717 of the patient protection and affordable care act, P.L. 111-148 (2010), as amended by the health care and education reconciliation act, P.L. 111-152 (2010), and any federal regulations or guidance issued under that section of the affordable care act.

(4) Each carrier offering or renewing a health benefit plan on or after January 1, 2016, must, within thirty days from the offer or renewal date, attest to the office of the insurance commissioner that the member transparency tools meet the requirements in this section and access to the tools is available on the home page within the health plan's secured member website. [2014 c 224 s 3.]

Intent—2014 c 224: "Consumers face a challenge finding reliable, consumer friendly information on health care pricing and quality. Greater transparency of health care prices and quality leads to engaged, activated consumers. Research indicates that engaged and educated consumers help control costs and improve quality with lower costs per patient, lower hospital readmission rates, and the use of higher quality providers. Washington is a leader in efforts to develop and publish provider quality information.

Although data is available today, research indicates the existing information is not user-friendly, consumers do not know which measures are most relevant, and quality ratings are inconsistent or nonstandardized. It is the intent of the legislature to ensure consumer tools are available to educate and engage patients in managing their care and understanding the costs and quality." [2014 c 224 s 1.]

RCW 48.43.008 Enrollment in employer-sponsored health plan—Person eligible for medical assistance. When the health care authority determines that it is cost-effective to enroll a person eligible for medical assistance under chapter 74.09 RCW in an employer-sponsored health plan, a carrier shall permit the enrollment of the person in the health plan for which he or she is otherwise eligible without regard to any open enrollment period restrictions. [2011 1st sp.s. c 15 s 77; 2007 c 259 s 24.]

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

Subheadings not law—2007 c 259: See note following RCW 7.70.060.

RCW 48.43.009 Health care sharing ministries. Health care sharing ministries are not health carriers as defined in RCW 48.43.005 or insurers as defined in RCW 48.01.050. For purposes of this section,

"health care sharing ministry" has the same meaning as in 26 U.S.C. Sec. 5000A. [2011 c 314 s 18.]

RCW 48.43.012 Health plans—Preexisting conditions—Rules. (1) No carrier may reject an individual for an individual or group health benefit plan based upon preexisting conditions of the individual.

(2) No carrier may deny, exclude, or otherwise limit coverage for an individual's preexisting health conditions including, but not limited to, preexisting condition exclusions or waiting periods.

(3) No carrier may avoid the requirements of this section through the creation of a new rate classification or the modification of an existing rate classification. A new or changed rate classification will be deemed an attempt to avoid the provisions of this section if the new or changed classification would substantially discourage applications for coverage from individuals who are higher than average health risks. These provisions apply only to individuals who are Washington residents.

(4) Unless preempted by federal law, the commissioner shall adopt any rules necessary to implement this section, consistent with federal rules and guidance in effect on January 1, 2017, implementing the patient protection and affordable care act. [2019 c 33 s 2; 2011 c 315 s 3; 2001 c 196 s 6; 2000 c 79 s 19.]

Effective date—2019 c 33: See note following RCW 48.43.005.

Intent—2011 c 315: See note following RCW 48.43.005.

Effective date—2001 c 196: See note following RCW 48.20.025.

Effective date—Severability—2000 c 79: See notes following RCW 48.04.010.

RCW 48.43.01211 Health plans—Eligibility—Health status-related factors—Rules. (1) A health carrier or health plan may not establish rules for eligibility, including continued eligibility, of any individual to enroll under the terms of the plan or coverage based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

(a) Health status;

(b) Medical condition, including both physical and mental illnesses;

(c) Claims experience;

(d) Receipt of health care;

(e) Medical history;

(f) Genetic information;

(g) Evidence of insurability, including conditions arising out of acts of domestic violence;

(h) Disability; or

(i) Any other health status-related factor determined appropriate by the commissioner.

(2) Unless preempted by federal law, the commissioner shall adopt any rules necessary to implement this section, consistent with federal rules and guidance in effect on January 1, 2017, implementing the patient protection and affordable care act. [2019 c 33 s 3.]

Effective date—2019 c 33: See note following RCW 48.43.005.

RCW 48.43.0122 Individual health benefit plans—Open enrollment and special enrollment periods—Rules—Enforcement. (1) The commissioner shall adopt rules establishing and implementing requirements for the open enrollment periods and special enrollment periods that carriers must follow for individual health benefit plans.

(2) The commissioner shall monitor the sale of individual health benefit plans and if a carrier refuses to sell guaranteed issue policies to persons in compliance with rules adopted by the commissioner pursuant to subsection (1) of this section, the commissioner may levy fines or suspend or revoke a certificate of authority as provided in chapter 48.05 RCW. [2019 c 33 s 11; 2011 c 315 s 4.]

Effective date—2019 c 33: See note following RCW 48.43.005.

Intent—2011 c 315: See note following RCW 48.43.005.

RCW 48.43.0123 Health plans—Rescission of coverage—Rules. (1) A health plan or health carrier offering group or individual coverage may not rescind such coverage with respect to an enrollee once the enrollee is covered under the plan or coverage involved, except that this section does not apply to a covered person who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage. The plan or coverage may not be canceled except as permitted under RCW 48.43.035 or 48.43.038.

(2) The commissioner shall adopt any rules necessary to implement this section, consistent with federal rules and guidance in effect on January 1, 2017, implementing the patient protection and affordable care act. [2019 c 33 s 8.]

Effective date—2019 c 33: See note following RCW 48.43.005.

RCW 48.43.0124 Health plans—Cost sharing for essential health benefits—Rules. (1) For plan years beginning in 2020, the cost sharing incurred under a health plan for the essential health benefits may not exceed the following amounts:

(a) For self-only coverage:

(i) The amount required under federal law for the calendar year; or

(ii) If there are no cost-sharing requirements under federal law, eight thousand two hundred dollars increased by the premium adjustment percentage for the calendar year.

(b) For coverage other than self-only coverage:

(i) The amount required under federal law for the calendar year; or

(ii) If there are no cost-sharing requirements under federal law, sixteen thousand four hundred dollars increased by the premium adjustment percentage for the calendar year.

(2) Regardless of whether an enrollee is covered by a self-only plan or a plan that is other than self-only, the enrollee's cost

sharing for the essential health benefits may not exceed the self-only annual limitation on cost sharing.

(3) For purposes of this section, "the premium adjustment percentage for the calendar year" means the percentage, if any, by which the average per capita premium for health insurance in Washington for the preceding year, as estimated by the commissioner no later than April 1st of such preceding year, exceeds such average per capita premium for 2020 as determined by the commissioner.

(4) Unless preempted by federal law, the commissioner shall adopt any rules necessary to implement this section, consistent with federal rules and guidance in effect on January 1, 2017, implementing the patient protection and affordable care act. [2019 c 33 s 10.]

Effective date—2019 c 33: See note following RCW 48.43.005.

RCW 48.43.0125 Essential health benefits—Annual or lifetime dollar limits. A health carrier may not impose annual or lifetime dollar limits on an essential health benefit, other than those permitted as reference-based limitations under rules adopted by the commissioner. [2019 c 33 s 12.]

Effective date—2019 c 33: See note following RCW 48.43.005.

RCW 48.43.0126 Summary of benefits and explanation of coverage—Standards and requirements—Notice of modification—Fines—Standards for definitions of health insurance terms—Rules. (1) The commissioner shall develop standards for use by a health carrier offering individual or group coverage, in compiling and providing to applicants and enrollees a summary of benefits and coverage explanation that accurately describes the benefits and coverage under the applicable plan. In developing the standards, the commissioner must use the standards developed under 42 U.S.C. Sec. 300gg-15 in use on April 17, 2019.

(2) The standards must provide for the following:

(a) The standards must ensure that the summary of benefits and coverage is presented in a uniform format that does not exceed four pages in length and does not include print smaller than twelve-point font.

(b) The standards must ensure that the summary is presented in a culturally and linguistically appropriate manner and utilizes terminology understandable by the average plan enrollee.

(c) The standards must ensure that the summary of benefits and coverage includes:

(i) Uniform definitions of standard insurance and medical terms, consistent with the standard definitions developed under this section, so that consumers may compare health insurance coverage and understand the terms of coverage, or exceptions to such coverage;

(ii) A description of the coverage, including cost sharing for:

(A) The essential health benefits; and

(B) Other benefits identified by the commissioner;

(iii) The exceptions, reductions, and limitations on coverage;

(iv) The cost-sharing provisions, including deductible, coinsurance, and copayment obligations;

(v) The renewability and continuation of coverage provisions;

(vi) A coverage facts label that includes examples to illustrate common benefits scenarios, including pregnancy and serious or chronic medical conditions and related cost sharing. The scenarios must be based on recognized clinical practice guidelines;

(vii) A statement of whether the plan:

(A) Provides minimum essential coverage under 26 U.S.C. Sec. 5000A(f); and

(B) Ensures that the plan share of the total allowed costs of benefits provided under the plan is no less than sixty percent of the costs;

(viii) A statement that the outline is a summary of the policy or certificate and that the coverage document itself should be consulted to determine the governing contractual provisions; and

(ix) A contact number for the consumer to call with additional questions and a website where a copy of the actual individual coverage policy or group certificate of coverage may be reviewed and obtained.

(3) The commissioner shall periodically review and update the standards developed under this section.

(4) A health carrier must provide a summary of benefits and coverage explanation to:

(a) An applicant at the time of application;

(b) An enrollee prior to the time of enrollment or reenrollment, as applicable; and

(c) A policyholder or certificate holder at the time of issuance of the policy or delivery of the certificate.

(5) A health carrier may provide the summary of benefits and coverage either in paper or electronically.

(6) If a health carrier makes any material modification in any of the terms of the plan that is not reflected in the most recently provided summary of benefits and coverage, the carrier shall provide notice of the modification to enrollees no later than sixty days prior to the date on which the modification will become effective.

(7) A health carrier that fails to provide the information required under this section is subject to a fine of no more than one thousand dollars for each failure. A failure with respect to each enrollee constitutes a separate offense for purposes of this subsection.

(8) The commissioner shall, by rule, provide for the development of standards for the definitions of terms used in health insurance coverage, including the following:

(a) Insurance-related terms, including premium; deductible; coinsurance; copayment; out-of-pocket limit; preferred provider; nonpreferred provider; out-of-network copayments; usual, customary, and reasonable fees; excluded services; grievance; appeals; and any other terms the commissioner determines are important to define so that consumers may compare health insurance coverage and understand the terms of their coverage; and

(b) Medical terms, including hospitalization, hospital outpatient care, emergency room care, physician services, prescription drug coverage, durable medical equipment, home health care, skilled nursing care, rehabilitation services, hospice services, emergency medical transportation, and any other terms the commissioner determines are important to define so that consumers may compare the medical benefits offered by health insurance and understand the extent of those medical benefits or exceptions to those benefits.

(9) Unless preempted by federal law, the commissioner shall adopt any rules necessary to implement this section, consistent with federal

rules and guidance in effect on January 1, 2017, implementing the patient protection and affordable care act. [2019 c 33 s 13.]

Effective date—2019 c 33: See note following RCW 48.43.005.

RCW 48.43.0127 Group health plans—Waiting period—Rules. (1) A group health plan and a health carrier offering group health coverage may not apply any waiting period that exceeds ninety days.

(2) Unless preempted by federal law, the commissioner shall adopt any rules necessary to implement this section, consistent with federal rules and guidance in effect on January 1, 2017, implementing the patient protection and affordable care act. [2019 c 33 s 14.]

Effective date—2019 c 33: See note following RCW 48.43.005.

RCW 48.43.0128 Nongrandfathered health plans and plans issued or renewed on or after January 1, 2022—Prohibited discrimination—Rules. (1) A health carrier offering a nongrandfathered health plan or a plan deemed by the 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 student at an accredited higher education institution may not:

(a) In its benefit design or implementation of its benefit design, discriminate against individuals because of their age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions; and

(b) With respect to the health plan or plan deemed by the 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 student at an accredited higher education institution, discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation.

(2) Nothing in this section may be construed to prevent a carrier from appropriately utilizing reasonable medical management techniques.

(3) For health plans issued or renewed on or after January 1, 2022:

(a) A health carrier may not deny or limit coverage for gender-affirming treatment when that treatment is prescribed to an individual because of, related to, or consistent with a person's gender expression or identity, as defined in RCW 49.60.040, is medically necessary, and is prescribed in accordance with accepted standards of care.

(b) A health carrier may not apply categorical cosmetic or blanket exclusions to gender-affirming treatment. When prescribed as medically necessary gender-affirming treatment, a health carrier may not exclude as cosmetic services facial feminization surgeries and other facial gender-affirming treatment, such as tracheal shaves, hair electrolysis, and other care such as mastectomies, breast reductions, breast implants, or any combination of gender-affirming procedures, including revisions to prior treatment.

(c) A health carrier may not issue an adverse benefit determination denying or limiting access to gender-affirming services,

unless a health care provider with experience prescribing or delivering gender-affirming treatment has reviewed and confirmed the appropriateness of the adverse benefit determination.

(d) Health carriers must comply with all network access rules and requirements established by the commissioner.

(4) For the purposes of this section, "gender-affirming treatment" means a service or product that a health care provider, as defined in RCW 70.02.010, prescribes to an individual to treat any condition related to the individual's gender identity and is prescribed in accordance with generally accepted standards of care. Gender-affirming treatment must be covered in a manner compliant with the federal mental health parity and addiction equity act of 2008 and the federal affordable care act. Gender-affirming treatment can be prescribed to two spirit, transgender, nonbinary, intersex, and other gender diverse individuals.

(5) Nothing in this section may be construed to mandate coverage of a service that is not medically necessary.

(6) By December 1, 2022, the commissioner, in consultation with the health care authority and the department of health, must issue a report on geographic access to gender-affirming treatment across the state. The report must include the number of gender-affirming providers offering care in each county, the carriers and medicaid managed care organizations those providers have active contracts with, and the types of services provided by each provider in each region. The commissioner must update the report biennially and post the report on its website.

(7) The commissioner shall adopt any rules necessary to implement subsections (3), (4), and (5) of this section.

(8) Unless preempted by federal law, the commissioner shall adopt any rules necessary to implement subsections (1) and (2) of this section, consistent with federal rules and guidance in effect on January 1, 2017, implementing the patient protection and affordable care act. [2025 c 243 s 8; 2021 c 280 s 3; 2020 c 228 s 9; 2019 c 33 s 15.]

Short title—2021 c 280: See note following RCW 49.60.178.

Effective date—2019 c 33: See note following RCW 48.43.005.

RCW 48.43.013 Health carriers—Timely payments. (1)(a) Except as provided in (b) of this subsection, for health care services provided to covered persons, a carrier shall pay or deny a claim from a provider or facility as soon as practical, but no later than 30 calendar days after the receipt of a clean claim by the carrier.

(b) For claims that are not clean, within 21 calendar days of receipt of the claim, the carrier shall send remittance advice or other electronic notice to the provider or facility acknowledging the date of receipt of the claim and including one of the following:

(i) That the carrier is denying payment on all or part of the claim and the specific reason for the denial. The denial shall identify the portion of the claim that is denied and the specific reasons for the denial; or

(ii) That additional information or documentation is needed to process the claim. This notice must include a request for the specific information or documentation needed to process the claim. The carrier

shall make a good faith effort to request all information or documentation needed to process the claim in a single request and may not make any additional requests for information or documentation for 30 calendar days after receipt of the claim.

(c)(i) For claims for which the carrier receives all information or documentation requested by the carrier in a notice issued pursuant to (b)(ii) of this subsection, the carrier shall consider the claim a clean claim and shall pay or deny the claim within 30 calendar days, except as agreed to in writing by the parties on a claim-by-claim basis. The 30 calendar days time period does not apply until the carrier receives all information or documentation requested by the carrier.

(ii) For claims for which a provider or facility fails to submit information or documentation requested under subsection (1)(b)(ii) of this section within 21 calendar days of receipt of the carrier's request, the carrier's obligation to pay or deny the claim under this subsection is extended to 40 calendar days following the carrier's receipt of requested information or documentation.

(d) The receipt date of a claim or additional information or documentation is the date a carrier receives either written or electronic notice of the claim or additional information or documentation. A carrier must establish a reasonable method for confirming receipt of claims and additional information or documentation and responding to provider and facility inquiries about claims.

(2)(a) A carrier shall pay interest on the amount of any claims for which the carrier fails to comply with the timeline and notice requirements of subsection (1) of this section. Interest shall accrue on each such claim until the claim is resolved by payment, denial, or the final outcome of an appeals process.

(b) Interest shall be assessed at the following rates and shall be calculated monthly as simple interest prorated for any portion of a month:

(i) Beginning on calendar day one and through calendar day 60 following a carrier's failure to comply with any notice or claim settlement requirement in subsection (1)(a) or (b) of this section, interest shall be assessed at the rate of one percent per month on the amount of the unresolved claim.

(ii) Beginning on calendar day 61 following a carrier's failure to comply with any notice or claim settlement requirement in subsection (1)(a) or (b) of this section and until the claim is resolved, interest shall be assessed at the rate of one and one-half percent per month on the amount of the unresolved claim.

(c) Any interest paid under this subsection shall be the carrier's responsibility and not be applied by the carrier to a covered person's deductible, copayment, coinsurance, or any similar obligation of the covered person.

(d) The carrier shall add the interest payable to the amount of the unpaid claim and may not require or request the provider or facility to submit an additional claim.

(e) For any claim for which the carrier failed to comply with the requirements of subsection (1)(a) or (b) of this section that is unresolved for more than 90 calendar days, the carrier may be subject to an administrative penalty as determined by the commissioner in rule. In determining the appropriateness of an administrative penalty, the commissioner shall consider whether a carrier has engaged in a pattern of violations of subsection (1)(a) or (b) of this section.

(3) The requirements of this section do not apply to claims for which a carrier has documented evidence of fraud or material misrepresentation by providers, facilities, or covered persons, supported by claims review, data analysis, audit activities, or patterns thereof.

(4) Providers, facilities, and carriers are not required to comply with the requirements of this section 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, cybersecurity attack, declaration of a natural disaster, or the result of a strike, lockout, or other labor dispute.

(5) 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, health care benefit manager, 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.

(6) Nothing in this section limits any existing authority of the office of the insurance commissioner under this title to oversee and enforce carrier compliance with applicable statutes and rules.

(7)(a) The requirements of this section apply to health plans filed or renewed on or after January 1, 2027.

(b) This section applies only to health carriers offering health plans subject to regulation by the commissioner and to health plans offered through the public employees' benefits board and school employees' benefits board programs. This section does not apply to medicaid managed care plans administered under chapter 74.09 RCW.

(c) This section applies only to claims submitted by:

(i) A health care provider or health care facility that is a participating provider or facility under a contract with a health carrier; or

(ii) An Indian health care provider as defined in RCW 43.71B.010 including those who are not contracted or participating providers.

(d) Except as provided in subsection (7)(c)(ii) of this section, nothing in this section is intended to modify or supersede payment requirements applicable to nonparticipating providers or facilities, including those governed by RCW 48.49.160.

(8) The commissioner may adopt rules to implement this section.

(9) For purposes of this section:

(a) "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. A claim does not lose the status of "clean claim" due to issues related to carrier internal processing or systems.

(b) "Remittance advice" means a written or electronic communication issued by a carrier to a provider that explains the outcome of claim adjudication and includes, at a minimum, the amount paid, any amounts denied or adjusted, and the reason codes and

explanations supporting the carrier's payment determination. [2026 c 158 s 2.]

Finding—Intent—2026 c 158: "(1) The legislature finds that timeliness of payment and administrative burden related to obtaining payment from health carriers are contributing factors to the financial vulnerability for health care providers and health care facilities and impact availability of care and delay the determination of cost sharing for patients.

(2) It is the intent of the legislature to increase transparency and accountability for claims payment timeliness by updating payment standards to better reflect claims operations and provide an objective and quantifiable standard." [2026 c 158 s 1.]

RCW 48.43.016 Utilization management standards and criteria—Health carrier requirements—Definitions. ***(Effective until January 1, 2027.)*** (1) A health carrier or its contracted entity that imposes different prior authorization standards and criteria for a covered service among tiers of contracting providers of the same licensed profession in the same health plan shall inform an enrollee which tier an individual provider or group of providers is in by posting the information on its website in a manner accessible to both enrollees and providers.

(2)(a) A health carrier or its contracted entity may not require utilization management or review of any kind including, but not limited to, prior, concurrent, or postservice authorization for an initial evaluation and management visit and up to six treatment visits with a contracting provider in a new episode of care for each of the following: Chiropractic, physical therapy, occupational therapy, acupuncture and Eastern medicine, massage therapy, or speech and hearing therapies. Visits for which utilization management or review is prohibited under this section are subject to quantitative treatment limits of the health plan. Notwithstanding RCW 48.43.515(5) this section may not be interpreted to limit the ability of a health plan to require a referral or prescription for the therapies listed in this section.

(b) For visits for which utilization management or review is prohibited under this section, a health carrier or its contracted entity may not:

(i) Deny or limit coverage on the basis of medical necessity or appropriateness; or

(ii) Retroactively deny care or refuse payment for the visits.

(3) A health carrier shall post on its website and provide upon the request of a covered person or contracting provider any prior authorization standards, criteria, or information the carrier uses for medical necessity decisions.

(4) A health care provider with whom a health carrier consults regarding a decision to deny, limit, or terminate a person's covered health care services must hold a license, certification, or registration, in good standing and must be in the same or related health field as the health care provider being reviewed or of a specialty whose practice entails the same or similar covered health care service.

(5) A health carrier may not require a provider to provide a discount from usual and customary rates for health care services not

covered under a health plan, policy, or other agreement, to which the provider is a party.

(6) Nothing in this section prevents a health carrier from denying coverage based on insurance fraud.

(7) For purposes of this section:

(a) "New episode of care" means treatment for a new condition or diagnosis for which the enrollee has not been treated by a provider of the same licensed profession within the previous ninety days and is not currently undergoing any active treatment.

(b) "Contracting provider" does not include providers employed within an integrated delivery system operated by a carrier licensed under chapter 48.44 or 48.46 RCW. [2020 c 193 s 2; 2019 c 308 s 22; 2018 c 193 s 1; 2015 c 251 s 2.]

Intent—2020 c 193: "The legislature intends to facilitate patient access to appropriate therapies for newly diagnosed health conditions while recognizing the necessity for health carriers to employ reasonable utilization management techniques." [2020 c 193 s 1.]

Findings—2019 c 308: See note following RCW 18.06.010.

Effective date—2015 c 251: See note following RCW 41.05.074.

RCW 48.43.016 Utilization management standards and criteria—Requirements—Definitions. ***(Effective January 1, 2027.)*** (1) A health carrier or health care benefit manager as defined in RCW 48.200.020 that imposes different prior authorization standards and criteria for a covered service among tiers of contracting providers of the same licensed profession in the same health plan shall inform an enrollee which tier an individual provider or group of providers is in by posting the information on its website in a manner accessible to both enrollees and providers.

(2)(a) A health carrier or health care benefit manager as defined in RCW 48.200.020 may not require utilization management or review of any kind including, but not limited to, prior, concurrent, or postservice authorization for an initial evaluation and management visit and up to six treatment visits with a contracting provider in a new episode of care for each of the following: Chiropractic, physical therapy, occupational therapy, acupuncture and Eastern medicine, massage therapy, outpatient mental health care office visits, outpatient substance use disorder care office visits, or speech and hearing therapies. Outpatient mental health office visits do not include procedures performed on an outpatient basis. Visits for which utilization management or review is prohibited under this section are subject to any quantitative treatment limits of the health plan. Notwithstanding RCW 48.43.515(5) this section may not be interpreted to limit the ability of a health plan to require a referral or prescription for the therapies listed in this section. Quantitative treatment limitations and nonquantitative treatment limitations, including any referral and prescription requirements, for mental health or substance use disorder care shall comply with the requirements of the mental health parity and addiction equity act, state law, and any implementing regulations.

(b) For visits for which utilization management or review is prohibited under this section, a health carrier or health care benefit manager as defined in RCW 48.200.020 may not:

(i) Deny or limit coverage on the basis of medical necessity or appropriateness; or

(ii) Retroactively deny care or refuse payment for the visits.

(3) A health carrier shall post on its website and provide upon the request of a covered person or contracting provider any prior authorization standards, criteria, or information the carrier uses for medical necessity decisions.

(4) A health care provider with whom a health carrier consults regarding a decision to deny, limit, or terminate a person's covered health care services must hold a license, certification, or registration, in good standing and must be in the same or related health field as the health care provider being reviewed or of a specialty whose practice entails the same or similar covered health care service.

(5) A health carrier may not require a provider to provide a discount from usual and customary rates for health care services not covered under a health plan, policy, or other agreement, to which the provider is a party.

(6) Nothing in this section prevents a health carrier from denying coverage based on insurance fraud.

(7) For purposes of this section:

(a) "New episode of care" means treatment for a new condition or diagnosis for which the enrollee has not been treated by a provider of the same licensed profession within the previous ninety days and is not currently undergoing any active treatment.

(b) "Contracting provider" does not include providers employed within an integrated delivery system operated by a carrier licensed under chapter 48.44 or 48.46 RCW. [2025 c 227 s 3; 2020 c 193 s 2; 2019 c 308 s 22; 2018 c 193 s 1; 2015 c 251 s 2.]

Effective date—2025 c 227 ss 1-8: See note following RCW 48.43.766.

Findings—Intent—Rules—2025 c 227: See notes following RCW 48.43.766.

Intent—2020 c 193: "The legislature intends to facilitate patient access to appropriate therapies for newly diagnosed health conditions while recognizing the necessity for health carriers to employ reasonable utilization management techniques." [2020 c 193 s 1.]

Findings—2019 c 308: See note following RCW 18.06.010.

Effective date—2015 c 251: See note following RCW 41.05.074.

RCW 48.43.0161 Prior authorization practices—Carrier annual reporting requirements—Commissioner's standardized report. (1) By October 1, 2026, and annually thereafter, for individual and group health plans issued by a carrier that has written at least one percent of the total accident and health insurance premiums written by all companies authorized to offer accident and health insurance in

Washington in the most recently available year, the carrier shall report to the commissioner the following aggregated and deidentified data related to the carrier's prior authorization practices and experience for the prior plan year:

(a) The total number of prior authorization requests, approvals, and denials. The carrier must report these totals separately for approvals or denials made by the carrier directly and for approvals or denials made by a health care benefit manager as defined in RCW 48.200.020 that is delegated to make prior authorization determinations either directly or indirectly on behalf of the carrier. In the report, carriers must also indicate:

(i) The percentage of total denials that were aided by artificial intelligence;

(ii) The percent of prior authorization determinations made after the standard and expedited authorization request turnaround times stated in RCW 48.43.830; and

(iii) The total number of nonelectronic standard and nonelectronic expedited prior authorization requests;

(b) Lists of the 10 inpatient medical or surgical codes:

(i) With the highest total number of prior authorization requests during the previous plan year, including the total number of prior authorization requests for each code and the percent of approved requests for each code;

(ii) With the highest percentage of approved prior authorization requests during the previous plan year, including the total number of prior authorization requests for each code and the percent of approved requests for each code; and

(iii) With the highest percentage of prior authorization requests that were initially denied and then subsequently approved on appeal, including the total number of prior authorization requests for each code and the percent of requests that were initially denied and then subsequently approved for each code;

(c) Lists of the 10 outpatient medical or surgical codes:

(i) With the highest total number of prior authorization requests during the previous plan year, including the total number of prior authorization requests for each code and the percent of approved requests for each code;

(ii) With the highest percentage of approved prior authorization requests during the previous plan year, including the total number of prior authorization requests for each code and the percent of approved requests for each code; and

(iii) With the highest percentage of prior authorization requests that were initially denied and then subsequently approved on appeal, including the total number of prior authorization requests for each code and the percent of requests that were initially denied and then subsequently approved for each code;

(d) Lists of the 10 inpatient mental health and substance use disorder service codes:

(i) With the highest total number of prior authorization requests during the previous plan year, including the total number of prior authorization requests for each code and the percent of approved requests for each code;

(ii) With the highest percentage of approved prior authorization requests during the previous plan year, including the total number of prior authorization requests for each code and the percent of approved requests for each code; and

(iii) With the highest percentage of prior authorization requests that were initially denied and then subsequently approved on appeal, including the total number of prior authorization requests for each code and the percent of requests that were initially denied and then subsequently approved for each code;

(e) Lists of the 10 outpatient mental health and substance use disorder service codes:

(i) With the highest total number of prior authorization requests during the previous plan year, including the total number of prior authorization requests for each code and the percent of approved requests for each code;

(ii) With the highest percentage of approved prior authorization requests during the previous plan year, including the total number of prior authorization requests for each code and the percent of approved requests for each code; and

(iii) With the highest percentage of prior authorization requests that were initially denied and then subsequently approved on appeal, including the total number of prior authorization requests for each code and the percent of requests that were initially denied and then subsequently approved;

(f) Lists of the 10 durable medical equipment codes:

(i) With the highest total number of prior authorization requests during the previous plan year, including the total number of prior authorization requests for each code and the percent of approved requests for each code;

(ii) With the highest percentage of approved prior authorization requests during the previous plan year, including the total number of prior authorization requests for each code and the percent of approved requests for each code; and

(iii) With the highest percentage of prior authorization requests that were initially denied and then subsequently approved on appeal, including the total number of prior authorization requests for each code and the percent of requests that were initially denied and then subsequently approved for each code;

(g) Lists of the 10 diabetes supplies and equipment codes:

(i) With the highest total number of prior authorization requests during the previous plan year, including the total number of prior authorization requests for each code and the percent of approved requests for each code;

(ii) With the highest percentage of approved prior authorization requests during the previous plan year, including the total number of prior authorization requests for each code and the percent of approved requests for each code; and

(iii) With the highest percentage of prior authorization requests that were initially denied and then subsequently approved on appeal, including the total number of prior authorization requests for each code and the percent of requests that were initially denied and then subsequently approved for each code;

(h) Lists of the 10 prescription drugs:

(i) With the highest total number of prior authorization requests during the previous plan year, including the total number of prior authorization requests for each prescription drug and the percent of approved requests for each prescription drug;

(ii) With the highest percentage of approved prior authorization requests during the previous plan year, including the total number of prior authorization requests for each prescription drug and the percent of approved requests for each prescription drug; and

(iii) With the highest percentage of prior authorization requests that were initially denied and then subsequently approved on appeal, including the total number of prior authorization requests for each prescription drug and the percent of requests that were initially denied and then subsequently approved for each prescription drug; and

(i) The average determination response time in hours for prior authorization requests to the carrier in total reported under (a) of this subsection and with respect to each code reported under (b) through (h) of this subsection for each of the following categories of prior authorization:

(i) Expedited decisions;

(ii) Standard decisions; and

(iii) Extenuating circumstances decisions.

(2)(a) By January 1, 2021, and annually thereafter, the commissioner shall aggregate and deidentify the data collected under subsection (1)(b) through (h) of this section into a standard report and may not identify the name of the carrier that submitted the data. The commissioner must make the report available to interested parties.

(b) The report must contain trend data for total authorization requests, approvals, and denials submitted under subsection (1)(a) of this section separately for each carrier directly and for each health care benefit manager, as defined in RCW 48.200.020, that is delegated to make prior authorization determinations either directly or indirectly on behalf of the carrier.

(3) The commissioner may request additional information from carriers reporting data under this section.

(4) The commissioner may adopt rules to implement this section. In adopting rules, the commissioner must consult stakeholders including carriers, health care practitioners, health care facilities, and patients.

(5) For the purpose of this section, "prior authorization" means a mandatory process that a carrier or its designated or contracted representative requires a provider or facility to follow before a service is delivered, to determine if a service is a benefit and meets the requirements for medical necessity, clinical appropriateness, level of care, or effectiveness in relation to the applicable plan, including any term used by a carrier or its designated or contracted representative to describe this process. [2026 c 157 s 8; 2023 c 382 s 4; 2020 c 316 s 1.]

Finding—Intent—2026 c 157: See note following RCW 48.43.830.

Effective date—2023 c 382 s 4: "Section 4 of this act takes effect January 1, 2024." [2023 c 382 s 5.]

RCW 48.43.021 Personally identifiable health information—Restrictions on release. Except as otherwise required by statute or rule, a carrier and the Washington state health insurance pool, and persons acting at the direction of or on behalf of a carrier or the pool, who are in receipt of an enrollee's or applicant's personally identifiable health information included in the standard health questionnaire shall not disclose the identifiable health information unless such disclosure is explicitly authorized in writing by the person who is the subject of the information. [2000 c 79 s 22.]

Effective date—Severability—2000 c 79: See notes following RCW 48.04.010.

RCW 48.43.022 Enrollee identification card—Social security number restriction. After December 31, 2005, a health carrier that issues a card identifying a person as an enrollee, and requires the person to present the card to providers for purposes of claims processing, may not display on the card an identification number that includes more than a four-digit portion of the person's complete social security number. [2004 c 115 s 1.]

RCW 48.43.023 Pharmacy identification cards—Rules. (1) A health carrier that provides coverage for prescription drugs provided on an outpatient basis and issues a card or other technology for claims processing, or an administrator of a health benefit plan including, but not limited to, third-party administrators for self-insured plans, pharmacy benefits managers, and state administered plans, shall issue to its enrollees a pharmacy identification card or other technology containing all information required for proper prescription drug claims adjudication.

(2) Upon renewal of the health benefit plan, information on the pharmacy identification card or other technology shall be made current by the health carrier or other entity that issues the card.

(3) Nothing in this section shall be construed to require any health carrier or administrator of a health benefit plan to issue a pharmacy identification card or other technology separate from another identification card issued to an enrollee under the health benefit plan if the identification card contains all of the information required under subsection (1) of this section.

(4) This section applies to health benefit plans that are delivered, issued for delivery, or renewed on or after July 1, 2003. For the purposes of this section, renewal of a health benefit policy, contract, or plan occurs on each anniversary of the date on which coverage was first effective on the person or persons covered by the health benefit plan.

(5) The insurance commissioner may adopt rules to implement chapter 106, Laws of 2001, taking into consideration any relevant standards developed by the national council for prescription drug programs and the requirements of the federal health insurance portability and accountability act of 1996. [2001 c 106 s 2.]

Intent—2001 c 106: "It is the intent of the legislature to improve care to patients by minimizing confusion, eliminating unnecessary paperwork, decreasing administrative burdens, and streamlining dispensing of prescription products paid for by third-party payors." [2001 c 106 s 1.]

RCW 48.43.028 Eligibility to purchase certain health benefit plans—Small employers and small groups. To the extent required of the federal health insurance portability and accountability act of 1996, the eligibility of an employer or group to purchase a health benefit plan set forth in RCW 48.21.045(1)(b), 48.44.023(1)(b), and

48.46.066(1)(b) must be extended to all small employers and small groups as defined in RCW 48.43.005. [2001 c 196 s 10.]

Effective date—2001 c 196: See note following RCW 48.20.025.

RCW 48.43.035 Group health benefit plans—Guaranteed issue and continuity of coverage—Exceptions. For group health benefit plans, the following shall apply:

(1) All health carriers shall accept for enrollment any state resident within the group to whom the plan is offered and within the carrier's service area and provide or assure the provision of all covered services regardless of age, sex, family structure, ethnicity, race, health condition, geographic location, employment status, socioeconomic status, other condition or situation, or the provisions of RCW 49.60.174(2). The insurance commissioner may grant a temporary exemption from this subsection, if, upon application by a health carrier the commissioner finds that the clinical, financial, or administrative capacity to serve existing enrollees will be impaired if a health carrier is required to continue enrollment of additional eligible individuals.

(2) Except as provided in subsection (5) of this section, all health plans shall contain or incorporate by endorsement a guarantee of the continuity of coverage of the plan. For the purposes of this section, a plan is "renewed" when it is continued beyond the earliest date upon which, at the carrier's sole option, the plan could have been terminated for other than nonpayment of premium. The carrier may consider the group's anniversary date as the renewal date for purposes of complying with the provisions of this section.

(3) The guarantee of continuity of coverage required in health plans shall not prevent a carrier from canceling or nonrenewing a health plan for:

(a) Nonpayment of premium;

(b) Violation of published policies of the carrier approved by the insurance commissioner;

(c) Covered persons entitled to become eligible for medicare benefits by reason of age who fail to apply for a medicare supplement plan or medicare cost, risk, or other plan offered by the carrier pursuant to federal laws and regulations;

(d) Covered persons who fail to pay any deductible or copayment amount owed to the carrier and not the provider of health care services;

(e) Covered persons committing fraudulent acts as to the carrier;

(f) Covered persons who materially breach the health plan; or

(g) Change or implementation of federal or state laws that no longer permit the continued offering of such coverage.

(4) The provisions of this section do not apply in the following cases:

(a) A carrier has zero enrollment on a product;

(b) A carrier replaces a product and the replacement product is provided to all covered persons within that class or line of business, includes all of the services covered under the replaced product, and does not significantly limit access to the kind of services covered under the replaced product. The health plan may also allow unrestricted conversion to a fully comparable product;

(c) No sooner than January 1, 2005, a carrier discontinues offering a particular type of health benefit plan offered for groups of up to two hundred if: (i) The carrier provides notice to each group of the discontinuation at least ninety days prior to the date of the discontinuation; (ii) the carrier offers to each group provided coverage of this type the option to enroll, with regard to small employer groups, in any other small employer group plan, or with regard to groups of up to two hundred, in any other applicable group plan, currently being offered by the carrier in the applicable group market; and (iii) in exercising the option to discontinue coverage of this type and in offering the option of coverage under (c)(ii) of this subsection, the carrier acts uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for this coverage;

(d) A carrier discontinues offering all health coverage in the small group market or for groups of up to two hundred, or both markets, in the state and discontinues coverage under all existing group health benefit plans in the applicable market involved if: (i) The carrier provides notice to the commissioner of its intent to discontinue offering all such coverage in the state and its intent to discontinue coverage under all such existing health benefit plans at least one hundred eighty days prior to the date of the discontinuation of coverage under all such existing health benefit plans; and (ii) the carrier provides notice to each covered group of the intent to discontinue the existing health benefit plan at least one hundred eighty days prior to the date of discontinuation. In the case of discontinuation under this subsection, the carrier may not issue any group health coverage in this state in the applicable group market involved for a five-year period beginning on the date of the discontinuation of the last health benefit plan not so renewed. This subsection (4) does not require a carrier to provide notice to the commissioner of its intent to discontinue offering a health benefit plan to new applicants when the carrier does not discontinue coverage of existing enrollees under that health benefit plan; or

(e) A carrier is withdrawing from a service area or from a segment of its service area because the carrier has demonstrated to the insurance commissioner that the carrier's clinical, financial, or administrative capacity to serve enrollees would be exceeded.

(5) The provisions of this section do not apply to health plans deemed by the insurance commissioner to be unique or limited or have a short-term purpose, after a written request for such classification by the carrier and subsequent written approval by the insurance commissioner. [2010 c 292 s 2; 2004 c 244 s 4; 2000 c 79 s 24; 1995 c 265 s 7.]

Application—Contingent effective date—2010 c 292: See notes following RCW 48.43.005.

Application—2004 c 244: See note following RCW 48.21.045.

Effective date—Severability—2000 c 79: See notes following RCW 48.04.010.

Captions not law—Effective dates—Savings—Severability—1995 c 265: See notes following RCW 70.47.015.

RCW 48.43.038 Individual health plans—Guarantee of continuity of coverage—Exceptions. (1) Except as provided in subsection (4) of this section, all individual health plans shall contain or incorporate by endorsement a guarantee of the continuity of coverage of the plan. For the purposes of this section, a plan is "renewed" when it is continued beyond the earliest date upon which, at the carrier's sole option, the plan could have been terminated for other than nonpayment of premium.

(2) The guarantee of continuity of coverage required in individual health plans shall not prevent a carrier from canceling or nonrenewing a health plan for:

(a) Nonpayment of premium;

(b) Violation of published policies of the carrier approved by the commissioner;

(c) Covered persons entitled to become eligible for medicare benefits by reason of age who fail to apply for a medicare supplement plan or medicare cost, risk, or other plan offered by the carrier pursuant to federal laws and regulations;

(d) Covered persons who fail to pay any deductible or copayment amount owed to the carrier and not the provider of health care services;

(e) Covered persons committing fraudulent acts as to the carrier;

(f) Covered persons who materially breach the health plan; or

(g) Change or implementation of federal or state laws that no longer permit the continued offering of such coverage.

(3) This section does not apply in the following cases:

(a) A carrier has zero enrollment on a product;

(b) A carrier is withdrawing from a service area or from a segment of its service area because the carrier has demonstrated to the commissioner that the carrier's clinical, financial, or administrative capacity to serve enrollees would be exceeded;

(c) No sooner than the first day of the month following the expiration of a one hundred eighty-day period beginning on March 23, 2000, a carrier discontinues offering a particular type of health benefit plan offered in the individual market if: (i) The carrier provides notice to each covered individual provided coverage of this type of such discontinuation at least ninety days prior to the date of the discontinuation; (ii) the carrier offers to each individual provided coverage of this type the option, without being subject to the standard health questionnaire, to enroll in any other individual health benefit plan currently being offered by the carrier; and (iii) in exercising the option to discontinue coverage of this type and in offering the option of coverage under (c)(ii) of this subsection, the carrier acts uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for such coverage; or

(d) A carrier discontinues offering all individual health coverage in the state and discontinues coverage under all existing individual health benefit plans if: (i) The carrier provides notice to the commissioner of its intent to discontinue offering all individual health coverage in the state and its intent to discontinue coverage under all existing health benefit plans at least one hundred eighty days prior to the date of the discontinuation of coverage under all existing health benefit plans; and (ii) the carrier provides notice to each covered individual of the intent to discontinue his or her existing health benefit plan at least one hundred eighty days prior to

the date of such discontinuation. In the case of discontinuation under this subsection, the carrier may not issue any individual health coverage in this state for a five-year period beginning on the date of the discontinuation of the last health plan not so renewed. Nothing in this subsection (3) shall be construed to require a carrier to provide notice to the commissioner of its intent to discontinue offering a health benefit plan to new applicants where the carrier does not discontinue coverage of existing enrollees under that health benefit plan.

(4) The provisions of this section do not apply to health plans deemed by the commissioner to be unique or limited or have a short-term purpose, after a written request for such classification by the carrier and subsequent written approval by the commissioner. [2000 c 79 s 25.]

Effective date—Severability—2000 c 79: See notes following RCW 48.04.010.

RCW 48.43.039 Grace period—Notification or information—Information concerning delinquencies or nonpayment of premiums—Defined. (1) For an enrollee who is in the second or third month of the grace period, an issuer of a qualified health plan shall:

(a) Upon request by a health care provider or health care facility, provide information regarding the enrollee's eligibility status in real time;

(b) Notify a health care provider or health care facility that an enrollee is in the grace period within three business days after submittal of a claim or status request for services provided; and

(c) If the health care provider or health care facility is providing care to an enrollee in the grace period, the provider or facility shall, wherever possible, encourage the enrollee to pay delinquent premiums to the issuer and provide information regarding the impact of nonpayment of premiums on access to services.

(2) The information or notification required under subsection (1) of this section must, at a minimum:

(a) Indicate "grace period" or use the appropriate national coding standard as the reason for pending the claim if a claim is pended due to the enrollee's grace period status; and

(b) Except for notifications provided electronically, indicate that enrollee is in the second or third month of the grace period.

(3) No earlier than January 1, 2016, and once the exchange has terminated premium aggregation functionality for qualified health plans offered in the individual exchange and issuers are accepting all payments from enrollees directly, an issuer of a qualified health plan shall:

(a) For an enrollee in the grace period, include a statement in a delinquency notice that concisely explains the impact of nonpayment of premiums on access to coverage and health care services and encourages the enrollee to contact the issuer regarding coverage options that may be available;

(b) For an enrollee who has exhausted the grace period, include a statement in a termination notice for nonpayment of premium informing the enrollee that other coverage options such as medicaid may be available and to contact the issuer or the exchange for additional information; and

(c) For a delinquency notice described in this subsection, include concise information on how a subsidized enrollee may report to the exchange a change in income or circumstances, including any deadline for doing so, and an explanation that it may result in a change in premium or cost-sharing amount or program eligibility.

(4) Upon the transfer of premium collection to the qualified health plan, each qualified health plan must provide detailed reports to the exchange to support the legislative reporting requirements.

(5) For purposes of this section, "grace period" means nonpayment of premiums by an enrollee receiving advance payments of the premium tax credit, as defined in section 1412 of the patient protection and affordable care act, P.L. 111-148, as amended by the health care and education reconciliation act, P.L. 111-152, and implementing regulations issued by the federal department of health and human services. [2018 c 44 s 9; 2015 3rd sp.s. c 33 s 4; 2014 c 84 s 3; 2014 c 84 s 2.]

Contingent effective date—2014 c 84 s 3: "Section 3 of this act takes effect January 1st following the issuance of a report under section 2(3) of this act indicating that coverage was terminated due to nonpayment of premium for ten thousand or more enrollees who were in the grace period in that calendar year. In no case may section 3 of this act take effect before January 1, 2015. The health benefit exchange must provide notice of the effective date of section 3 of this act to affected parties, the chief clerk of the house of representatives, the secretary of the senate, the office of the code reviser, and others as deemed appropriate by the health benefit exchange." [2014 c 84 s 4.] The health benefit exchange issued a report meeting the contingency requirements of this section on December 1, 2014; therefore, the effective date of section 3, chapter 84, Laws of 2014 is January 1, 2015.

RCW 48.43.041 Individual health benefit plans—Mandatory benefits. (1) All individual health benefit plans, other than catastrophic health plans, offered or renewed on or after October 1, 2000, shall include benefits described in this section. Nothing in this section shall be construed to require a carrier to offer an individual health benefit plan.

(a) Maternity services that include, with no enrollee cost-sharing requirements beyond those generally applicable cost-sharing requirements: Diagnosis of pregnancy; prenatal care; delivery; care for complications of pregnancy; physician services; hospital services; operating or other special procedure rooms; radiology and laboratory services; appropriate medications; anesthesia; and services required under RCW 48.43.115; and

(b) Prescription drug benefits with at least a two thousand dollar benefit payable by the carrier annually.

(2) If a carrier offers a health benefit plan that is not a catastrophic health plan to groups, and it chooses to offer a health benefit plan to individuals, it must offer at least one health benefit plan to individuals that is not a catastrophic health plan. [2000 c 79 s 26.]

Effective dates—2000 c 79 ss 26, 38, and 39: "(1) Section 38 of this act takes effect July 1, 2000.

(2) Section 39 of this act takes effect September 1, 2000.

(3) *Section 26 of this act takes effect on the first day of the month following the expiration of a one hundred eighty-day period beginning on the effective date of section 25 of this act." [2000 c 79 s 50.]

***Reviser's note:** Section 26 of this act takes effect October 1, 2000.

Severability—2000 c 79: See note following RCW 48.04.010.

RCW 48.43.043 Colorectal cancer examinations and laboratory tests—Required benefits or coverage. (1) Health plans issued or renewed on or after July 1, 2008, must provide benefits or coverage for colorectal cancer examinations and laboratory tests consistent with the guidelines or recommendations of the United States preventive services task force or the federal centers for disease control and prevention. Benefits or coverage must be provided:

(a) For any of the colorectal screening examinations and tests in the selected guidelines or recommendations, at a frequency identified in such guidelines or recommendations, as deemed appropriate by the patient's physician after consultation with the patient; and

(b) To a covered individual who is:

(i) At least fifty years old; or

(ii) Less than fifty years old and at high risk or very high risk for colorectal cancer according to such guidelines or recommendations.

(2) To encourage colorectal cancer screenings, patients and health care providers must not be required to meet burdensome criteria or overcome significant obstacles to secure such coverage. An individual may not be required to pay an additional deductible or coinsurance for testing that is greater than an annual deductible or coinsurance established for similar benefits. If the health plan does not cover a similar benefit, a deductible or coinsurance may not be set at a level that materially diminishes the value of the colorectal cancer benefit required.

(3)(a) A health carrier is not required under this section to provide for a referral to a nonparticipating health care provider, unless the carrier does not have an appropriate health care provider that is available and accessible to administer the screening exam and that is a participating health care provider with respect to such treatment.

(b) If a health carrier refers an individual to a nonparticipating health care provider pursuant to this section, screening exam services or resulting treatment, if any, must be provided at no additional cost to the individual beyond what the individual would otherwise pay for services provided by a participating health care provider. [2007 c 23 s 1.]

RCW 48.43.045 Health plan requirements—Annual reports—Exemptions. (1) Every health plan delivered, issued for delivery, or renewed by a health carrier on and after January 1, 1996, shall:

(a) Permit every category of health care provider to provide health services or care included in the basic essential health benefits benchmark plan established by the commissioner consistent with RCW 48.43.715, to the extent that:

(i) The provision of such health services or care is within the health care providers' permitted scope of practice;

(ii) The providers agree to abide by standards related to:

(A) Provision, utilization review, and cost containment of health services;

(B) Management and administrative procedures; and

(C) Provision of cost-effective and clinically efficacious health services; and

(iii) The plan covers such services or care in the essential health benefits benchmark plan. The reference to the essential health benefits does not create a mandate to cover a service that is otherwise not a covered benefit.

(b) Annually report the names and addresses of all officers, directors, or trustees of the health carrier during the preceding year, and the amount of wages, expense reimbursements, or other payments to such individuals, unless substantially similar information is filed with the commissioner or the national association of insurance commissioners. This requirement does not apply to a foreign or alien insurer regulated under chapter 48.20 or 48.21 RCW that files a supplemental compensation exhibit in its annual statement as required by law.

(2) The requirements of subsection (1)(a) of this section do not apply to a licensed health care profession regulated under Title 18 RCW when the licensing statute for the profession states that such requirements do not apply. [2015 c 237 s 2; 2007 c 253 s 12; 2007 c 98 s 18; 2006 c 25 s 7; 1997 c 231 s 205; 1995 c 265 s 8.]

Effective date—Implementation—2007 c 253: See RCW 18.250.901 and 18.250.902.

Effective dates—2007 c 98: See RCW 18.74.912.

Short title—Part headings and captions not law—Severability—Effective dates—1997 c 231: See notes following RCW 48.43.005.

Captions not law—Effective dates—Savings—Severability—1995 c 265: See notes following RCW 70.47.015.

RCW 48.43.047 Health plans—Minimum coverage for preventive services—No cost-sharing requirements. (1) A nongrandfathered health plan issued on or after April 1, 2026, must, at a minimum, provide coverage for the following preventive services:

(a) Evidence-based items or services that have a rating of A or B in the recommendations of the United States preventive services task force in effect on June 30, 2025, and items and services included in rules adopted by the insurance commissioner under this section with respect to the enrollee;

(b) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the health resources and services administration in effect on June 30, 2025, and preventive care and screenings included in rules adopted by the insurance commissioner under this section;

(c) With respect to women, additional preventive care and screenings that are not listed with a rating of A or B by the United

States preventive services task force but that are provided for in comprehensive guidelines supported by the health resources and services administration in effect on June 30, 2025, and preventive care and screenings included in rules adopted by the insurance commissioner under this section; and

(d) Immunizations that have in effect a recommendation from the department of health under RCW 43.70.527.

(2) A nongrandfathered health plan must provide coverage for:

(a) The preventive services required to be covered under subsection (1)(a) through (c) of this section consistent with federal rules and guidance related to coverage of such preventive services in effect on June 30, 2025, and rules adopted by the insurance commissioner under this section; and

(b) Immunizations required to be covered under subsection (1)(d) of this section consistent with department of health guidance issued under RCW 43.70.527.

(3) A nongrandfathered health plan must provide coverage for the preventive services required to be covered under subsections (1) and (2) of this section for plan years that begin on or after the date that is one year after the date the recommendation or guideline is issued.

(4)(a) Except as provided in (b) of this subsection, the health plan may not impose cost-sharing requirements for the preventive services required to be covered under subsections (1) and (2) of this section when the services are provided by an in-network provider. If a plan does not have in its network a provider who can provide an item or service described in subsections (1) and (2) of this section, the plan must cover the item or service when performed by an out-of-network provider and may not impose cost sharing with respect to the item or service.

(b) For a health plan offered as a qualifying health plan for a health savings account, the carrier may apply cost sharing to coverage of the services required to be covered under subsections (1) and (2) of this section only at the minimum level necessary to preserve the enrollee's ability to claim tax exempt contributions and withdrawals from the enrollee's health savings account under internal revenue service laws and regulations.

(5) A carrier may use reasonable medical management techniques to determine the frequency, method, treatment, or setting for an item or service described in subsections (1) and (2) of this section to the extent not specified in the relevant recommendation or guideline, federal rules and guidance related to the coverage of preventive services in effect on June 30, 2025, department of health guidance issued under RCW 43.70.527, and any rules adopted by the insurance commissioner.

(6) The insurance commissioner may adopt rules necessary to implement the requirements of this section, including rules modifying coverage requirements for preventive services under subsection (1)(a) through (c) of this section based on the addition of preventive services or other changes to the recommendations and guidelines referenced in subsection (1)(a) through (c) of this section that are made after June 30, 2025. Any rules adopted by the insurance commissioner must be as or more favorable to enrollees with respect to coverage of preventive services than the recommendations and guidelines in effect on June 30, 2025. In adopting any rules under this subsection, the insurance commissioner must:

(a) Consult with the health care authority and department of health; and

(b) Consider the recommendations of the department of health issued under RCW 43.70.527 and recommendations issued by the United States preventive services task force, the health resources and services administration, and experts and expert organizations that the commissioner in their discretion deems relevant and based on reasonable scientific evidence and judgment. [2026 c 13 s 3; 2024 c 314 s 1; 2018 c 14 s 1.]

Intent—Effective date—2026 c 13: See notes following RCW 43.70.527.

RCW 48.43.055 Procedures for review and adjudication of health care provider complaints—Requirements. (1) Except as provided by subsection (2) of this section, each health carrier as defined under RCW 48.43.005 shall file with the commissioner its procedures for review and adjudication of complaints initiated by health care providers. Procedures filed under this section shall provide a fair review for consideration of complaints. Every health carrier shall provide reasonable means allowing any health care provider aggrieved by actions of the health carrier to be heard after submitting a written request for review. If the health carrier fails to grant or reject a request within thirty days after it is made, the complaining health care provider may proceed as if the complaint had been rejected. A complaint that has been rejected by the health carrier may be submitted to nonbinding mediation. Mediation shall be conducted under chapter 7.07 RCW, or any other rules of mediation agreed to by the parties. This section is solely for resolution of provider complaints. Complaints by, or on behalf of, a covered person are subject to the grievance processes in RCW 48.43.530.

(2) For purposes of out-of-network payment disputes between a health carrier and health care provider covered under the provisions of chapter 48.49 RCW, the arbitration provisions of chapter 48.49 RCW apply. [2019 c 427 s 28; 2005 c 172 s 19; 2002 c 300 s 6; 1995 c 265 s 20.]

Findings—Intent—Effective date—2019 c 427: See RCW 48.49.003 and 48.49.900.

Short title—Effective date—2005 c 172: See RCW 7.07.900 and 7.07.904.

Captions not law—Effective dates—Savings—Severability—1995 c 265: See notes following RCW 70.47.015.

RCW 48.43.059 Payments made by a second-party payment process—Definition. (1) For the purposes of this section, "second-party payment process" means a process in which: (a) An individual has an account under his or her name maintained with a financial institution and is either managed by the financial institution or an entity that, with the express agreement with the individual, has established the account on behalf of the individual with a financial institution; (b) the account is funded with funds from the individual or his or her

family members or in a manner otherwise consistent with federal law including, but not limited to, federal guidance implementing the federal patient protection and affordable care act; and (c) the account is under the control of the covered person, such that the covered person may authorize payments from the account.

(2) All issuers must accept any payments made by a second-party payment process; however, no issuer need accept payment by a second-party payment process if the second-party payer is controlled by or receives funding from any entity where such entity may be reimbursed by an issuer for providing health care services or if the account under the control of the covered person is funded by any such entity, except those third-party entities from whom federal law requires such issuer to accept payment.

(3) Payments made under subsection (2) of this section may be made with any legal tender denominated in United States dollars. [2015 c 284 s 2.]

Recognition—Intent—2015 c 284: "(1) The legislature recognizes that under regulations implementing the federal patient protection and affordable care act, issuers offering individual market qualified health plans are required to accept third-party premium and cost-sharing payments from the Ryan White HIV/AIDS program under Title XXVI of the public health service act, Indian tribes, tribal organizations or urban Indian organizations, and state and federal government programs. However, federal regulators have stated that they have serious concerns about payments made on a third-party basis by hospitals, health care providers, and other commercial entities using their own funds because of the potential that such payments could cause distortions in the insurance market.

(2) The legislature intends to clarify that an entity that makes premium payments from accounts that are owned and controlled by the covered person do not constitute a third party for the purposes of acceptance of premium payments by an issuer. The legislature does not intend to impact third-party payment programs required under federal law, including, but not limited to, federal guidance implementing the federal patient protection and affordable care act." [2015 c 284 s 1.]

RCW 48.43.065 Right of individuals to receive services—Right of providers, carriers, and facilities to refuse to participate in or pay for services for reason of conscience or religion—Requirements. (1) The legislature recognizes that every individual possesses a fundamental right to exercise their religious beliefs and conscience. The legislature further recognizes that in developing public policy, conflicting religious and moral beliefs must be respected. Therefore, while recognizing the right of conscientious objection to participating in specific health services, the state shall also recognize the right of individuals enrolled with plans containing the basic health plan services to receive the full range of services covered under the plan.

(2)(a) No individual health care provider, religiously sponsored health carrier, or health care facility may be required by law or contract in any circumstances to participate in the provision of or payment for a specific service if they object to so doing for reason of conscience or religion. No person may be discriminated against in employment or professional privileges because of such objection.

(b) The provisions of this section are not intended to result in an enrollee being denied timely access to any service included in the basic health plan services. Each health carrier shall:

(i) Provide written notice to enrollees, upon enrollment with the plan, listing services that the carrier refuses to cover for reason of conscience or religion;

(ii) Provide written information describing how an enrollee may directly access services in an expeditious manner; and

(iii) Ensure that enrollees refused services under this section have prompt access to the information developed pursuant to (b)(ii) of this subsection.

(c) The insurance commissioner shall establish by rule a mechanism or mechanisms to recognize the right to exercise conscience while ensuring enrollees timely access to services and to assure prompt payment to service providers.

(3)(a) No individual or organization with a religious or moral tenet opposed to a specific service may be required to purchase coverage for that service or services if they object to doing so for reason of conscience or religion.

(b) The provisions of this section shall not result in an enrollee being denied coverage of, and timely access to, any service or services excluded from their benefits package as a result of their employer's or another individual's exercise of the conscience clause in (a) of this subsection.

(c) The insurance commissioner shall define by rule the process through which health carriers may offer the basic health plan services to individuals and organizations identified in (a) and (b) of this subsection in accordance with the provisions of subsection (2)(c) of this section.

(4) Nothing in this section requires a health carrier, health care facility, or health care provider to provide any health care services without appropriate payment of premium or fee. [1995 c 265 s 25.]

Captions not law—Effective dates—Savings—Severability—1995 c 265: See notes following RCW 70.47.015.

RCW 48.43.071 Health care information—Requirement to provide free copy to covered person appealing denial of social security benefits—Exceptions. Upon request of a covered person or a covered person's personal representative, an issuer shall provide the covered person or representative with one copy of the covered person's health care information free of charge if the covered person is appealing the denial of federal supplemental security income or social security disability benefits. The issuer may provide the health care information in either paper or electronic format. An issuer is not required to provide a covered person or a covered person's personal representative with a free copy of health care information that has previously been provided free of charge pursuant to a request within the preceding two years. For purposes of this section, "health care information" has the same meaning as in RCW 70.02.010. [2018 c 87 s 4.]

RCW 48.43.072 Required reproductive health care coverage—Restrictions on copayments, deductibles, and other form of cost sharing. (1) A health plan or student health plan, including student health plans deemed by the insurance commissioner to have a short-term limited purpose or duration or to be guaranteed renewable while the covered person is enrolled as a regular full-time undergraduate or graduate student at an accredited higher education institution, shall provide coverage for:

(a) All contraceptive drugs, devices, and other products, approved by the federal food and drug administration, including over-the-counter contraceptive drugs, devices, and products, approved by the federal food and drug administration. This includes condoms, regardless of the gender or sexual orientation of the covered person, and regardless of whether they are to be used for contraception or exclusively for the prevention of sexually transmitted infections;

(b) Voluntary sterilization procedures;

(c) The consultations, examinations, procedures, and medical services that are necessary to prescribe, dispense, insert, deliver, distribute, administer, or remove the drugs, devices, and other products or services in (a) and (b) of this subsection;

(d) The following preventive services:

(i) Screening for physical, mental, sexual, and reproductive health care needs that arise from a sexual assault; and

(ii) Well-person preventive visits;

(e) Medically necessary services and prescription medications for the treatment of physical, mental, sexual, and reproductive health care needs that arise from a sexual assault; and

(f) The following reproductive health-related over-the-counter drugs and products approved by the federal food and drug administration: Prenatal vitamins for pregnant persons; and breast pumps for covered persons expecting the birth or adoption of a child.

(2) The coverage required by subsection (1) of this section:

(a) May not require copayments, deductibles, or other forms of cost sharing:

(i) Except for:

(A) The medically necessary services and prescription medications required by subsection (1)(e) of this section; and

(B) The drugs and products in subsection (1)(f) of this section; or

(ii) Unless the health plan is offered as a qualifying health plan for a health savings account. For such a qualifying health plan, the carrier must establish the plan's cost sharing for the coverage required by subsection (1) of this section at the minimum level necessary to preserve the enrollee's ability to claim tax exempt contributions and withdrawals from the enrollee's health savings account under internal revenue service laws and regulations; and

(b) May not require a prescription to trigger coverage of over-the-counter contraceptive drugs, devices, and products, approved by the federal food and drug administration, except those reproductive health-related drugs and products as set forth in subsection (1)(f) of this section.

(3) A health carrier may not deny the coverage required in subsection (1) of this section because an enrollee changed the enrollee's contraceptive method within a twelve-month period.

(4) Except as otherwise authorized under this section, a health benefit plan may not impose any restrictions or delays on the coverage

required under this section, such as medical management techniques that limit enrollee choice in accessing the full range of contraceptive drugs, devices, or other products, approved by the federal food and drug administration.

(5) Benefits provided under this section must be extended to all enrollees, enrolled spouses, and enrolled dependents.

(6) This section may not be construed to allow for denial of care on the basis of race, color, national origin, sex, sexual orientation, gender expression or identity, marital status, age, citizenship, immigration status, or disability.

(7) A health plan or student health plan, including student health plans deemed by the insurance commissioner to have a short-term limited purpose or duration or to be guaranteed renewable while the covered person is enrolled as a regular full-time undergraduate or graduate student at an accredited higher education institution, issued or renewed on or after January 1, 2021, may not issue automatic initial denials of coverage for reproductive health care services that are ordinarily or exclusively available to individuals of one gender, based on the fact that the individual's gender assigned at birth, gender identity, or gender otherwise recorded in one or more government-issued documents, is different from the one to which such health services are ordinarily or exclusively available.

(8) The definitions in this subsection apply throughout this section unless the context clearly requires otherwise.

(a) "Gender expression" means a person's gender-related appearance and behavior, whether or not stereotypically associated with the person's gender assigned at birth.

(b) "Gender identity" means a person's internal sense of the person's own gender, regardless of the person's gender assigned at birth.

(c) "Reproductive health care services" means any medical services or treatments, including pharmaceutical and preventive care service or treatments, directly involved in the reproductive system and its processes, functions, and organs involved in reproduction, in all stages of life. Reproductive health care services does not include infertility treatment.

(d) "Reproductive system" includes, but is not limited to: Genitals, gonads, the uterus, ovaries, fallopian tubes, and breasts.

(e) "Well-person preventive visits" means the preventive annual visits recommended by the federal health resources and services administration women's preventive services guidelines, with the understanding that those visits must be covered for women, and when medically appropriate, for transgender, nonbinary, and intersex individuals.

(9) This section may not be construed to authorize discrimination on the basis of gender identity or expression, or perceived gender identity or expression, in the provision of nonreproductive health care services.

(10) The commissioner, under RCW 48.30.300, and the human rights commission, under chapter 49.60 RCW[,] shall share enforcement authority over complaints of discrimination under this section as set forth in RCW 49.60.178.

(11) The commissioner may adopt rules to implement this section. [2019 c 399 s 3; 2018 c 119 s 2.]

Recommendations—Preexposure and postexposure prophylaxis financial support awareness—2019 c 399: "The department of health shall develop recommendations for increasing awareness about financial support that is available for preexposure and postexposure prophylaxis. The department of health shall consult with the state board of health, the health care authority, and the health benefit exchange in developing its recommendation related to outreach and education to affected populations. By December 1, 2019, the department of health shall provide its recommendations to the appropriate committees of the legislature." [2019 c 399 s 7.]

Effective dates—2019 c 399 ss 2 and 3: See note following RCW 74.09.875.

Findings—Short title—2019 c 399: See notes following RCW 74.09.875.

Findings—Declarations—2018 c 119: "The legislature finds and declares that:

(1) Washington has a long history of protecting gender equity and women's reproductive health;

(2) Access to the full range of health benefits and preventive services, as guaranteed under the laws of this state, provides all Washingtonians with the opportunity to lead healthier and more productive lives;

(3) Reproductive health care is the care necessary to support the reproductive system, the capability to reproduce, and the freedom and services necessary to decide if, when, and how often to do so, which can include contraception, cancer and disease screenings, abortion, preconception, maternity, prenatal, and postpartum care. This care is an essential part of primary care for women and teens, and often reproductive health issues are the primary reason they seek routine medical care;

(4) Neither a woman's income level nor her type of insurance should prevent her from having access to a full range of reproductive health care, including contraception and abortion services;

(5) Restrictions and barriers to health coverage for reproductive health care have a disproportionate impact on low-income women, women of color, immigrant women, and young women, and these women are often already disadvantaged in their access to the resources, information, and services necessary to prevent an unintended pregnancy or to carry a healthy pregnancy to term;

(6) This state has a history of supporting and expanding timely access to comprehensive contraceptive access to prevent unintended pregnancy;

(7) Existing state and federal law should be enhanced to ensure greater contraceptive coverage and timely access for all individuals covered by health plans in Washington to all methods of contraception approved by the federal food and drug administration;

(8) Nearly half of pregnancies in both the United States and Washington are unintended. Unintended pregnancy is associated with negative outcomes, such as delayed prenatal care, maternal depression, increased risk of physical violence during pregnancy, low birth weight, decreased mental and physical health during childhood, and lower education attainment for the child;

(9) Access to contraception has been directly connected to the economic success of women and the ability of women to participate in society equally;

(10) Cost-sharing requirements and other barriers can dramatically reduce the use of preventive health care measures, particularly for women in lower income households, and eliminating cost sharing and other barriers for contraceptives leads to sizable increases in the use of preventive health care measures;

(11) It is vital that the full range of contraceptives are available to women because contraindications may restrict the use of certain types of contraceptives and because women need access to the contraceptive method most effective for their health;

(12) Medical management techniques such as denials, step therapy, or prior authorization in public and private health care coverage can impede access to the most effective contraceptive methods;

(13) Many insurance companies do not typically cover male methods of contraception, or they require high cost sharing despite the critical role men play in the prevention of unintended pregnancy; and

(14) Restrictions on abortion coverage interfere with a woman's personal, private pregnancy decision making, with his or her health and well-being, and with his or her constitutionally protected right to safe and legal medical abortion care." [2018 c 119 s 1.]

RCW 48.43.0725 Reproductive health plan coverage—Immediate postpartum contraception devices. (1) For births taking place in a licensed hospital or birthing center, a health plan must allow a provider to separately bill for devices, implants, professional services, or a combination thereof, associated with immediate postpartum contraception and may not consider such devices, implants, services, or combinations thereof to be part of any payments for general obstetric procedures.

(2) For purposes of this section, "immediate postpartum contraception" means the postpartum insertion of intrauterine devices or contraceptive implants performed before the patient is discharged from the hospital or birthing center and includes the devices or implants themselves.

(3) This section does not apply to facility services associated with immediate postpartum contraception.

(4) Nothing in this section affects an enrollee's right to directly access women's health care services, including contraceptive services.

(5) This section applies to health plans issued or renewed on or after January 1, 2023. [2022 c 122 s 3.]

Findings—Intent—2022 c 122: See note following RCW 41.05.430.

RCW 48.43.073 Required abortion coverage—Limitations. (1)(a) Except as provided in subsection (5) of this section, if a health plan issued or renewed on or after January 1, 2019, provides coverage for maternity care or services, the health plan must also provide a covered person with substantially equivalent coverage to permit the abortion of a pregnancy. Except as provided in subsection (5) of this section, if a student health plan, including student health plans deemed by the insurance commissioner to have a short-term limited

purpose or duration or to be guaranteed renewable while the covered person is enrolled as a regular full-time undergraduate or graduate student at an accredited higher education institution, issued or renewed on or after January 1, 2022, provides coverage for maternity care or services, the health plan must also provide a covered person with substantially equivalent coverage to permit the abortion of a pregnancy.

(b) Except as provided in (c) of this subsection, for health plans issued or renewed on or after January 1, 2024, a health carrier may not impose cost sharing for abortion of a pregnancy.

(c) For a health plan that provides coverage for abortion of a pregnancy and is offered as a qualifying health plan for a health savings account, the health carrier shall establish the plan's cost sharing for the coverage required by this section at the minimum level necessary to preserve the enrollee's ability to claim tax exempt contributions and withdrawals from the enrollee's health savings account under internal revenue service laws and regulations.

(2)(a) Except as provided in (b) of this subsection, a health plan or student health plan subject to subsection (1) of this section may not limit in any way a person's access to services related to the abortion of a pregnancy.

(b)(i) Coverage for the abortion of a pregnancy may be subject to terms and conditions generally applicable to the health plan or student health plan's coverage of maternity care or services.

(ii) A health plan or student health plan is not required to cover abortions that would be unlawful under RCW 9.02.120.

(3) Nothing in this section may be interpreted to limit in any way an individual's constitutionally or statutorily protected right to voluntarily terminate a pregnancy.

(4) This section does not, pursuant to 42 U.S.C. Sec. 18054(a)(6), apply to a multistate plan that does not provide coverage for the abortion of a pregnancy.

(5) If the application of this section to a health plan or student health plan results in noncompliance with federal requirements that are a prescribed condition to the allocation of federal funds to the state, this section is inapplicable to the plan to the minimum extent necessary for the state to be in compliance. The inapplicability of this section to a specific health plan or student health plan under this subsection does not affect the operation of this section in other circumstances. [2023 c 194 s 1; 2021 c 53 s 1; 2018 c 119 s 3.]

Findings—Declarations—2018 c 119: See note following RCW 48.43.072.

RCW 48.43.074 Qualified health plans—Single invoice billing—Certification of compliance required in the segregation plan for premium amounts attributable to coverage of abortion services. (1) The legislature intends to codify the state's current practice of requiring health carriers to bill enrollees with a single invoice and to segregate into a separate account the premium attributable to abortion services for which federal funding is prohibited. Washington has achieved full compliance with section 1303 of the federal patient protection and affordable care act by requiring health carriers to submit a single invoice to enrollees and to segregate into a separate

account the premium amounts attributable to coverage of abortion services for which federal funding is prohibited. Further, section 1303 states that the act does not preempt or otherwise have any effect on state laws regarding the prohibition of, or requirement of, coverage, funding, or procedural requirements on abortions.

(2) In accordance with RCW 48.43.073 related to requirements for coverage and funding of abortion services, an issuer offering a qualified health plan must:

(a) Bill enrollees and collect payment through a single invoice that includes all benefits and services covered by the qualified health plan; and

(b) Include in the segregation plan required under applicable federal and state law a certification that the issuer's billing and payment processes meet the requirements of this section. [2019 c 399 s 5.]

Effective date—2019 c 399 s 5: "Section 5 of this act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately [May 13, 2019]." [2019 c 399 s 10.]

Findings—Short title—2019 c 399: See notes following RCW 74.09.875.

Recommendations—Preexposure and postexposure prophylaxis financial support awareness—2019 c 399: See note following RCW 48.43.072.

RCW 48.43.076 Digital breast examinations—Cost sharing. (1) Except as provided in subsection (2) of this section, for nongrandfathered health plans issued or renewed on or after January 1, 2024, that include coverage of supplemental breast examinations and diagnostic breast examinations, health carriers may not impose cost sharing for such examinations.

(2) For a health plan that provides coverage of supplemental breast examinations and diagnostic breast examinations and is offered as a qualifying health plan for a health savings account, the health carrier shall establish the plan's cost sharing for the coverage of the services described in this section at the minimum level necessary to preserve the enrollee's ability to claim tax exempt contributions from their health savings account under internal revenue service laws and regulations.

(3) For purposes of this section:

(a) "Diagnostic breast examination" means a medically necessary and appropriate examination of the breast, including an examination using diagnostic mammography, digital breast tomosynthesis, also called three dimensional mammography, breast magnetic resonance imaging, or breast ultrasound, that is used to evaluate an abnormality:

(i) Seen or suspected from a screening examination for breast cancer; or

(ii) Detected by another means of examination.

(b) "Supplemental breast examination" means a medically necessary and appropriate examination of the breast, including an examination using breast magnetic resonance imaging or breast ultrasound, that is:

(i) Used to screen for breast cancer when there is no abnormality seen or suspected; and

(ii) Based on personal or family medical history, or additional factors that may increase the individual's risk of breast cancer. [2023 c 366 s 2.]

Intent—2023 c 366: "(1) In 1989 the legislature enacted Substitute House Bill No. 1074 requiring disability insurers, group disability insurers, health care service contractors, health maintenance organizations, and plans offered to public employees that provide benefits for hospital or medical care to provide benefits for screening and diagnostic mammography services.

(2) In 2010 the United States congress enacted the patient protection and affordable care act, which required coverage of certain preventative care services including screening mammograms with no cost sharing.

(3) In 2013 the Washington state office of the insurance commissioner adopted rules establishing the essential health benefits benchmark plan, which listed diagnostic and screening mammogram services as state benefit requirements under preventative and wellness services.

(4) In 2018 the legislature enacted Senate Bill No. 5912 which directed the office of the insurance commissioner to clarify that the existing mandates for mammography included coverage for tomosynthesis, also known as three-dimensional mammography, under the same terms and conditions allowed for mammography.

(5) The legislature intends to establish that the requirements for coverage of mammography services predated the affordable care act and are already included in the state's essential health benefits benchmark plan. Furthermore, the legislature intends to prohibit cost sharing for certain types of breast examinations." [2023 c 366 s 1.]

RCW 48.43.078 Digital breast tomosynthesis—Intent to ensure women with access—Commissioner's and health care authority's duty to clarify mandates. (1) Digital breast tomosynthesis, also called three-dimensional mammography, is the latest advancement in breast imaging. Studies indicate that digital breast tomosynthesis can result in a forty-one percent increase in invasive cancer detection, a fifteen percent decrease in the recall rate from screening mammography, and a twenty-nine percent increase in the detection of all breast cancers. In addition, the American college of radiology has indicated that tomosynthesis is no longer investigational. Therefore, it is the intent of the legislature to ensure women have access to the most effective breast imaging and to clarify that the existing mandate for mammography must include tomosynthesis.

(2) The legislature directs the office of the insurance commissioner to clarify that the existing mandates for mammography in RCW 48.20.393, 48.21.225, 48.44.325, and 48.46.275 include coverage for tomosynthesis under the same terms and conditions currently allowed for mammography. The application of a deductible and cost sharing is prohibited, consistent with 42 U.S.C. Sec. 300-gg-13.

(3) The legislature also directs the health care authority to clarify that the existing mandate for mammography in RCW 41.05.180 includes coverage for tomosynthesis under the same terms and conditions currently allowed for mammography. The application of a deductible and cost sharing is prohibited, consistent with 42 U.S.C. Sec. 300-gg-13. [2018 c 115 s 1.]

RCW 48.43.081 Anatomic pathology services—Payment for services—Definitions. (1) A clinical laboratory or physician, located in this state, or in another state, providing anatomic pathology services for patients in this state, shall present or cause to be presented a claim, bill, or demand for payment for these services only to the following:

(a) The patient;

(b) The responsible insurer or other third-party payer;

(c) The hospital, public health clinic, or nonprofit health clinic ordering such services;

(d) A direct patient-provider primary care practice regulated by chapter 48.150 RCW, provided the practice:

(i) Is in compliance with all applicable provisions of law to regulate that practice;

(ii) Has furnished a written confirmation to the physician or laboratory providing the anatomic pathology service that the patient is not covered for anatomic pathology services under any health insurance plan or program;

(iii) Furnishes the patient with an itemized bill that does not, directly or indirectly, mark up or increase the actual amount billed by the physician or clinical laboratory that performed the service; and

(iv) Discloses to the patient, through printed material or through a website, that all anatomic pathology services are billed at exactly the amount charged for the service by the physician or laboratory that provided the service, and the identity of the provider;

(e) The referring laboratory, excluding a laboratory of a physician's office or group practice that does not perform the professional component of the anatomic pathology service for which such claim, bill, or demand is presented; or

(f) Governmental agencies or their specified public or private agent, agency, or organization on behalf of the recipient of the services.

(2) Except for a physician at a referring laboratory that has been billed pursuant to subsection (1)(d) or (6) of this section, no licensed practitioner in the state may, directly or indirectly, charge, bill, or otherwise solicit payment for anatomic pathology services unless such services were rendered personally by the licensed practitioner or under the licensed practitioner's direct supervision in accordance with section 353 of the public health service act (42 U.S.C. Sec. 263a).

(3) No patient, insurer, third-party payer, hospital, public health clinic, or nonprofit health clinic may be required to reimburse any licensed practitioner for charges or claims submitted in violation of this section.

(4) Nothing in this section may be construed to mandate the assignment of benefits for anatomic pathology services as defined in this section.

(5) For purposes of this section, "anatomic pathology services" means:

(a) Histopathology or surgical pathology, meaning the gross and microscopic examination performed by a physician or under the supervision of a physician, including histologic processing;

(b) Cytopathology, meaning the microscopic examination of cells from the following: (i) Fluids, (ii) aspirates, (iii) washings, (iv) brushings, or (v) smears, including the pap test examination performed by a physician or under the supervision of a physician;

(c) Hematology, meaning the microscopic evaluation of bone marrow aspirates and biopsies performed by a physician, or under the supervision of a physician, and peripheral blood smears when the attending or treating physician, or technologist requests that a blood smear be reviewed by a pathologist;

(d) Subcellular pathology or molecular pathology, meaning the assessment of a patient specimen for the detection, localization, measurement, or analysis of one or more protein or nucleic acid targets; and

(e) Blood-banking services performed by pathologists.

(6) The provisions of this section do not prohibit billing of a referring laboratory for anatomic pathology services in instances where a sample or samples must be sent to another physician or laboratory for consultation or histologic processing, except that for purposes of this subsection the term "referring laboratory" does not include a laboratory of a physician's office or group practice that does not perform the professional component of the anatomic pathology service involved.

(7) The uniform disciplinary act, chapter 18.130 RCW, governs the discipline of any practitioner who violates the provisions of this section. [2012 c 100 s 1; 2011 c 128 s 1.]

Retroactive application—2012 c 100: "Section 1 of this act applies retroactively to July 22, 2011, so that no entity is liable for having presented or caused to be presented a claim, bill, or demand for payment to a direct patient-provider primary care practice in accordance with section 1(1)(d) of this act." [2012 c 100 s 2.]

RCW 48.43.083 Chiropractor services—Participating provider agreement—Health carrier reimbursement. (1) A health carrier must reimburse a chiropractor who has signed a participating provider agreement for services determined by the carrier to be medically necessary if:

(a) The service is:

(i) Covered chiropractic health care, as defined in RCW 48.43.515, by the health plan under which the enrollee received the services; and

(ii) Provided by the chiropractor, or the chiropractor's employee specified in RCW 18.25.190 (2) or (3) who works in the same location as the chiropractor and to whom the chiropractor, pursuant to rules adopted by the Washington state chiropractic quality assurance commission, has delegated the service. The employee must meet the health carrier's reasonable qualifications for all such providers in

the relevant class, including but not limited to standards for education and background checks, as applicable; and

(b) The chiropractor complies with the terms and conditions of the participating provider agreement. Violations of the participating provider agreement by an employee of the chiropractor to whom he or she has delegated a service may be deemed by the carrier to have been committed by the chiropractor.

(2) If a health carrier offers a participating provider agreement to a chiropractor within a single practice organized as a sole proprietorship, partnership, or corporation, the carrier must offer the same participating provider agreement to any other chiropractor within that practice providing services at the same location. The agreement may allow either party to terminate it without cause. [2007 c 502 s 1.]

Savings—2007 c 502: "This act does not affect any existing right acquired or liability or obligation incurred prior to January 1, 2008." [2007 c 502 s 3.]

Severability—2007 c 502: "If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected." [2007 c 502 s 4.]

Effective date—2007 c 502: "This act takes effect January 1, 2008." [2007 c 502 s 5.]

RCW 48.43.085 Health carrier may not prohibit its enrollees from contracting for services outside the health care plan. 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. The provisions of this section shall be disclosed pursuant to *RCW 48.43.095(2). The insurance commissioner is prohibited from adopting rules regarding this section. [1996 c 312 s 3.]

***Reviser's note:** RCW 48.43.095 was repealed by 2000 c 5 s 29, effective July 1, 2001.

RCW 48.43.087 Contracting for services at enrollee's expense—Mental health care practitioner—Conditions—Exception. (1) For purposes of this section:

(a) "Health carrier" includes disability insurers regulated under chapter 48.20 or 48.21 RCW, health care services contractors regulated under chapter 48.44 RCW, plans operating under the health care authority under chapter 41.05 RCW, the basic health plan operating under chapter 70.47 RCW, the state health insurance pool operating under chapter 48.41 RCW, insuring entities regulated under this chapter, and health maintenance organizations regulated under chapter 48.46 RCW.

(b) "Intermediary" means a person duly authorized to negotiate and execute provider contracts with health carriers on behalf of mental health care practitioners.

(c) Consistent with their lawful scopes of practice, "mental health care practitioners" includes only the following: Any generally recognized medical specialty of practitioners licensed under chapter 18.57 or 18.71 RCW who provide mental health services, advanced practice psychiatric nurses as authorized by the state board of nursing under chapter 18.79 RCW, psychologists licensed under chapter 18.83 RCW, and mental health counselors, marriage and family therapists, and social workers licensed under chapter 18.225 RCW.

(d) "Mental health services" means outpatient services.

(2) Consistent with federal and state law and rule, no contract between a mental health care practitioner and an intermediary or between a mental health care practitioner and a health carrier that is written, amended, or renewed after June 6, 1996, may contain a provision prohibiting a practitioner and an enrollee from agreeing to contract for services solely at the expense of the enrollee as follows:

(a) On the exhaustion of the enrollee's mental health care coverage;

(b) During an appeal or an adverse certification process;

(c) When an enrollee's condition is excluded from coverage; or

(d) For any other clinically appropriate reason at any time.

(3) If a mental health care practitioner provides services to an enrollee during an appeal or adverse certification process, the practitioner must provide to the enrollee written notification that the enrollee is responsible for payment of these services, unless the health carrier elects to pay for services provided.

(4) This section does not apply to a mental health care practitioner who is employed full time on the staff of a health carrier. [2025 c 58 s 5050; 2001 c 251 s 33; 1996 c 304 s 1.]

Explanatory note—2025 c 58: See note following RCW 1.16.050.

Severability—2001 c 251: See RCW 18.225.900.

RCW 48.43.091 Health carrier coverage of outpatient mental health services—Requirements. Every health carrier that provides coverage for any outpatient mental health service shall comply with the following requirements:

(1) In performing a utilization review of mental health services for a specific enrollee, the utilization review is limited to accessing only the specific health care information contained in the enrollee's record.

(2) In performing an audit of a provider that has furnished mental health services to a carrier's enrollees, the audit is limited to accessing only the records of enrollees covered by the specific health carrier for which the audit is being performed, except as otherwise permitted by RCW 70.02.050 and *71.05.630. [1999 c 87 s 1.]

***Reviser's note:** RCW 71.05.630 was repealed by 2013 c 200 s 34, effective July 1, 2014.

RCW 48.43.093 Health carrier coverage of emergency medical services—Requirements—Conditions. (1)(a) A health carrier shall cover emergency services provided to a covered person if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. In addition, a health carrier shall not require prior authorization of emergency services if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. With respect to care obtained from a nonparticipating hospital emergency department or behavioral health emergency services provider, a health carrier shall cover emergency services. In addition, a health carrier shall not require prior authorization of emergency services.

(b) A health carrier shall cover emergency services without limiting what constitutes an emergency medical condition solely on the basis of diagnosis codes. Any determination of whether the prudent layperson standard has been met must be based on all pertinent documentation and be focused on the presenting symptoms and not solely on the final diagnosis.

(2) Coverage of emergency services may be subject to applicable in-network copayments, coinsurance, and deductibles, as provided in chapter 48.49 RCW.

(3) Nothing in this section is to be construed as prohibiting a health carrier from:

(a) Requiring notification of stabilization or inpatient admission within the time frame specified in its contract with the hospital or behavioral health emergency services provider or as soon thereafter as medically possible but no less than twenty-four hours; or

(b) Requiring a hospital or emergency behavioral health emergency services provider to make a documented good faith effort to notify the covered person's health carrier within 48 hours of stabilization, or by the end of the business day following the day the stabilization occurs, whichever is later, if the covered person needs to be stabilized. If a health carrier requires such notification, the health carrier shall provide access to an authorized representative seven days a week to receive notifications.

(4) Except to the extent provided otherwise in this section, follow-up care that is a direct result of the emergency must be obtained in accordance with the health plan's usual terms and conditions of coverage. All other terms and conditions of coverage may be applied to emergency services. [2022 c 263 s 3; 2019 c 427 s 3; 1997 c 231 s 301.]

Effective date—2022 c 263: See note following RCW 43.371.100.

Findings—Intent—Effective date—2019 c 427: See RCW 48.49.003 and 48.49.900.

Short title—Part headings and captions not law—Severability—Effective dates—1997 c 231: See notes following RCW 48.43.005.

RCW 48.43.094 Pharmacist provided services—Health plan requirements. ***(Effective until June 30, 2027.)*** (1) For health plans issued or renewed on or after January 1, 2017:

(a) Benefits shall not be denied for any health care service performed by a pharmacist licensed under chapter 18.64 RCW if:

(i) The service performed was within the lawful scope of such person's license;

(ii) The plan would have provided benefits if the service had been performed by a physician licensed under chapter 18.71 or 18.57 RCW, an *advanced registered nurse practitioner licensed under chapter 18.79 RCW, or a physician's assistant licensed under chapter 18.71A RCW; and

(iii) The pharmacist is included in the plan's network of participating providers; and

(b) The health plan must include an adequate number of pharmacists in its network of participating medical providers.

(2) The participation of pharmacies in the plan network's drug benefit does not satisfy the requirement that plans include pharmacists in their networks of participating medical providers.

(3) For health benefit plans issued or renewed on or after January 1, 2016, but before January 1, 2017, health plans that delegate credentialing agreements to contracted health care facilities must accept credentialing for pharmacists employed or contracted by those facilities. Health plans must reimburse facilities for covered services provided by network pharmacists within the pharmacists' scope of practice per negotiations with the facility.

(4) This section does not supersede the requirements of RCW 48.43.045. [2020 c 80 s 36; 2015 c 237 s 1.]

***Reviser's note:** The term "advanced registered nurse practitioner" was changed to "advanced practice registered nurse" by 2024 c 239 s 1, effective June 30, 2027.

Effective date—2020 c 80 ss 12-59: See note following RCW 7.68.030.

Intent—2020 c 80: See note following RCW 18.71A.010.

Lead organization and advisory committee—2015 c 237: "(1) The insurance commissioner shall designate a lead organization to establish and facilitate an advisory committee to implement the provisions of section 1 of this act. The lead organization and advisory committee shall develop best practice recommendations on standards for credentialing, privileging, billing, and payment processes to ensure pharmacists are adequately included and appropriately utilized in participating provider networks of health plans. In developing these standards, the committee shall also discuss topics as they relate to implementation including current credentialing requirements for health care providers consistent with chapter 18.64 RCW, existing processes of similarly situated health care providers, pharmacist training, care coordination, and the role of pharmacist prescriptive authority agreements pursuant to WAC 246-863-100.

(2) The lead organization shall create an advisory committee including, but not limited to, representatives of the following stakeholders:

(a) The insurance commissioner or designee;

(b) The secretary of health or designee;

(c) An organization representing pharmacists;

(d) An organization representing physicians;

(e) An organization representing hospitals;
(f) A hospital conducting internal credentialing of pharmacists;
(g) A clinic with pharmacists providing medical services;
(h) A community pharmacy with pharmacists providing medical services;
(i) The two largest health carriers in Washington based upon enrollment;
(j) A health care system that coordinates care and coverage;
(k) A school or college of pharmacy in Washington;
(l) A representative from a pharmacy benefit manager or organization that represents pharmacy benefit managers; and
(m) Other representatives appointed by the insurance commissioner.
(3) No later than December 1, 2015, the advisory committee shall present initial best practice recommendations to the insurance commissioner and the department of health. If necessary, the insurance commissioner or department of health may adopt rules to implement the standards developed by the lead organization and advisory committee. The advisory committee will remain intact to assist the insurance commissioner or department of health in rule making. The rules adopted by the insurance commissioner or the department of health must be consistent with the recommendations developed by the advisory committee.
(4) For purposes of this section, "lead organization" means a private sector organization or organizations designated by the insurance commissioner to lead development of processes, guidelines, and standards to streamline health care administration to be adopted by payors and providers of health care services operating in the state." [2015 c 237 s 3.]

RCW 48.43.094 Pharmacist provided services—Health plan requirements. ***(Effective June 30, 2027.)*** (1) For health plans issued or renewed on or after January 1, 2017:
(a) Benefits shall not be denied for any health care service performed by a pharmacist licensed under chapter 18.64 RCW if:
(i) The service performed was within the lawful scope of such person's license;
(ii) The plan would have provided benefits if the service had been performed by a physician licensed under chapter 18.71 or 18.57 RCW, an advanced practice registered nurse licensed under chapter 18.79 RCW, or a physician's assistant licensed under chapter 18.71A RCW; and
(iii) The pharmacist is included in the plan's network of participating providers; and
(b) The health plan must include an adequate number of pharmacists in its network of participating medical providers.
(2) The participation of pharmacies in the plan network's drug benefit does not satisfy the requirement that plans include pharmacists in their networks of participating medical providers.
(3) For health benefit plans issued or renewed on or after January 1, 2016, but before January 1, 2017, health plans that delegate credentialing agreements to contracted health care facilities must accept credentialing for pharmacists employed or contracted by those facilities. Health plans must reimburse facilities for covered

services provided by network pharmacists within the pharmacists' scope of practice per negotiations with the facility.

(4) This section does not supersede the requirements of RCW 48.43.045. [2025 c 58 s 5104; 2020 c 80 s 36; 2015 c 237 s 1.]

Effective date—2025 c 58 ss 5058-5170: See note following RCW 7.68.030.

Explanatory note—2025 c 58: See note following RCW 1.16.050.

Effective date—2020 c 80 ss 12-59: See note following RCW 7.68.030.

Intent—2020 c 80: See note following RCW 18.71A.010.

Lead organization and advisory committee—2015 c 237: "(1) The insurance commissioner shall designate a lead organization to establish and facilitate an advisory committee to implement the provisions of section 1 of this act. The lead organization and advisory committee shall develop best practice recommendations on standards for credentialing, privileging, billing, and payment processes to ensure pharmacists are adequately included and appropriately utilized in participating provider networks of health plans. In developing these standards, the committee shall also discuss topics as they relate to implementation including current credentialing requirements for health care providers consistent with chapter 18.64 RCW, existing processes of similarly situated health care providers, pharmacist training, care coordination, and the role of pharmacist prescriptive authority agreements pursuant to WAC 246-863-100.

(2) The lead organization shall create an advisory committee including, but not limited to, representatives of the following stakeholders:

(a) The insurance commissioner or designee;

(b) The secretary of health or designee;

(c) An organization representing pharmacists;

(d) An organization representing physicians;

(e) An organization representing hospitals;

(f) A hospital conducting internal credentialing of pharmacists;

(g) A clinic with pharmacists providing medical services;

(h) A community pharmacy with pharmacists providing medical services;

(i) The two largest health carriers in Washington based upon enrollment;

(j) A health care system that coordinates care and coverage;

(k) A school or college of pharmacy in Washington;

(l) A representative from a pharmacy benefit manager or organization that represents pharmacy benefit managers; and

(m) Other representatives appointed by the insurance commissioner.

(3) No later than December 1, 2015, the advisory committee shall present initial best practice recommendations to the insurance commissioner and the department of health. If necessary, the insurance commissioner or department of health may adopt rules to implement the standards developed by the lead organization and advisory committee. The advisory committee will remain intact to assist the insurance

commissioner or department of health in rule making. The rules adopted by the insurance commissioner or the department of health must be consistent with the recommendations developed by the advisory committee.

(4) For purposes of this section, "lead organization" means a private sector organization or organizations designated by the insurance commissioner to lead development of processes, guidelines, and standards to streamline health care administration to be adopted by payors and providers of health care services operating in the state." [2015 c 237 s 3.]

RCW 48.43.096 Medication synchronization policy required for health plans covering prescription drugs—Requirements—Definitions. (1) A health benefit plan issued or renewed after December 31, 2015, that provides coverage for prescription drugs must implement a medication synchronization policy for the dispensing of prescription drugs to the plan's enrollees.

(a) If an enrollee requests medication synchronization for a new prescription, the health plan must permit filling the drug: (i) For less than a one-month supply of the drug if synchronization will require more than a fifteen-day supply of the drug; or (ii) for more than a one-month supply of the drug if synchronization will require a fifteen-day supply of the drug or less.

(b) The health benefit plan shall adjust the enrollee cost-sharing for a prescription drug subject to coinsurance that is dispensed for less than the standard refill amount for the purpose of synchronizing the medications.

(c) The health benefit plan shall adjust the enrollee cost-sharing for a prescription drug with a copayment that is dispensed for less than the standard refill amount for the purpose of synchronizing the medications by:

(i) Discounting the copayment rate by fifty percent;

(ii) Discounting the copayment rate based on fifteen-day increments; or

(iii) Any other method that meets the intent of this section and is approved by the office of the insurance commissioner.

(2) Upon request of an enrollee, the prescribing provider or pharmacist shall:

(a) Determine that filling or refilling the prescription is in the best interest of the enrollee, taking into account the appropriateness of synchronization for the drug being dispensed;

(b) Inform the enrollee that the prescription will be filled to less than the standard refill amount for the purpose of synchronizing his or her medications; and

(c) Deny synchronization on the grounds of threat to patient safety or suspected fraud or abuse.

(3) For purposes of this section, the following terms have the following meanings unless the context clearly requires otherwise:

(a) "Medication synchronization" means the coordination of medication refills for a patient taking two or more medications for a chronic condition such that the patient's medications are refilled on the same schedule for a given time period.

(b) "Prescription" has the same meaning as in RCW 18.64.011. [2015 c 213 s 1.]

RCW 48.43.0961 Continuity of coverage for health plans covering prescription drugs for behavioral health. (1) Except as provided in subsection (2) of this section, for health plans that include prescription drug coverage issued or renewed on or after January 1, 2025, a health carrier or its health care benefit manager may not require the substitution of a nonpreferred drug with a preferred drug in a given therapeutic class, or increase an enrollee's cost-sharing obligation mid-plan year for the drug, if the prescription is for a refill of an antipsychotic, antidepressant, antiepileptic, or other drug prescribed to the enrollee to treat a serious mental illness, the enrollee is medically stable on the drug, and a participating provider continues to prescribe the drug.

(2) Nothing in this section prohibits:

(a) The carrier from requiring generic substitution during the current plan year;

(b) The carrier from adding new drugs to its formulary during the current plan year;

(c) The carrier from removing a drug from its formulary for reasons of patient safety concerns, drug recall or removal from the market, or medical evidence indicating no therapeutic effect of the drug; or

(d) A participating provider from prescribing a different drug that is covered by the plan and medically appropriate for the enrollee.

(3) For the purposes of this section:

(a) "Refill" means a second or subsequent filling of a previously issued prescription.

(b) "Serious mental illness" means a mental disorder, as defined in the most recent edition of the diagnostic and statistical manual of mental disorders published by the American psychiatric association, that results in serious functional impairment that substantially interferes with or limits one or more major life activities. [2023 c 325 s 1.]

RCW 48.43.097 Filing of financial statements—Every health carrier. Every health carrier holding a registration from the commissioner shall file its financial statements as required by this code and by the commissioner in accordance with the accounting practices and procedures manuals as adopted by the national association of insurance commissioners, unless otherwise provided by law. [1999 c 33 s 3.]

RCW 48.43.105 Preparation of documents that compare health carriers—Immunity—Due diligence. (1) A public or private entity who exercises due diligence in preparing a document of any kind that compares health carriers of any kind is immune from civil liability from claims based on the document and the contents of the document.

(2)(a) There is absolute immunity to civil liability from claims based on such a comparison document and its contents if the information was provided by the carrier, was substantially accurately presented, and contained the effective date of the information that the carrier supplied, if any.

(b) Where due diligence efforts to obtain accurate information have been taken, there is immunity from claims based on such a

comparison document and its contents if the publisher of the comparison document asked for such information from the carrier, was refused, and relied on any usually reliable source for the information including, but not limited to, carrier enrollees, customers, insurance producers, or providers. The carrier enrollees, customers, insurance producers, or providers are likewise immune from civil liability on claims based on information they provided if they believed the information to be accurate and had exercised due diligence in their efforts to confirm the accuracy of the information provided.

(3) The immunity from liability contained in this section applies only if the comparison document contains the following in a conspicuous place and in easy to read typeface:

> This comparison is based on information believed to be reliable by its publisher, but the accuracy of the information cannot be guaranteed. Caution is suggested to all readers who are encouraged to confirm data of importance to the reader before any purchasing or other decisions are made.

(4) The insurance commissioner is prohibited from adopting rules regarding this section. [2008 c 217 s 48; 1996 c 312 s 5.]

Severability—Effective date—2008 c 217: See notes following RCW 48.03.020.

RCW 48.43.115 Maternity services—Intent—Definitions—Patient preference—Clinical sovereignty of provider—Notice to policyholders—Application. *(Effective until June 30, 2027.)* (1) The legislature recognizes the role of health care providers as the appropriate authority to determine and establish the delivery of quality health care services to maternity patients and their newly born children. It is the intent of the legislature to recognize patient preference and the clinical sovereignty of providers as they make determinations regarding services provided and the length of time individual patients may need to remain in a health care facility after giving birth. It is not the intent of the legislature to diminish a carrier's ability to utilize managed care strategies but to ensure the clinical judgment of the provider is not undermined by restrictive carrier contracts or utilization review criteria that fail to recognize individual postpartum needs.

(2) Unless otherwise specifically provided, the following definitions apply throughout this section:

(a) "Attending provider" means a provider who: Has clinical hospital privileges consistent with RCW 70.43.020; is included in a provider network of the carrier that is providing coverage; and is a physician licensed under chapter 18.57 or 18.71 RCW, a certified nurse midwife licensed under chapter 18.79 RCW, a midwife licensed under chapter 18.50 RCW, a physician's assistant licensed under chapter 18.71A RCW, or an *advanced registered nurse practitioner licensed under chapter 18.79 RCW.

(b) "Health carrier" or "carrier" means disability insurers regulated under chapter 48.20 or 48.21 RCW, health care services contractors regulated under chapter 48.44 RCW, health maintenance organizations regulated under chapter 48.46 RCW, plans operating under the health care authority under chapter 41.05 RCW, the state health

insurance pool operating under chapter 48.41 RCW, and insuring entities regulated under this chapter.

(3)(a) Every health carrier that provides coverage for maternity services must permit the attending provider, in consultation with the mother, to make decisions on the length of inpatient stay, rather than making such decisions through contracts or agreements between providers, hospitals, and insurers. These decisions must be based on accepted medical practice.

(b) Covered eligible services may not be denied for inpatient, postdelivery care to a mother and her newly born child after a vaginal delivery or a cesarean section delivery for such care as ordered by the attending provider in consultation with the mother.

(c) At the time of discharge, determination of the type and location of follow-up care must be made by the attending provider in consultation with the mother rather than by contract or agreement between the hospital and the insurer. These decisions must be based on accepted medical practice.

(d) Covered eligible services may not be denied for follow-up care, including in-person care, as ordered by the attending provider in consultation with the mother. Coverage for providers of follow-up services must include, but need not be limited to, attending providers as defined in this section, home health agencies licensed under chapter 70.127 RCW, and registered nurses licensed under chapter 18.79 RCW.

(e) This section does not require attending providers to authorize care they believe to be medically unnecessary.

(f) Coverage for the newly born child must be no less than the coverage of the child's mother for no less than three weeks, even if there are separate hospital admissions.

(4) A carrier that provides coverage for maternity services may not deselect, terminate the services of, require additional documentation from, require additional utilization review of, reduce payments to, or otherwise provide financial disincentives to any attending provider or health care facility solely as a result of the attending provider or health care facility ordering care consistent with this section. This section does not prevent any insurer from reimbursing an attending provider or health care facility on a capitated, case rate, or other financial incentive basis.

(5) Every carrier that provides coverage for maternity services must provide notice to policyholders regarding the coverage required under this section. The notice must be in writing and must be transmitted at the earliest of the next mailing to the policyholder, the yearly summary of benefits sent to the policyholder, or January 1 of the year following June 6, 1996.

(6) This section does not establish a standard of medical care.

(7) This section applies to coverage for maternity services under a contract issued or renewed by a health carrier after June 6, 1996, and applies to plans operating under the health care authority under chapter 41.05 RCW beginning January 1, 1998. [2020 c 80 s 37; 2003 c 248 s 14; 1996 c 281 s 1.]

***Reviser's note:** The term "advanced registered nurse practitioner" was changed to "advanced practice registered nurse" by 2024 c 239 s 1, effective June 30, 2027.

Effective date—2020 c 80 ss 12-59: See note following RCW 7.68.030.

Intent—2020 c 80: See note following RCW 18.71A.010.

Short title—1996 c 281: "This act shall be known as "the Erin Act."" [1996 c 281 s 3.]

RCW 48.43.115 Maternity services—Intent—Definitions—Patient preference—Clinical sovereignty of provider—Notice to policyholders—Application. ***(Effective June 30, 2027.)*** (1) The legislature recognizes the role of health care providers as the appropriate authority to determine and establish the delivery of quality health care services to maternity patients and their newly born children. It is the intent of the legislature to recognize patient preference and the clinical sovereignty of providers as they make determinations regarding services provided and the length of time individual patients may need to remain in a health care facility after giving birth. It is not the intent of the legislature to diminish a carrier's ability to utilize managed care strategies but to ensure the clinical judgment of the provider is not undermined by restrictive carrier contracts or utilization review criteria that fail to recognize individual postpartum needs.

(2) Unless otherwise specifically provided, the following definitions apply throughout this section:

(a) "Attending provider" means a provider who: Has clinical hospital privileges consistent with RCW 70.43.020; is included in a provider network of the carrier that is providing coverage; and is a physician licensed under chapter 18.57 or 18.71 RCW, a certified nurse midwife licensed under chapter 18.79 RCW, a midwife licensed under chapter 18.50 RCW, a physician's assistant licensed under chapter 18.71A RCW, or an advanced practice registered nurse licensed under chapter 18.79 RCW.

(b) "Health carrier" or "carrier" means disability insurers regulated under chapter 48.20 or 48.21 RCW, health care services contractors regulated under chapter 48.44 RCW, health maintenance organizations regulated under chapter 48.46 RCW, plans operating under the health care authority under chapter 41.05 RCW, the state health insurance pool operating under chapter 48.41 RCW, and insuring entities regulated under this chapter.

(3)(a) Every health carrier that provides coverage for maternity services must permit the attending provider, in consultation with the mother, to make decisions on the length of inpatient stay, rather than making such decisions through contracts or agreements between providers, hospitals, and insurers. These decisions must be based on accepted medical practice.

(b) Covered eligible services may not be denied for inpatient, postdelivery care to a mother and her newly born child after a vaginal delivery or a cesarean section delivery for such care as ordered by the attending provider in consultation with the mother.

(c) At the time of discharge, determination of the type and location of follow-up care must be made by the attending provider in consultation with the mother rather than by contract or agreement between the hospital and the insurer. These decisions must be based on accepted medical practice.

(d) Covered eligible services may not be denied for follow-up care, including in-person care, as ordered by the attending provider in consultation with the mother. Coverage for providers of follow-up

services must include, but need not be limited to, attending providers as defined in this section, home health agencies licensed under chapter 70.127 RCW, and registered nurses licensed under chapter 18.79 RCW.

(e) This section does not require attending providers to authorize care they believe to be medically unnecessary.

(f) Coverage for the newly born child must be no less than the coverage of the child's mother for no less than three weeks, even if there are separate hospital admissions.

(4) A carrier that provides coverage for maternity services may not deselect, terminate the services of, require additional documentation from, require additional utilization review of, reduce payments to, or otherwise provide financial disincentives to any attending provider or health care facility solely as a result of the attending provider or health care facility ordering care consistent with this section. This section does not prevent any insurer from reimbursing an attending provider or health care facility on a capitated, case rate, or other financial incentive basis.

(5) Every carrier that provides coverage for maternity services must provide notice to policyholders regarding the coverage required under this section. The notice must be in writing and must be transmitted at the earliest of the next mailing to the policyholder, the yearly summary of benefits sent to the policyholder, or January 1 of the year following June 6, 1996.

(6) This section does not establish a standard of medical care.

(7) This section applies to coverage for maternity services under a contract issued or renewed by a health carrier after June 6, 1996, and applies to plans operating under the health care authority under chapter 41.05 RCW beginning January 1, 1998. [2025 c 58 s 5105; 2020 c 80 s 37; 2003 c 248 s 14; 1996 c 281 s 1.]

Effective date—2025 c 58 ss 5058-5170: See note following RCW 7.68.030.

Explanatory note—2025 c 58: See note following RCW 1.16.050.

Effective date—2020 c 80 ss 12-59: See note following RCW 7.68.030.

Intent—2020 c 80: See note following RCW 18.71A.010.

Short title—1996 c 281: "This act shall be known as "the Erin Act."" [1996 c 281 s 3.]

RCW 48.43.121 Ground ambulance services organizations—Coverage. (1) For health plans issued or renewed on or after January 1, 2025, a health carrier shall provide coverage for ground ambulance transports to behavioral health emergency services providers for enrollees who are experiencing an emergency medical condition as defined in RCW 48.43.005. A health carrier may not require prior authorization of ground ambulance services if a prudent layperson acting reasonably would have believed that an emergency medical condition existed.

(2) Coverage of ground ambulance transports to behavioral health emergency services providers may be subject to applicable in-network

copayments, coinsurance, and deductibles, as provided in chapter 48.49 RCW. [2024 c 218 s 12.]

RCW 48.43.125 Coverage at a long-term care facility following hospitalization—Definition. (1) A carrier that provides coverage for a person at a long-term care facility following the person's hospitalization shall, upon the request of the person or his or her legal representative as authorized in RCW 7.70.065, provide such coverage at the facility in which the person resided immediately prior to the hospitalization if:

(a) The person's primary care physician determines that the medical care needs of the person can be met at the requested facility;

(b) The requested facility has all applicable licenses and certifications, and is not under a stop placement order that prevents the person's readmission;

(c) The requested facility agrees to accept payment from the carrier for covered services at the rate paid to similar facilities that otherwise contract with the carrier to provide such services; and

(d) The requested facility, with regard to the following, agrees to abide by the standards, terms, and conditions required by the carrier of similar facilities with which the carrier otherwise contracts: (i) Utilization review, quality assurance, and peer review; and (ii) management and administrative procedures, including data and financial reporting that may be required by the carrier.

(2) For purposes of this section, "long-term care facility" or "facility" means a nursing facility licensed under chapter 18.51 RCW, continuing care retirement community defined under RCW 70.38.025, or assisted living facility licensed under chapter 18.20 RCW. [2012 c 10 s 43; 1999 c 312 s 2.]

Application—2012 c 10: See note following RCW 18.20.010.

Findings—1999 c 312: "The legislature finds that a long-term care facility is home for any individual who resides there, and the individual has the right to receive services in his or her own home and to be cared for by the organization with which he or she has a contractual agreement to provide housing and related services. The legislature further finds that restricting individuals from returning to the long-term care facility in which they were residing prior to hospitalization may detrimentally impact the health and well-being of frail individuals and their families." [1999 c 312 s 1.]

Short title—1999 c 312: "This act may be known and cited as the Kitson act." [1999 c 312 s 3.]

RCW 48.43.135 Hearing instruments—Coverage. (1) For nongrandfathered group health plans other than small group health plans issued or renewed on or after January 1, 2024, and for health plans issued or renewed on or after January 1, 2026, a health carrier shall include coverage for hearing instruments, including bone conduction hearing devices. This section does not include coverage of over-the-counter hearing instruments.

(2) Coverage shall also include the initial assessment, fitting, adjustment, auditory training, and ear molds as necessary to maintain

optimal fit. Coverage of the services in this subsection shall include services for enrollees who intend to obtain or have already obtained any hearing instrument, including an over-the-counter hearing instrument.

(3)(a) Until the date specified in (b) of this subsection, a health carrier shall provide coverage for hearing instruments as provided in subsection (1) of this section at no less than $3,000 per ear with hearing loss every 36 months.

(b) For health plans issued or renewed on or after January 1, 2026, a health carrier shall provide coverage for hearing instruments as provided in subsection (1) of this section every 36 months per ear with hearing loss and may not establish any lifetime or annual limit on the dollar amount of coverage for services described in subsection (1) or (2) of this section for any individual, whether provided in-network or out-of-network.

(c) A health carrier may require prior authorization or adopt other appropriate utilization controls in approving coverage for medically necessary hearing instruments.

(4) The services and hearing instruments covered under this section are not subject to the enrollee's deductible unless the health plan is offered as a qualifying health plan for a health savings account. For such a qualifying health plan, the carrier may apply a deductible to coverage of the services covered under this section only at the minimum level necessary to preserve the enrollee's ability to claim tax exempt contributions and withdrawals from the enrollee's health savings account under internal revenue service laws and regulations.

(5) Coverage for a minor under 18 years of age shall be available under this section only after the minor has received medical clearance within the preceding six months from:

(a) An otolaryngologist for an initial evaluation of hearing loss; or

(b) A licensed physician, which indicates there has not been a substantial change in clinical status since the initial evaluation by an otolaryngologist.

(6) For the purposes of this section:

(a) "Hearing instrument" has the same meaning as defined in RCW 18.35.010.

(b) "Over-the-counter hearing instrument" has the same meaning as "over-the-counter hearing aid" in 21 C.F.R. Sec. 800.30 as of December 28, 2022. [2025 c 243 s 9; 2023 c 245 s 1.]

RCW 48.43.176 Eosinophilic gastrointestinal associated disorder—Elemental formula. (1) Each health benefit plan issued or renewed after December 31, 2015, must offer benefits or coverage for medically necessary elemental formula, regardless of delivery method, when a licensed physician or other health care provider with prescriptive authority:

(a) Diagnoses a patient with an eosinophilic gastrointestinal associated disorder; and

(b) Orders and supervises the use of the elemental formula.

(2) Nothing in this section prohibits a health benefit plan from requiring prior authorization or imposing other appropriate utilization controls in approving coverage for medically necessary elemental formula. [2014 c 115 s 2.]

RCW 48.43.180 Denturist services. Notwithstanding any provision of any certified health plan covering dental care as provided for in this chapter, effective January 1, 1995, benefits shall not be denied thereunder for any service performed by a denturist licensed under chapter 18.30 RCW if (1) the service performed was within the lawful scope of such person's license, and (2) such plan would have provided benefits if such service had been performed by a dentist licensed under chapter 18.32 RCW. [1995 c 1 s 23 (Initiative Measure No. 607, approved November 8, 1994).]

Short title—1995 c 1 (Initiative Measure No. 607): See RCW 18.30.900.

RCW 48.43.185 General anesthesia services for dental procedures. (1) Each group health benefit plan that provides coverage for hospital, medical, or ambulatory surgery center services must cover general anesthesia services and related facility charges in conjunction with any dental procedure performed in a hospital or ambulatory surgical center if such anesthesia services and related facility charges are medically necessary because the covered person:

(a) Is under the age of seven, or physically or developmentally disabled, with a dental condition that cannot be safely and effectively treated in a dental office; or

(b) Has a medical condition that the person's physician determines would place the person at undue risk if the dental procedure were performed in a dental office. The procedure must be approved by the person's physician.

(2) Each group health benefit plan or group dental plan that provides coverage for dental services must cover medically necessary general anesthesia services in conjunction with any covered dental procedure performed in a dental office if the general anesthesia services are medically necessary because the covered person is under the age of seven or physically or developmentally disabled.

(3) This section does not prohibit a group health benefit plan or group dental plan from:

(a) Applying cost-sharing requirements, maximum annual benefit limitations, and prior authorization requirements to the services required under this section; or

(b) Covering only those services performed by a health care provider, or in a health care facility, that is part of its provider network; nor does it limit the health carrier in negotiating rates and contracts with specific providers.

(4) This section does not apply to medicare supplement policies, or supplemental contracts covering a specified disease or other limited benefits.

(5) For the purpose of this section, "general anesthesia services" means services to induce a state of unconsciousness accompanied by a loss of protective reflexes, including the ability to maintain an airway independently and respond purposefully to physical stimulation or verbal command.

(6) This section applies to group health benefit plans and group dental plans issued or renewed on or after January 1, 2002. [2001 c 321 s 2.]

RCW 48.43.190 Payment of chiropractic services—Parity. (1)(a) A health carrier may not pay a chiropractor less for a service or procedure identified under a particular physical medicine and rehabilitation code, evaluation and management code, or spinal manipulation code, as listed in a nationally recognized services and procedures code book such as the American medical association current procedural terminology code book, than it pays any other type of provider licensed under Title 18 RCW for a service or procedure under the same or substantially similar code, except as provided in (b) of this subsection. A carrier may not circumvent this requirement by creating a chiropractor-specific code not listed in the nationally recognized code book otherwise used by the carrier for provider payment.

(b) This section does not affect a health carrier's:

(i) Implementation of a health care quality improvement program to promote cost-effective and clinically efficacious health care services, including but not limited to pay-for-performance payment methodologies and other programs fairly applied to all health care providers licensed under Title 18 RCW that are designed to promote evidence-based and research-based practices;

(ii) Health care provider contracting to comply with the network adequacy standards;

(iii) Authority to pay in-network providers differently than out-of-network providers; and

(iv) Authority to pay a chiropractor less than another provider for procedures or services under the same or a substantially similar code based upon differences in the cost of maintaining a practice or carrying malpractice insurance, as recognized by a nationally accepted reimbursement methodology.

(c) This section does not, and may not be construed to:

(i) Require the payment of provider billings that do not meet the definition of a clean claim as set forth in rules adopted by the commissioner;

(ii) Require any health plan to include coverage of any condition; or

(iii) Expand the scope of practice for any health care provider.

(2) This section applies only to payments made on or after January 1, 2009. [2018 c 181 s 1; 2008 c 304 s 1.]

Rules—2018 c 181 s 1: "The office of the insurance commissioner may adopt any rules necessary to implement section 1 of this act." [2018 c 181 s 2.]

Effective date—2018 c 181 s 1: "Section 1 of this act takes effect January 1, 2019." [2018 c 181 s 3.]

RCW 48.43.195 Contraceptive drugs—Twelve-month refill coverage. (1) A health benefit plan issued or renewed on or after January 1, 2026, that includes coverage for contraceptive drugs must provide reimbursement for a 12-month supply of contraceptive drugs obtained at one time by the enrollee, unless the enrollee requests a smaller supply or the prescribing provider instructs that the enrollee must receive a smaller supply. The health plan must allow enrollees to receive the contraceptive drugs on-site at the provider's office, if available. Any dispensing practices required by the plan must follow

clinical guidelines for appropriate prescribing and dispensing to ensure the health of the patient while maximizing access to effective contraceptive drugs.

(2) Nothing in this section prohibits a health plan from limiting refills that may be obtained in the last quarter of the plan year if a 12-month supply of the contraceptive drug has already been dispensed during the plan year.

(3) For purposes of this section, "contraceptive drugs" means all drugs approved by the United States food and drug administration that are used to prevent pregnancy, including, but not limited to, hormonal drugs administered orally, transdermally, and intravaginally. [2025 c 147 s 1; 2017 c 293 s 2.]

Effective date—2025 c 147: "This act takes effect January 1, 2026." [2025 c 147 s 2.]

Finding—Intent—2017 c 293: "The legislature finds that a significant percentage of pregnancies are unintended and could be averted with broader access to health care and effective contraception. Research suggests that moving from twenty-eight day dispensing of contraceptive drugs to twelve-month dispensing improves adherence to maintenance of the drugs and effective use of the contraceptives. It is therefore the intent of the legislature to require private health insurers to require dispensing of contraceptive drugs with up to a twelve-month supply provided at one time." [2017 c 293 s 1.]

DISCLOSURE OF MATERIAL TRANSACTIONS

RCW 48.43.200 Disclosure of certain material transactions—Report—Information is confidential. (1) Every certified health plan domiciled in this state shall file a report with the commissioner disclosing material acquisitions and dispositions of assets or material nonrenewals, cancellations, or revisions of ceded reinsurance agreements unless these acquisitions and dispositions of assets or material nonrenewals, cancellations, or revisions of ceded reinsurance agreements have been submitted to the commissioner for review, approval, or information purposes under other provisions of this title or other requirements.

(2) The report required in subsection (1) of this section is due within fifteen days after the end of the calendar month in which any of the transactions occur.

(3) One complete copy of the report, including any exhibits or other attachments filed as part of the report, shall be filed with the:

(a) Commissioner; and

(b) National association of insurance commissioners.

(4) All reports obtained by or disclosed to the commissioner under this section and RCW 48.43.205 through 48.43.225 are exempt from public inspection and copying and shall not be subject to subpoena. These reports shall not be made public by the commissioner, the national association of insurance commissioners, or any other person, except to insurance departments of other states, without the prior written consent of the certified health plan to which it pertains

unless the commissioner, after giving the certified health plan that would be affected by disclosure notice and a hearing under chapter 48.04 RCW, determines that the interest of policyholders, subscribers, shareholders, or the public will be served by the publication, in which event the commissioner may publish all or any part of the report in the manner he or she deems appropriate. [1995 c 86 s 7.]

RCW 48.43.205 Material acquisitions or dispositions. No acquisitions or dispositions of assets need be reported pursuant to RCW 48.43.200 if the acquisitions or dispositions are not material. For purposes of RCW 48.43.200 through 48.43.225, a material acquisition, or the aggregate of any series of related acquisitions during any thirty-day period; or disposition, or the aggregate of any series of related dispositions during any thirty-day period is an acquisition or disposition that is nonrecurring and not in the ordinary course of business and involves more than five percent of the reporting certified health plan's total assets as reported in its most recent statutory statement filed with the commissioner. [1995 c 86 s 8.]

RCW 48.43.210 Asset acquisitions—Asset dispositions. (1) Asset acquisitions subject to RCW 48.43.200 through 48.43.225 include every purchase, lease, exchange, merger, consolidation, succession, or other acquisition other than the construction or development of real property by or for the reporting certified health plan or the acquisition of materials for such purpose.

(2) Asset dispositions subject to RCW 48.43.200 through 48.43.225 include every sale, lease, exchange, merger, consolidation, mortgage, hypothecation, abandonment, destruction, other disposition, or assignment, whether for the benefit of creditors or otherwise. [1995 c 86 s 9.]

RCW 48.43.215 Report of a material acquisition or disposition of assets—Information required. (1) The following information is required to be disclosed in any report of a material acquisition or disposition of assets:

(a) Date of the transaction;

(b) Manner of acquisition or disposition;

(c) Description of the assets involved;

(d) Nature and amount of the consideration given or received;

(e) Purpose of or reason for the transaction;

(f) Manner by which the amount of consideration was determined;

(g) Gain or loss recognized or realized as a result of the transaction; and

(h) Names of the persons from whom the assets were acquired or to whom they were disposed.

(2) Certified health plans are required to report material acquisitions and dispositions on a nonconsolidated basis unless the certified health plan is part of a consolidated group of insurers that utilizes a pooling arrangement or one hundred percent reinsurance agreement that affects the solvency and integrity of the certified health plan's reserves and such certified health plan ceded substantially all of its direct and assumed business to the pool. A

certified health plan has ceded substantially all of its direct and assumed business to a pool if the certified health plan has less than one million dollars total direct plus assumed written premiums during a calendar year that are not subject to a pooling arrangement and the net income of the business not subject to the pooling arrangement represents less than five percent of the certified health plan's net worth. [1995 c 86 s 10.]

RCW 48.43.220 Material nonrenewals, cancellations, or revisions of ceded reinsurance agreements. (1) No nonrenewals, cancellations, or revisions of ceded reinsurance agreements need be reported under RCW 48.43.200 if the nonrenewals, cancellations, or revisions are not material. For purposes of RCW 48.43.200 through 48.43.225, a material nonrenewal, cancellation, or revision is one that affects:

(a) More than fifty percent of a certified health plan's total reserve credit taken for business ceded, on an annualized basis, as indicated in the certified health plan's most recent annual statement;

(b) More than ten percent of a certified health plan's total cession when it is replaced by one or more unauthorized reinsurers; or

(c) Previously established collateral requirements, when they have been reduced or waived as respects one or more unauthorized reinsurers representing collectively more than ten percent of a total cession.

(2) However, a filing is not required if the certified health plan's total reserve credit taken for business ceded represents, on an annualized basis, less than ten percent of the statutory reserve requirement prior to any cession. [1995 c 86 s 11.]

RCW 48.43.225 Report of a material nonrenewal, cancellation, or revision of ceded reinsurance agreements—Information required. (1) The following is required to be disclosed in any report of a material nonrenewal, cancellation, or revision of ceded reinsurance agreements:

(a) The effective date of the nonrenewal, cancellation, or revision;

(b) The description of the transaction with an identification of the initiator;

(c) The purpose of or reason for the transaction; and

(d) If applicable, the identity of the replacement reinsurers.

(2) Certified health plans are required to report all material nonrenewals, cancellations, or revisions of ceded reinsurance agreements on a nonconsolidated basis unless the certified health plan is part of a consolidated group of insurers which utilizes a pooling arrangement or one hundred percent reinsurance agreement that affects the solvency and integrity of the certified health plan's reserves and the certified health plan ceded substantially all of its direct and assumed business to the pool. A certified health plan has ceded substantially all of its direct and assumed business to a pool if the certified health plan has less than one million dollars total direct plus assumed written premiums during a calendar year that are not subject to a pooling arrangement and the net income of the business not subject to the pooling arrangement represents less than five percent of the certified health plan's net worth. [1995 c 86 s 12.]

MISCELLANEOUS

RCW 48.43.290 Coverage for prescribed durable medical equipment and mobility enhancing equipment—Sales and use taxes—Definitions. (1) Health plans issued or renewed on or after January 1, 2011, that include coverage for prescribed durable medical equipment and mobility enhancing equipment must include the sales tax or use tax calculation in plan payment, consistent with the application of sales tax in chapter 82.08 RCW or use tax in chapter 82.12 RCW.

(2) The payment for covered durable medical equipment and mobility enhancing equipment must:

(a) Reflect the negotiated provider agreement for the prescribed equipment; and

(b) Separately identify the sales tax or use tax calculation that is included in the payment if the provider submitting a claim or invoice for reimbursement submits to the health plan a claim or invoice with a separate line item for the geographically adjusted sales tax.

(3) The following definitions apply to this section unless the context clearly requires otherwise.

(a) "Durable medical equipment" means equipment, including repair and replacement parts for durable medical equipment that:

(i) Can withstand repeated use;

(ii) Is primarily and customarily used to serve a medical purpose;

(iii) Generally is not useful to a person in the absence of illness or injury; and

(iv) Is not worn in or on the body.

(b) "Mobility enhancing equipment" means equipment, including repair and replacement parts for mobility enhancing equipment that:

(i) Is primarily and customarily used to provide or increase the ability to move from one place to another and that is appropriate for use either in a home or a motor vehicle;

(ii) Is not generally used by persons with normal mobility; and

(iii) Does not include any motor vehicle or equipment on a motor vehicle normally provided by a motor vehicle manufacturer. [2010 c 44 s 1.]

RISK-BASED CAPITAL STANDARDS FOR HEALTH CARRIERS

RCW 48.43.300 Definitions. The definitions in this section apply throughout RCW 48.43.300 through 48.43.370 unless the context clearly requires otherwise.

(1) "Adjusted RBC report" means an RBC report that has been adjusted by the commissioner in accordance with RCW 48.43.305(4).

(2) "Corrective order" means an order issued by the commissioner specifying corrective actions that the commissioner has determined are required.

(3) "Domestic carrier" means any carrier domiciled in this state, or any person or entity subject to chapter 48.42 RCW domiciled in this state.

(4) "Foreign or alien carrier" means any carrier that is licensed to do business in this state but is not domiciled in this state, or any person or entity subject to chapter 48.42 RCW not domiciled in this state.

(5) "NAIC" means the national association of insurance commissioners.

(6) "Negative trend" means, with respect to a carrier, a negative trend over a period of time, as determined in accordance with the "trend test calculation" included in the RBC instructions.

(7) "RBC" means risk-based capital.

(8) "RBC instructions" means the RBC report including risk-based capital instructions adopted by the NAIC, as such RBC instructions may be amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC.

(9) "RBC level" means a carrier's company action level RBC, regulatory action level RBC, authorized control level RBC, or mandatory control level RBC where:

(a) "Company action level RBC" means, with respect to any carrier, the product of 2.0 and its authorized control level RBC;

(b) "Regulatory action level RBC" means the product of 1.5 and its authorized control level RBC;

(c) "Authorized control level RBC" means the number determined under the risk-based capital formula in accordance with the RBC instructions;

(d) "Mandatory control level RBC" means the product of .70 and the authorized control level RBC.

(10) "RBC plan" means a comprehensive financial plan containing the elements specified in RCW 48.43.310(2). If the commissioner rejects the RBC plan, and it is revised by the carrier, with or without the commissioner's recommendation, the plan shall be called the "revised RBC plan."

(11) "RBC report" means the report required in RCW 48.43.305.

(12) "Total adjusted capital" means the sum of:

(a) Either a carrier's statutory capital and surplus or net worth, or both, as determined in accordance with statutory accounting applicable to the annual financial statements required to be filed with the commissioner; and

(b) Other items, if any, as the RBC instructions may provide. [1998 c 241 s 1.]

RCW 48.43.305 Report of RBC levels—Distribution of report—Formula for determination—Commissioner may make adjustments. (1) Every domestic carrier shall, on or prior to the filing date of March 1st, prepare and submit to the commissioner a report of its RBC levels as of the end of the calendar year just ended, in a form and containing such information as is required by the RBC instructions. In addition, every domestic carrier shall file its RBC report:

(a) With the NAIC in accordance with the RBC instructions; and

(b) With the insurance commissioner in any state in which the carrier is authorized to do business, if the insurance commissioner has notified the carrier of its request in writing, in which case the carrier shall file its RBC report not later than the later of:

(i) Fifteen days from the receipt of notice to file its RBC report with that state; or

(ii) The filing date.

(2) A carrier's RBC shall be determined in accordance with the formula set forth in the RBC instructions. The formula shall take into account (and may adjust for the covariance between):

(a) The risk with respect to the carrier's assets;

(b) The risk of adverse insurance experience with respect to the carrier's liabilities and obligations;

(c) The interest rate risk with respect to the carrier's business; and

(d) All other business risks and such other relevant risks as are set forth in the RBC instructions; determined in each case by applying the factors in the manner set forth in the RBC instructions.

(3) An excess of capital over the amount produced by the risk-based capital requirements contained in RCW 48.43.300 through 48.43.370 and the formulas, schedules, and instructions referenced in RCW 48.43.300 through 48.43.370 is desirable in the business of insurance. Accordingly, carriers should seek to maintain capital above the RBC levels required by RCW 48.43.300 through 48.43.370. Additional capital is used and useful in the insurance business and helps to secure a carrier against various risks inherent in, or affecting, the business of insurance and not accounted for or only partially measured by the risk-based capital requirements contained in RCW 48.43.300 through 48.43.370.

(4) If a domestic carrier files an RBC report that in the judgment of the commissioner is inaccurate, then the commissioner shall adjust the RBC report to correct the inaccuracy and shall notify the carrier of the adjustment. The notice shall contain a statement of the reason for the adjustment. [1998 c 241 s 2.]

RCW 48.43.310 Company action level event—Required RBC plan—Commissioner's review—Notification—Challenge by carrier. (1) "Company action level event" means any of the following events:

(a) The filing of an RBC report by a carrier which indicates that:

(i) The carrier's total adjusted capital is greater than or equal to its regulatory action level RBC but less than its company action level RBC; or

(ii) The carrier has total adjusted capital which is greater than or equal to its company action level RBC but less than the product of its authorized control level RBC and 3 and has a negative trend;

(b) The notification by the commissioner to the carrier of an adjusted RBC report that indicates an event in (a) of this subsection, provided the carrier does not challenge the adjusted RBC report under RCW 48.43.330; or

(c) If, under RCW 48.43.330, a carrier challenges an adjusted RBC report that indicates the event in (a) of this subsection, the notification by the commissioner to the carrier that the commissioner has, after a hearing, rejected the carrier's challenge.

(2) In the event of a company action level event, the carrier shall prepare and submit to the commissioner an RBC plan that:

(a) Identifies the conditions that contribute to the company action level event;

(b) Contains proposals of corrective actions that the carrier intends to take and would be expected to result in the elimination of the company action level event;

(c) Provides projections of the carrier's financial results in the current year and at least the four succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory operating income, net income, capital, surplus, capital and surplus, and net worth. The projections for both new and renewal business might include separate projections for each major line of business and separately identify each significant income, expense, and benefit component;

(d) Identifies the key assumptions impacting the carrier's projections and the sensitivity of the projections to the assumptions; and

(e) Identifies the quality of, and problems associated with, the carrier's business, including but not limited to its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business, and use of reinsurance, if any, in each case.

(3) The RBC plan shall be submitted:

(a) Within forty-five days of the company action level event; or

(b) If the carrier challenges an adjusted RBC report under RCW 48.43.330, within forty-five days after notification to the carrier that the commissioner has, after a hearing, rejected the carrier's challenge.

(4) Within sixty days after the submission by a carrier of an RBC plan to the commissioner, the commissioner shall notify the carrier whether the RBC plan may be implemented or is, in the judgment of the commissioner, unsatisfactory. If the commissioner determines the RBC plan is unsatisfactory, the notification to the carrier shall set forth the reasons for the determination, and may set forth proposed revisions that will render the RBC plan satisfactory. Upon notification from the commissioner, the carrier shall prepare a revised RBC plan, that may incorporate by reference any revisions proposed by the commissioner, and shall submit the revised RBC plan to the commissioner:

(a) Within forty-five days after the notification from the commissioner; or

(b) If the carrier challenges the notification from the commissioner under RCW 48.43.330, within forty-five days after a notification to the carrier that the commissioner has, after a hearing, rejected the carrier's challenge.

(5) In the event of a notification by the commissioner to a carrier that the carrier's RBC plan or revised RBC plan is unsatisfactory, the commissioner may, subject to the carrier's rights to a hearing under RCW 48.43.330, specify in the notification that the notification constitutes a regulatory action level event.

(6) Every domestic carrier that files an RBC plan or revised RBC plan with the commissioner shall file a copy of the RBC plan or revised RBC plan with the insurance commissioner in any state in which the carrier is authorized to do business if:

(a) Such state has an RBC provision substantially similar to RCW 48.43.335(1); and

(b) The insurance commissioner of that state has notified the carrier of its request for the filing in writing, in which case the carrier shall file a copy of the RBC plan or revised RBC plan in that state no later than the later of:

(i) Fifteen days after the receipt of notice to file a copy of its RBC plan or revised plan with the state; or

(ii) The date on which the RBC plan or revised RBC plan is filed under subsections (3) and (4) of this section. [2012 c 211 s 8; 1998 c 241 s 3.]

RCW 48.43.315 Regulatory action level event—Required RBC plan—Commissioner's review—Notification—Challenge by carrier. (1) "Regulatory action level event" means, with respect to any carrier, any of the following events:

(a) The filing of an RBC report by the carrier which indicates that the carrier's total adjusted capital is greater than or equal to its authorized control level RBC but less than its regulatory action level RBC;

(b) The notification by the commissioner to a carrier of an adjusted RBC report that indicates the event in (a) of this subsection, provided the carrier does not challenge the adjusted RBC report under RCW 48.43.330;

(c) If, under RCW 48.43.330, the carrier challenges an adjusted RBC report that indicates the event in (a) of this subsection, the notification by the commissioner to the carrier that the commissioner has, after a hearing, rejected the carrier's challenge;

(d) The failure of the carrier to file an RBC report by the filing date, unless the carrier has provided an explanation for such failure that is satisfactory to the commissioner and has cured the failure within ten days after the filing date;

(e) The failure of the carrier to submit an RBC plan to the commissioner within the time period set forth in RCW 48.43.310(3);

(f) Notification by the commissioner to the carrier that:

(i) The RBC plan or revised RBC plan submitted by the carrier is, in the judgment of the commissioner, unsatisfactory; and

(ii) The notification constitutes a regulatory action level event with respect to the carrier, provided the carrier has not challenged the determination under RCW 48.43.330;

(g) If, under RCW 48.43.330, the carrier challenges a determination by the commissioner under (f) of this subsection, the notification by the commissioner to the carrier that the commissioner has, after a hearing, rejected the challenge;

(h) Notification by the commissioner to the carrier that the carrier has failed to adhere to its RBC plan or revised RBC plan, but only if such failure has a substantial adverse effect on the ability of the carrier to eliminate the company action level event in accordance with its RBC plan or revised RBC plan and the commissioner has so stated in the notification, provided the carrier has not challenged the determination under RCW 48.43.330; or

(i) If, under RCW 48.43.330, the carrier challenges a determination by the commissioner under (h) of this subsection, the notification by the commissioner to the carrier that the commissioner has, after a hearing, rejected the challenge.

(2) In the event of a regulatory action level event the commissioner shall:

(a) Require the carrier to prepare and submit an RBC plan or, if applicable, a revised RBC plan;

(b) Perform the examination or analysis the commissioner deems necessary of the assets, liabilities, and operations of the carrier including a review of its RBC plan or revised RBC plan; and

(c) Subsequent to the examination or analysis, issue an order specifying those corrective actions the commissioner determines are required.

(3) In determining corrective actions, the commissioner may take into account those factors deemed relevant with respect to the carrier based upon the commissioner's examination or analysis of the assets, liabilities, and operations of the carrier, including, but not limited to, the results of any sensitivity tests undertaken pursuant to the RBC instructions. The RBC plan or revised RBC plan shall be submitted:

(a) Within forty-five days after the occurrence of the regulatory action level event;

(b) If the carrier challenges an adjusted RBC report under RCW 48.43.330 and the challenge is not frivolous in the judgment of the commissioner within forty-five days after the notification to the carrier that the commissioner has, after a hearing, rejected the carrier's challenge; or

(c) If the carrier challenges a revised RBC plan under RCW 48.43.330 and the challenge is not frivolous in the judgment of the commissioner, within forty-five days after the notification to the carrier that the commissioner has, after a hearing, rejected the carrier's challenge.

(4) The commissioner may retain actuaries and investment experts and other consultants as may be necessary in the judgment of the commissioner to review the carrier's RBC plan or revised RBC plan, examine or analyze the assets, liabilities, and operations of the carrier and formulate the corrective order with respect to the carrier. The fees, costs, and expenses relating to consultants shall be borne by the affected carrier or other party as directed by the commissioner. [1998 c 241 s 4.]

RCW 48.43.320 Authorized control level event—Commissioner's options. (1) "Authorized control level event" means any of the following events:

(a) The filing of an RBC report by the carrier which indicates that the carrier's total adjusted capital is greater than or equal to its mandatory control level RBC but less than its authorized control level RBC;

(b) The notification by the commissioner to the carrier of an adjusted RBC report that indicates the event in (a) of this subsection, provided the carrier does not challenge the adjusted RBC report under RCW 48.43.330;

(c) If, under RCW 48.43.330, the carrier challenges an adjusted RBC report that indicates the event in (a) of this subsection, notification by the commissioner to the carrier that the commissioner has, after a hearing, rejected the carrier's challenge;

(d) The failure of the carrier to respond, in a manner satisfactory to the commissioner, to a corrective order, provided the carrier has not challenged the corrective order under RCW 48.43.330; or

(e) If the carrier has challenged a corrective order under RCW 48.43.330 and the commissioner has, after a hearing, rejected the challenge or modified the corrective order, the failure of the carrier to respond, in a manner satisfactory to the commissioner, to the corrective order subsequent to rejection or modification by the commissioner.

(2) In the event of an authorized control level event with respect to a carrier, the commissioner shall:

(a) Take those actions required under RCW 48.43.315 regarding a carrier with respect to which a regulatory action level event has occurred; or

(b) If the commissioner deems it to be in the best interests of either the policyholders or subscribers, or both, and creditors of the carrier and of the public, take those actions necessary to cause the carrier to be placed under regulatory control under chapter 48.31 RCW. In the event the commissioner takes such actions, the authorized control level event is sufficient grounds for the commissioner to take action under chapter 48.31 RCW, and the commissioner shall have the rights, powers, and duties with respect to the carrier as are set forth in chapter 48.31 RCW. In the event the commissioner takes actions under this subsection (2)(b) pursuant to an adjusted RBC report, the carrier is entitled to those protections afforded to carriers under the provisions of RCW 48.31.121 pertaining to summary proceedings. [1998 c 241 s 5.]

RCW 48.43.325 Mandatory control level event—Commissioner's duty—Regulatory control. (1) "Mandatory control level event" means any of the following events:

(a) The filing of an RBC report which indicates that the carrier's total adjusted capital is less than its mandatory control level RBC;

(b) Notification by the commissioner to the carrier of an adjusted RBC report that indicates the event in (a) of this subsection, provided the carrier does not challenge the adjusted RBC report under RCW 48.43.330; or

(c) If, under RCW 48.43.330, the carrier challenges an adjusted RBC report that indicates the event in (a) of this subsection, notification by the commissioner to the carrier that the commissioner has, after a hearing, rejected the carrier's challenge.

(2) In the event of a mandatory control level event, with respect to a carrier, the commissioner shall take those actions necessary to place the carrier under regulatory control under chapter 48.31 RCW. In that event, the mandatory control level event is sufficient grounds for the commissioner to take action under chapter 48.31 RCW, and the commissioner shall have the rights, powers, and duties with respect to the carrier as are set forth in chapter 48.31 RCW. If the commissioner takes actions pursuant to an adjusted RBC report, the carrier is entitled to the protections of RCW 48.31.121 pertaining to summary proceedings. However, the commissioner may forego action for up to ninety days after the mandatory control level event if the commissioner finds there is a reasonable expectation that the mandatory control level event may be eliminated within the ninety-day period. [1998 c 241 s 6.]

RCW 48.43.330 Carrier's right to hearing—Request by carrier—Date set by commissioner. (1) Upon notification to a carrier by the commissioner of any of the following, the carrier shall have the right to a hearing, in accordance with chapters 48.04 and 34.05 RCW, at which the carrier may challenge any determination or action by the commissioner:

(a) Of an adjusted RBC report; or

(b)(i) That the carrier's RBC plan or revised RBC plan is unsatisfactory; and

(ii) The notification constitutes a regulatory action level event with respect to such carrier; or

(c) That the carrier has failed to adhere to its RBC plan or revised RBC plan and that such failure has a substantial adverse effect on the ability of the carrier to eliminate the company action level event with respect to the carrier in accordance with its RBC plan or revised RBC plan; or

(d) Of a corrective order with respect to the carrier.

(2) The carrier shall notify the commissioner of its request for a hearing within five days after the notification by the commissioner under this section. Upon receipt of the carrier's request for a hearing, the commissioner shall set a date for the hearing. The date shall be no less than ten nor more than thirty days after the date of the carrier's request. [1998 c 241 s 7.]

RCW 48.43.335 Confidentiality of RBC reports and plans—Use of certain comparisons prohibited—Certain information intended solely for use by commissioner. (1) All RBC reports, to the extent the information therein is not required to be set forth in a publicly available annual statement schedule, and RBC plans, including the results or report of any examination or analysis of a carrier and any corrective order issued by the commissioner, with respect to any domestic carrier or foreign carrier that are filed with the commissioner constitute information that might be damaging to the carrier if made available to its competitors, and therefore shall be kept confidential by the commissioner. This information shall not be made public or be subject to subpoena, other than by the commissioner and then only for the purpose of enforcement actions taken by the commissioner.

(2) The comparison of a carrier's total adjusted capital to any of its RBC levels is a regulatory tool that may indicate the need for possible corrective action with respect to the carrier, and is not a means to rank carriers generally. Therefore, except as otherwise required under the provisions of RCW 48.43.300 through 48.43.370, the making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station, or in any other way, an advertisement, announcement, or statement containing an assertion, representation, or statement with regard to the RBC levels of any carrier, or of any component derived in the calculation, by any carrier, insurance producer, or other person engaged in any manner in the insurance business would be misleading and is therefore prohibited. However, if any materially false statement with respect to the comparison regarding a carrier's total adjusted capital to its RBC levels (or any of them) or an inappropriate comparison of any other amount to the carrier's RBC levels is published in any written publication and the carrier is able to demonstrate to the commissioner with substantial proof the falsity of such statement, or the inappropriateness, as the case may be, then the carrier may publish an announcement in a written publication if

the sole purpose of the announcement is to rebut the materially false statement.

(3) The RBC instructions, RBC reports, adjusted RBC reports, RBC plans, and revised RBC plans are intended solely for use by the commissioner in monitoring the solvency of carriers and the need for possible corrective action with respect to carriers and shall not be used by the commissioner for ratemaking nor considered or introduced as evidence in any rate proceeding nor used by the commissioner to calculate or derive any elements of an appropriate premium level or rate of return for any line of insurance that a carrier or any affiliate is authorized to write. [2008 c 217 s 49; 1998 c 241 s 8.]

Severability—Effective date—2008 c 217: See notes following RCW 48.03.020.

RCW 48.43.340 Powers or duties of commissioner not limited—Rules. (1) The provisions of RCW 48.43.300 through 48.43.370 are supplemental to any other provisions of the laws and rules of this state, and shall not preclude or limit any other powers or duties of the commissioner under such laws and rules, including, but not limited to, chapter 48.31 RCW.

(2) The commissioner may adopt reasonable rules necessary for the implementation of RCW 48.43.300 through 48.43.370. [1998 c 241 s 9.]

RCW 48.43.345 Foreign or alien carriers—Required RBC report—Commissioner may require RBC plan—Mandatory control level event. (1) Any foreign or alien carrier shall, upon the written request of the commissioner, submit to the commissioner an RBC report as of the end of the calendar year just ended by the later of:

(a) The date an RBC report would be required to be filed by a domestic carrier under RCW 48.43.300 through 48.43.370; or

(b) Fifteen days after the request is received by the foreign or alien carrier. Any foreign or alien carrier shall, at the written request of the commissioner, promptly submit to the commissioner a copy of any RBC plan that is filed with the insurance commissioner of any other state.

(2) In the event of a company action level event, regulatory action level event, or authorized control level event with respect to any foreign or alien carrier as determined under the RBC statute applicable in the state of domicile of the carrier or, if no RBC statute is in force in that state, under the provisions of RCW 48.43.300 through 48.43.370, if the insurance commissioner of the state of domicile of the foreign or alien carrier fails to require the foreign or alien carrier to file an RBC plan in the manner specified under that state's RBC statute or, if no RBC statute is in force in that state, under RCW 48.43.310, the commissioner may require the foreign or alien carrier to file an RBC plan with the commissioner. In this event, the failure of the foreign or alien carrier to file an RBC plan with the commissioner is grounds to order the carrier to cease and desist from writing new insurance business in this state.

(3) In the event of a mandatory control level event with respect to any foreign or alien carrier, if no domiciliary receiver has been appointed with respect to the foreign or alien carrier under the rehabilitation and liquidation statute applicable in the state of

domicile of the foreign or alien carrier, the commissioner may apply for an order under RCW 48.31.080 or 48.31.090 to conserve the assets within this state of foreign or alien carriers, and the occurrence of the mandatory control level event is considered adequate grounds for the application. [1998 c 241 s 10.]

RCW 48.43.350 No liability or cause of action against commissioner or department. There is no liability on the part of, and no cause of action shall arise against, the commissioner or insurance department or its employees or agents for any action taken by them in the performance of their powers and duties under RCW 48.43.300 through 48.43.370. [1998 c 241 s 11.]

RCW 48.43.355 Notice by commissioner to carrier—When effective. All notices by the commissioner to a carrier that may result in regulatory action are effective upon dispatch if transmitted by registered or certified mail, or in the case of any other transmission, are effective upon the carrier's receipt of such notice. [1998 c 241 s 12.]

RCW 48.43.360 Initial RBC reports—Calculation of initial RBC levels—Subsequent reports. For RBC reports to be filed by carriers commencing operations after June 11, 1998, those carriers shall calculate the initial RBC levels using financial projections, considering managed care arrangements, for its first full year in operation. Such projections, including the risk-based capital requirement, must be included as part of a comprehensive business plan that is submitted as part of the application for registration under RCW 48.44.040 and 48.46.030. The resulting RBC requirement shall be reported in the first RBC report submitted under RCW 48.43.305. For subsequent reports, the RBC results using actual financial data shall be included. [1998 c 241 s 13.]

RCW 48.43.366 Self-funded multiple employer welfare arrangements. A self-funded multiple employer welfare arrangement, as defined in RCW 48.125.010, is subject to the same RBC reporting requirements as a domestic carrier under RCW 48.43.300 through 48.43.370. [2004 c 260 s 19.]

Effective date—2004 c 260: See RCW 48.125.901.

RCW 48.43.370 RBC standards not applicable to certain carriers. RCW 48.43.300 through 48.43.370 shall not apply to a carrier which is subject to the provisions of RCW 48.05.430 through *48.05.490. [1998 c 241 s 15.]

***Reviser's note:** RCW 48.05.490 was repealed by 2006 c 25 s 11.

PRESCRIPTION DRUG UTILIZATION MANAGEMENT

RCW 48.43.400 Prescription drug utilization management—Definitions. The definitions in this section apply throughout this section and RCW 48.43.410 and 48.43.420 unless the context clearly requires otherwise.

(1) "Clinical practice guidelines" means a systemically developed statement to assist decision making by health care providers and patients about appropriate health care for specific clinical circumstances and conditions.

(2) "Clinical review criteria" means the written screening procedures, decision rules, medical protocols, and clinical practice guidelines used by a health carrier or prescription drug utilization management entity as an element in the evaluation of medical necessity and appropriateness of requested prescription drugs under a health plan.

(3) "Emergency fill" means a limited dispensed amount of medication that allows time for the processing of prescription drug utilization management.

(4) "Medically appropriate" means prescription drugs that under the applicable standard of care are appropriate: (a) To improve or preserve health, life, or function; (b) to slow the deterioration of health, life, or function; or (c) for the early screening, prevention, evaluation, diagnosis, or treatment of a disease, condition, illness, or injury.

(5) "Prescription drug utilization management" means a set of formal techniques used by a health carrier or prescription drug utilization management entity, that are designed to monitor the use of or evaluate the medical necessity, appropriateness, efficacy, or efficiency of prescription drugs including, but not limited to, prior authorization and step therapy protocols.

(6) "Prescription drug utilization management entity" means an entity affiliated with, under contract with, or acting on behalf of a health carrier to perform prescription drug utilization management.

(7) "Prior authorization" means a mandatory process that a carrier or prescription drug utilization management entity requires a provider or facility to follow to determine if a service is a benefit and meets the requirements for medical necessity, clinical appropriateness, level of care, or effectiveness in relation to the applicable plan.

(8) "Step therapy protocol" means a protocol or program that establishes the specific sequence in which prescription drugs for a specified medical condition will be covered by a health carrier. [2019 c 171 s 1.]

Rules—2019 c 171: See note following RCW 48.43.420.

RCW 48.43.410 Prescription drug utilization management—Clinical review criteria—Requirement to be evidence-based and updated regularly. ***(Effective until January 1, 2027.)*** For health plans delivered, issued for delivery, or renewed on or after January 1, 2021, clinical review criteria used to establish a prescription drug utilization management protocol must be evidence-based and updated on a regular basis through review of new evidence, research, and newly developed treatments. [2019 c 171 s 2.]

Rules—2019 c 171: See note following RCW 48.43.420.

RCW 48.43.410 Prescription drug utilization management—Clinical review criteria—Requirement to be evidence-based and updated regularly. *(Effective January 1, 2027.)* For health plans delivered, issued for delivery, or renewed on or after January 1, 2021, clinical review criteria used to establish a prescription drug utilization management protocol must be evidence-based and updated on a regular basis through review of new evidence, research, and newly developed treatments. For prescription drugs prescribed to treat mental health or substance use disorder conditions, clinical review criteria must meet the requirements of RCW 48.43.766. [2025 c 227 s 4; 2019 c 171 s 2.]

Effective date—2025 c 227 ss 1-8: See note following RCW 48.43.766.

Findings—Intent—Rules—2025 c 227: See notes following RCW 48.43.766.

Rules—2019 c 171: See note following RCW 48.43.420.

RCW 48.43.420 Prescription drug utilization management—Exception request process—Conditions, requirements, and time frames for approval or denial of requests—Emergency fill coverage—Notice of new policies and procedures. For health plans delivered, issued for delivery, or renewed on or after January 1, 2021:

(1) When coverage of a prescription drug for the treatment of any medical condition is subject to prescription drug utilization management, the patient and prescribing practitioner must have access to a clear, readily accessible, and convenient process to request an exception through which the prescription drug utilization management can be overridden in favor of coverage of a prescription drug prescribed by a treating health care provider. A health carrier or prescription drug utilization management entity may use its existing medical exceptions process to satisfy this requirement. The process must be easily accessible on the health carrier and prescription drug utilization management entity's website. Approval criteria must be clearly posted on the health carrier and prescription drug utilization management entity's website. This information must be in plain language and understandable to providers and patients.

(2) Health carriers must disclose all rules and criteria related to the prescription drug utilization management process to all participating providers, including the specific information and documentation that must be submitted by a health care provider or patient to be considered a complete exception request.

(3) An exception request must be granted if the health carrier or prescription drug utilization management entity determines that the evidence submitted by the provider or patient is sufficient to establish that:

(a) The required prescription drug is contraindicated or will likely cause a clinically predictable adverse reaction by the patient;

(b) The required prescription drug is expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug regimen;

(c) The patient has tried the required prescription drug or another prescription drug in the same pharmacologic class or a drug

with the same mechanism of action while under his or her current or a previous health plan, and such prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event;

(d) The patient is currently experiencing a positive therapeutic outcome on a prescription drug recommended by the patient's provider for the medical condition under consideration while on his or her current or immediately preceding health plan, and changing to the required prescription drug may cause clinically predictable adverse reactions, or physical or mental harm to, the patient; or

(e) The required prescription drug is not in the best interest of the patient, based on documentation of medical appropriateness, because the patient's use of the prescription drug is expected to:

(i) Create a barrier to the patient's adherence to or compliance with the patient's plan of care;

(ii) Negatively impact a comorbid condition of the patient;

(iii) Cause a clinically predictable negative drug interaction; or

(iv) Decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities.

(4) Upon the granting of an exception, the health carrier or prescription drug utilization management entity shall authorize coverage for the prescription drug prescribed by the patient's treating health care provider.

(5)(a) For nonurgent exception requests, the health carrier or prescription drug utilization management entity must:

(i) Within three business days notify the treating health care provider that additional information, as disclosed under subsection (2) of this section, is required in order to approve or deny the exception request, if the information provided is not sufficient to approve or deny the request; and

(ii) Within three business days of receipt of sufficient information from the treating health care provider as disclosed under subsection (2) of this section, approve a request if the information provided meets at least one of the conditions referenced in subsection (3) of this section or if deemed medically appropriate, or deny a request if the requested service does not meet at least one of the conditions referenced in subsection (3) of this section.

(b) For urgent exception requests, the health carrier or prescription drug utilization management entity must:

(i) Within one business day notify the treating health care provider that additional information, as disclosed under subsection (2) of this section, is required in order to approve or deny the exception request, if the information provided is not sufficient to approve or deny the request; and

(ii) Within one business day of receipt of sufficient information from the treating health care provider as disclosed under subsection (2) of this section, approve a request if the information provided meets at least one of the conditions referenced in subsection (3) of this section or if deemed medically appropriate, or deny a request if the requested service does not meet at least one of the conditions referenced in subsection (3) of this section.

(c) If a response by a health carrier or prescription drug utilization management entity is not received within the time frames established under this section, the exception request is deemed granted.

(d) For purposes of this subsection, exception requests are considered urgent when an enrollee is experiencing a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function, or when an enrollee is undergoing a current course of treatment using a nonformulary drug.

(6) Health carriers must cover an emergency supply fill if a treating health care provider determines an emergency fill is necessary to keep the patient stable while the exception request is being processed. This exception shall not be used to solely justify any further exemption.

(7) When responding to a prescription drug utilization management exception request, a health carrier or prescription drug utilization management entity shall clearly state in their response if the exception request was approved or denied. The health carrier must use clinical review criteria as referenced in RCW 48.43.410 for the basis of any denial. Any denial must be based upon and include the specific clinical review criteria relied upon for the denial and include information regarding how to appeal denial of the exception request. If the exception request from a treating health care provider is denied for administrative reasons, or for not including all the necessary information, the health carrier or prescription drug utilization management entity must inform the provider what additional information is needed and the deadline for its submission.

(8) The health carrier or prescription drug utilization management entity must permit a stabilized patient to remain on a drug during an exception request process.

(9) A health carrier must provide sixty days' notice to providers and patients for any new policies or procedures applicable to prescription drug utilization management protocols. New health carrier policies or procedures may not be applied retroactively.

(10) This section does not prevent:

(a) A health carrier or prescription drug utilization management entity from requiring a patient to try an AB-rated generic equivalent or a biological product that is an interchangeable biological product prior to providing coverage for the equivalent branded prescription drug;

(b) A health carrier or prescription drug utilization management entity from denying an exception for a drug that has been removed from the market due to safety concerns from the federal food and drug administration; or

(c) A health care provider from prescribing a prescription drug that is determined to be medically appropriate. [2019 c 171 s 3.]

Rules—2019 c 171: "The insurance commissioner shall adopt rules necessary for the implementation of this act." [2019 c 171 s 4.]

RCW 48.43.430 Prescription medication—Maximum charge at point of sale—Requirements. (1) Beginning January 1, 2021, the maximum amount a health carrier or pharmacy benefit manager may require a person to pay at the point of sale for a covered prescription medication is the lesser of:

(a) The applicable cost sharing for the prescription medication; or

(b) The amount the person would pay for the prescription medication if the person purchased the prescription medication without using a health plan.

(2) A health carrier or pharmacy benefit manager may not require a pharmacist to dispense a brand name prescription medication when a less expensive therapeutically equivalent generic prescription medication is available.

(3) For purposes of this section, "pharmacy benefit manager" has the same meaning as in *RCW 19.340.010. [2020 c 116 s 1.]

***Reviser's note:** RCW 19.340.010 was repealed by 2020 c 240 s 19, effective January 1, 2022. For later enactment, see RCW 48.200.020.

RCW 48.43.435 Prescription medication—Cost-sharing calculation—Application—Rules. (1)(a) Except as provided in (b) of this subsection, when calculating an enrollee's contribution to any applicable cost-sharing or out-of-pocket maximum, a health carrier offering a nongrandfathered health plan with a pharmacy benefit, or a health care benefit manager administering benefits for the health carrier, shall include any cost-sharing amounts paid by the enrollee directly or on behalf of the enrollee by another person for a covered prescription drug that is:

(i) Without a generic equivalent or a therapeutic equivalent preferred under the health plan's formulary;

(ii) With a generic equivalent or a therapeutic equivalent preferred under the health plan's formulary where the enrollee has obtained access to the drug through:

(A) Prior authorization;

(B) Step therapy; or

(C) The prescription drug exception request process under RCW 48.43.420; or

(iii) With a generic equivalent or therapeutic equivalent preferred under the health plan's formulary, throughout an exception request process under RCW 48.43.420, including any appeal of a denial of an exception request. If the health carrier utilizes a health care benefit manager to approve or deny exception requests, the exception request process for the purposes of this subsection (1)(a)(iii) also includes any time between the completion of the exception request process, including any appeal of a denial, and when the health care benefit manager communicates the status of the request to the health carrier.

(b) When calculating an enrollee's contribution to any applicable deductible, any amount paid on behalf of the enrollee by another person for a prescription drug that is not subject to payment of a deductible need not be included in the calculation, unless the terms of the enrollee's health plan require inclusion.

(2) Any cost-sharing amounts paid directly by or on behalf of the enrollee by another person for a covered prescription drug under subsection (1) of this section shall be applied towards the enrollee's applicable cost-sharing or out-of-pocket maximum in full at the time it is rendered.

(3) The commissioner may adopt any rules necessary to implement this section.

(4) This section applies to nongrandfathered health plans issued or renewed on or after January 1, 2023.

(5) This section does not apply to a qualifying health plan for a health savings account to the extent necessary to preserve the enrollee's ability to claim tax exempt contributions and withdrawals from the enrollee's health savings account under internal revenue service laws, regulations, and guidance.

(6) For purposes of this section:

(a) "Health care benefit manager" has the same meaning as in RCW 48.200.020.

(b) "Person" has the same meaning as in RCW 48.01.070. [2022 c 228 s 1.]

RCW 48.43.440 Human immunodeficiency virus postexposure prophylaxis drugs—Cost sharing and prior authorization. (1) Except as provided in subsection (2) of this section, for nongrandfathered health plans issued or renewed on or after January 1, 2025, a health carrier may not impose cost sharing or require prior authorization for the drugs that comprise at least one regimen recommended by the centers for disease control and prevention for human immunodeficiency virus postexposure prophylaxis.

(2) For a health plan that is offered as a qualifying health plan for a health savings account, the health carrier must establish the plan's cost sharing for the coverage required by this section at the minimum level necessary to preserve the enrollee's ability to claim tax exempt contributions and withdrawals from the enrollee's health savings account under the internal revenue service laws and regulations.

(3) Notwithstanding the coverage requirements of this section, a health plan shall reimburse a hospital that bills for a 28-day supply of any human immunodeficiency virus postexposure prophylaxis drugs or therapies dispensed or delivered to a patient in the emergency department for take-home use, pursuant to RCW 70.41.495, as a separate reimbursable expense. This reimbursable expense is separate from any bundled payment for emergency department services. [2024 c 251 s 3.]

Effective date—2024 c 251: See note following RCW 70.41.495.

HEALTH CARE PATIENT PROTECTION

RCW 48.43.500 Intent—Purpose—2000 c 5. It is the intent of the legislature that enrollees covered by health plans receive quality health care designed to maintain and improve their health. The purpose of chapter 5, Laws of 2000 is to ensure that health plan enrollees:

(1) Have improved access to information regarding their health plans;

(2) Have sufficient and timely access to appropriate health care services, and choice among health care providers;

(3) Are assured that health care decisions are made by appropriate medical personnel;

(4) Have access to a quick and impartial process for appealing plan decisions;

(5) Are protected from unnecessary invasions of health care privacy; and

(6) Are assured that personal health care information will be used only as necessary to obtain and pay for health care or to improve the quality of care. [2000 c 5 s 1.]

Application—2000 c 5: "This act applies to: Health plans as defined in RCW 48.43.005 offered, renewed, or issued by a carrier; medical assistance provided under RCW 74.09.522; the basic health plan offered under chapter 70.47 RCW; and health benefits provided under chapter 41.05 RCW." [2000 c 5 s 19.]

Short title—2000 c 5: "This act may be known and cited as the health care patient bill of rights." [2000 c 5 s 22.]

Captions not law—2000 c 5: "Captions used in this act are not any part of the law." [2000 c 5 s 24.]

Construction—2000 c 5: "To the extent permitted by law, if any provision of this act conflicts with state or federal law, such provision must be construed in a manner most favorable to the enrollee." [2000 c 5 s 26.]

Severability—2000 c 5: "If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected." [2000 c 5 s 27.]

Application to contracts—Effective dates—2000 c 5: "(1) Except as provided in subsections (2) and (3) of this section, this act applies to contracts entered into or renewing after June 30, 2001.

(2) Sections 13, 14, 15, and 16 of this act take effect January 1, 2001.

(3) Section 29 of this act takes effect July 1, 2001." [2000 c 5 s 28.]

RCW 48.43.505 Enrollee's and protected individual's right to privacy and confidential services—Health carrier or insurer duties—Requests for confidential communications—Rules. (1) Health carriers and insurers shall adopt policies and procedures that conform administrative, business, and operational practices to protect an enrollee's and protected individual's right to privacy or right to confidential health care services granted under state or federal laws.

(2) A health carrier may not require protected individuals to obtain the policyholder, primary subscriber, or other covered person's authorization to receive health care services or to submit a claim if the protected individual has the right to consent to care.

(3) A health carrier must recognize the right of a protected individual or enrollee to exclusively exercise rights granted under this section regarding health information related to care that the enrollee or protected individual has received.

(4) A health carrier or insurer must direct all communication regarding a protected individual's receipt of sensitive health care services directly to the protected individual receiving care, or to a physical or email address or telephone number specified by the protected individual. A carrier or insurer may not disclose nonpublic personal health information concerning sensitive health care services

provided to a protected individual to any person, including the policyholder, the primary subscriber, or any plan enrollees other than the protected individual receiving care, without the express written consent or verbal authorization on a recorded telephone line of the protected individual receiving care. Communications subject to this limitation include the following written, verbal, or electronic communications:

(a) Bills and attempts to collect payment;

(b) A notice of adverse benefits determinations;

(c) An explanations of benefits notice;

(d) A carrier's request for additional information regarding a claim;

(e) A notice of a contested claim;

(f) The name and address of a provider, a description of services provided, and other visit information; and

(g) Any written, oral, or electronic communication from a carrier that contains protected health information.

(5) Protected individuals may request that health carrier communications regarding the receipt of sensitive health care services be sent to another individual, including the policyholder, primary subscriber, or a health care provider, for the purposes of appealing adverse benefits determinations.

(6) Health carriers shall:

(a) Limit disclosure of any information, including personal health information, about a protected individual who is the subject of the information and shall direct communications containing such information directly to the protected individual, or to a physical or email address or telephone number specified by the protected individual, if he or she requests such a limitation, regardless of whether the information pertains to sensitive services;

(b) Permit protected individuals to use the form described in RCW 48.43.5051(2) and must also allow enrollees and protected individuals to make the request by telephone, email, or the internet;

(c) Ensure that requests for nondisclosure remain in effect until the protected individual revokes or modifies the request in writing;

(d) Limit disclosure of information under this subsection consistent with the protected individual's request; and

(e) Ensure that requests for nondisclosure are implemented no later than three business days after receipt of a request.

(7) Health carriers may not require a protected individual to waive any right to limit disclosure under this section as a condition of eligibility for or coverage under a health benefit plan.

(8) For the protection of patient confidentiality, any communication from a health carrier relating to the provision of health care services, if the communications disclose protected health information, including medical information or provider name and address, relating to receipt of sensitive services, must be provided in the form and format requested by the individual patient receiving care.

(9) The commissioner may adopt rules to implement this section after considering relevant standards adopted by national managed care accreditation organizations and the national association of insurance commissioners, and after considering the effect of those standards on the ability of carriers to undertake enrollee care management and disease management programs. [2019 c 56 s 3; 2000 c 5 s 5.]

Findings—Declarations—Effective date—2019 c 56: See notes following RCW 48.43.5051.

Application—Short title—Captions not law—Construction—Severability—Application to contracts—Effective dates—2000 c 5: See notes following RCW 48.43.500.

RCW 48.43.5051 Requests for confidential communications—Monitoring and ensuring compliance—Standardized form for submission of requests—Rules. (1) The commissioner shall:

(a) Develop a process for the regular collection of information from carriers on requests for confidential communications pursuant to RCW 48.43.505 for the purposes of monitoring compliance, including monitoring:

(i) The effectiveness of the process described in RCW 48.43.505 in allowing protected individuals to redirect insurance communications, the extent to which protected individuals are using the process, and whether the process is working properly; and

(ii) The education and outreach activities conducted by carriers to inform enrollees about their right to confidential communications;

(b) Establish a process for ensuring compliance; and

(c) Develop rules necessary to implement chapter 56, Laws of 2019.

(2) The commissioner shall work with stakeholders to develop and make available to the public a standardized form that a protected individual may submit to a carrier to make a confidential communications request. At minimum, this form must:

(a) Inform a protected individual about the protected individual's right to confidential communications;

(b) Allow a protected individual to indicate where to redirect communications, including a specified physical or email address or specified telephone number; and

(c) Include a disclaimer that it may take up to three business days from the date of receipt for a carrier to process the form. [2019 c 56 s 4.]

Findings—Declarations—2019 c 56: "The legislature finds and declares:

(1) All people deserve the right to choose the health services that are right for them, and the right to confidential access to those health services.

(2) When people are assured of the ability to confidentially access health care services, they are more likely to seek health services, disclose health risk behaviors to a clinician, and return for follow-up care.

(3) When denied confidential access to needed care, people may delay or forgo care, leading to higher rates of unprotected sex, unintended pregnancy, untreated sexually transmitted infections, and mental health issues, or they may turn to public health safety net funds or free clinics to receive confidential care—important resources that should be reserved for people who do not have insurance coverage." [2019 c 56 s 1.]

Effective date—2019 c 56: "This act takes effect January 1, 2020." [2019 c 56 s 8.]

RCW 48.43.510 Carrier required to disclose health plan information—Marketing and advertising restrictions—Rules. (1) A carrier that offers a health plan may not offer to sell a health plan to an enrollee or to any group representative, agent, employer, or enrollee representative without first offering to provide, and providing upon request, the following information before purchase or selection:

(a) A listing of covered benefits, including prescription drug benefits, if any, a copy of the current formulary, if any is used, definitions of terms such as generic versus brand name, and policies regarding coverage of drugs, such as how they become approved or taken off the formulary, and how consumers may be involved in decisions about benefits;

(b) A listing of exclusions, reductions, and limitations to covered benefits, and any definition of medical necessity or other coverage criteria upon which they may be based;

(c) A statement of the carrier's policies for protecting the confidentiality of health information;

(d) A statement of the cost of premiums and any enrollee cost-sharing requirements;

(e) A summary explanation of the carrier's review of adverse benefit determinations and grievance processes;

(f) A statement regarding the availability of a point-of-service option, if any, and how the option operates; and

(g) A convenient means of obtaining lists of participating primary care and specialty care providers, including disclosure of network arrangements that restrict access to providers within any plan network. The offer to provide the information referenced in this subsection (1) must be clearly and prominently displayed on any information provided to any prospective enrollee or to any prospective group representative, agent, employer, or enrollee representative.

(2) Upon the request of any person, including a current enrollee, prospective enrollee, or the insurance commissioner, a carrier must provide written information regarding any health care plan it offers, that includes the following written information:

(a) Any documents, instruments, or other information referred to in the medical coverage agreement;

(b) A full description of the procedures to be followed by an enrollee for consulting a provider other than the primary care provider and whether the enrollee's primary care provider, the carrier's medical director, or another entity must authorize the referral;

(c) Procedures, if any, that an enrollee must first follow for obtaining prior authorization for health care services;

(d) A written description of any reimbursement or payment arrangements, including, but not limited to, capitation provisions, fee-for-service provisions, and health care delivery efficiency provisions, between a carrier and a provider or network;

(e) Descriptions and justifications for provider compensation programs, including any incentives or penalties that are intended to encourage providers to withhold services or minimize or avoid referrals to specialists;

(f) An annual accounting of all payments made by the carrier which have been counted against any payment limitations, visit limitations, or other overall limitations on a person's coverage under a plan; however, the individual requesting an annual accounting may

only receive information about that individual's own care, and may not receive information pertaining to protected individuals who have requested confidential communications pursuant to RCW 48.43.505;

(g) A copy of the carrier's review of adverse benefit determinations grievance process for claim or service denial and its grievance process for dissatisfaction with care; and

(h) Accreditation status with one or more national managed care accreditation organizations, and whether the carrier tracks its health care effectiveness performance using the health employer data information set (HEDIS), whether it publicly reports its HEDIS data, and how interested persons can access its HEDIS data.

(3) Each carrier shall provide to all enrollees and prospective enrollees a list of available disclosure items.

(4) Nothing in this section requires a carrier or a health care provider to divulge proprietary information to an enrollee, including the specific contractual terms and conditions between a carrier and a provider.

(5) No carrier may advertise or market any health plan to the public as a plan that covers services that help prevent illness or promote the health of enrollees unless it:

(a) Provides all clinical preventive health services provided by the basic health plan, authorized by chapter 70.47 RCW;

(b) Monitors and reports annually to enrollees on standardized measures of health care and satisfaction of all enrollees in the health plan. The state department of health shall recommend appropriate standardized measures for this purpose, after consideration of national standardized measurement systems adopted by national managed care accreditation organizations and state agencies that purchase managed health care services; and

(c) Makes available upon request to enrollees its integrated plan to identify and manage the most prevalent diseases within its enrolled population, including cancer, heart disease, and stroke.

(6) No carrier may preclude or discourage its providers from informing an enrollee of the care he or she requires, including various treatment options, and whether in the providers' view such care is consistent with the plan's health coverage criteria, or otherwise covered by the enrollee's medical coverage agreement with the carrier. No carrier may prohibit, discourage, or penalize a provider otherwise practicing in compliance with the law from advocating on behalf of an enrollee with a carrier. Nothing in this section shall be construed to authorize a provider to bind a carrier to pay for any service.

(7) No carrier may preclude or discourage enrollees or those paying for their coverage from discussing the comparative merits of different carriers with their providers. This prohibition specifically includes prohibiting or limiting providers participating in those discussions even if critical of a carrier.

(8) Each carrier must communicate enrollee information required in chapter 5, Laws of 2000 by means that ensure that a substantial portion of the enrollee population can make use of the information. Carriers may implement alternative, efficient methods of communication to ensure enrollees have access to information including, but not limited to, website alerts, postcard mailings, and electronic communication in lieu of printed materials.

(9) The commissioner may adopt rules to implement this section. In developing rules to implement this section, the commissioner shall consider relevant standards adopted by national managed care

accreditation organizations and state agencies that purchase managed health care services, as well as opportunities to reduce administrative costs included in health plans. [2019 c 56 s 5; 2012 c 211 s 26; 2009 c 304 s 1; 2000 c 5 s 6.]

Findings—Declarations—Effective date—2019 c 56: See notes following RCW 48.43.5051.

Application—Short title—Captions not law—Construction—Severability—Application to contracts—Effective dates—2000 c 5: See notes following RCW 48.43.500.

RCW 48.43.515 Access to appropriate health services—Enrollee options—Rules. (1) Each enrollee in a health plan must have adequate choice among health care providers.

(2) Each carrier must allow an enrollee to choose a primary care provider who is accepting new enrollees from a list of participating providers. Enrollees 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 enrollee's request for the change.

(3) Each carrier must have a process whereby an enrollee with a complex or serious medical or psychiatric condition may receive a standing referral to a participating specialist for an extended period of time.

(4) Each carrier must provide for appropriate and timely referral of enrollees to a choice of specialists within the plan if specialty care is warranted. If the type of medical specialist needed for a specific condition is not represented on the specialty panel, enrollees must have access to nonparticipating specialty health care providers.

(5) Each carrier shall provide enrollees with direct access to the participating chiropractor of the enrollee's choice for covered chiropractic health care without the necessity of prior referral. Nothing in this subsection shall prevent carriers from restricting enrollees to seeing only providers 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.

(6) Each carrier must provide, upon the request of an enrollee, access by the enrollee to a second opinion regarding any medical diagnosis or treatment plan from a qualified participating provider of the enrollee's choice.

(7) 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 enrollees or, in group coverage arrangements involving periods of open enrollment, only until the end of the next open enrollment period. The provider's relationship with the carrier or subcontractor must be continued on the same terms and conditions as those of the contract the plan or subcontractor is terminating, except

for any provision requiring that the carrier assign new enrollees to the terminated provider.

(8) Every carrier shall meet the standards set forth in this section and any rules adopted by the commissioner to implement this section. In developing rules to implement this section, the commissioner shall consider relevant standards adopted by national managed care accreditation organizations and state agencies that purchase managed health care services. [2000 c 5 s 7.]

Application—Short title—Captions not law—Construction—Severability—Application to contracts—Effective dates—2000 c 5: See notes following RCW 48.43.500.

RCW 48.43.517 Enrollment of child participating in medical assistance program—Employer-sponsored health plan. When the health care authority has determined that it is cost-effective to enroll a child participating in a medical assistance program under chapter 74.09 RCW in an employer-sponsored health plan, the carrier shall permit the enrollment of the participant who is otherwise eligible for coverage in the health plan without regard to any open enrollment restrictions. The request for special enrollment shall be made by the authority or participant within sixty days of the authority's determination that the enrollment would be cost-effective. [2011 1st sp.s. c 15 s 78; 2007 c 5 s 7.]

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

RCW 48.43.520 Requirement to maintain a documented utilization review program description and written utilization review criteria—Rules. ***(Effective until January 1, 2027.)*** (1) Carriers that offer a health plan shall maintain a documented utilization review program description and written utilization review criteria based on reasonable medical evidence. The program must include a method for reviewing and updating criteria. Carriers shall make clinical protocols, medical management standards, and other review criteria available upon request to participating providers.

(2) The commissioner shall adopt, in rule, standards for this section after considering relevant standards adopted by national managed care accreditation organizations and state agencies that purchase managed health care services.

(3) A carrier shall not be required to use medical evidence or standards in its utilization review of religious nonmedical treatment or religious nonmedical nursing care. [2000 c 5 s 8.]

Application—Short title—Captions not law—Construction—Severability—Application to contracts—Effective dates—2000 c 5: See notes following RCW 48.43.500.

RCW 48.43.520 Requirement to maintain a documented utilization review program description and written utilization review and clinical review criteria—Rules. ***(Effective January 1, 2027.)*** (1) Carriers

that offer a health plan shall maintain a documented utilization review program description and written utilization review and clinical review criteria based on reasonable medical evidence. For mental health and substance use disorder services, as defined in RCW 48.43.766, clinical review criteria must meet the requirements of RCW 48.43.766. The program must include a method for reviewing and updating criteria. Carriers shall make clinical protocols, medical management standards, clinical review criteria as defined in RCW 48.43.766, and other review criteria available upon request to participating providers.

(2) The commissioner shall adopt, in rule, standards for this section after considering relevant standards adopted by national managed care accreditation organizations and state agencies that purchase managed health care services.

(3) A carrier shall not be required to use medical evidence or standards in its utilization review of religious nonmedical treatment or religious nonmedical nursing care. [2025 c 227 s 5; 2000 c 5 s 8.]

Effective date—2025 c 227 ss 1-8: See note following RCW 48.43.766.

Findings—Intent—Rules—2025 c 227: See notes following RCW 48.43.766.

Application—Short title—Captions not law—Construction—Severability—Application to contracts—Effective dates—2000 c 5: See notes following RCW 48.43.500.

RCW 48.43.525 Prohibition against retrospective denial of health plan coverage—Rules. (1) A health carrier that offers a health plan shall not retrospectively deny coverage or retrospectively modify to a service less intensive than that included in an approved request for emergency and nonemergency care that had prior authorization, including for medical necessity, under the plan's written policies at the time the care was rendered, unless:

(a) The approved prior authorization was based upon a material misrepresentation by the provider, facility, or covered person; or

(b) The underlying health plan coverage is lawfully rescinded, canceled, or terminated retrospectively through the date of service.

(2) Retrospective denials of services with an approved prior authorization or retrospective modification of an approved prior authorization to less intensive services due to a change in the carrier's determination of medical necessity are prohibited, shall not be considered adverse benefit determinations, and will not be required to follow the standard appeals processes in RCW 48.43.530 or any carrier policies related to their own grievance and appeals process. If an enrollee, or the provider requesting the authorization demonstrates the authorization was valid per the plan's written policies, then the carrier will deem the authorization approved and payable. Interest will be assessed on the associated claim submitted by the provider at the rate of one percent per month, retroactive to the date of submission. An enrollee, or provider on behalf of the enrollee, may seek review by an independent review organization under RCW 48.43.535 without the need to engage in, exhaust, or wait for any timelines related to the carrier's grievance process.

(3) This section does not prevent carriers from reimbursing only for services billed and rendered.

(4) The commissioner shall adopt, in rule, standards for this section after considering relevant standards adopted by national managed care accreditation organizations and state agencies that purchase managed health care services. [2026 c 157 s 5; 2000 c 5 s 9.]

Finding—Intent—2026 c 157: See note following RCW 48.43.830.

Application—Short title—Captions not law—Construction—Severability—Application to contracts—Effective dates—2000 c 5: See notes following RCW 48.43.500.

RCW 48.43.530 Requirement for carriers to have comprehensive grievance and appeal processes—Carrier's duties—Procedures—Appeals—Rules. (1) Each carrier and health plan must have fully operational, comprehensive grievance and appeal processes, and for plans that are not grandfathered, fully operational, comprehensive, and effective grievance and review of adverse benefit determination processes that comply with the requirements of this section and any rules adopted by the commissioner to implement this section. For the purposes of this section, the commissioner must consider applicable grievance and appeal or review of adverse benefit determination process standards adopted by national managed care accreditation organizations and state agencies that purchase managed health care services, and for health plans that are not grandfathered health plans as approved by the United States department of health and human services or the United States department of labor. In the case of coverage offered in connection with a group health plan, if either the carrier or the health plan complies with the requirements of this section and RCW 48.43.535, then the obligation to comply is satisfied for both the carrier and the plan with respect to the health insurance coverage.

(2) Each carrier and health plan must process as a grievance an enrollee's expression of dissatisfaction about customer service or the quality or availability of a health service. Each carrier must implement procedures for registering and responding to oral and written grievances in a timely and thorough manner.

(3) Each carrier and health plan must provide written notice to an enrollee or the enrollee's designated representative, and the enrollee's provider, of its decision to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits, including the admission to or continued stay in a health care facility. Such notice must be sent directly to a protected individual receiving care when accessing sensitive health care services or when a protected individual has requested confidential communication pursuant to RCW 48.43.505(5).

(4) An enrollee's written or oral request that a carrier reconsider its decision to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits, including the admission to, or continued stay in, a health care facility must be processed as follows:

(a) When the request is made under a grandfathered health plan, the plan and the carrier must process it as an appeal;

(b) When the request is made under a health plan that is not grandfathered, the plan and the carrier must process it as a review of an adverse benefit determination; and

(c) Neither a carrier nor a health plan, whether grandfathered or not, may require that an enrollee file a complaint or grievance prior to seeking appeal of a decision or review of an adverse benefit determination under this subsection.

(5) To process an appeal, each plan that is not grandfathered and each carrier offering that plan must:

(a) Provide written notice to the enrollee when the appeal is received;

(b) Assist the enrollee with the appeal process;

(c) Make its decision regarding the appeal within thirty days of the date the appeal is received. An appeal must be expedited if the enrollee's provider or the carrier's medical director reasonably determines that following the appeal process response timelines could seriously jeopardize the enrollee's life, health, or ability to regain maximum function. The decision regarding an expedited appeal must be made within seventy-two hours of the date the appeal is received;

(d) Cooperate with a representative authorized in writing by the enrollee;

(e) Consider information submitted by the enrollee;

(f) Investigate and resolve the appeal; and

(g) Provide written notice of its resolution of the appeal to the enrollee and, with the permission of the enrollee, to the enrollee's providers. The written notice must explain the carrier's and health plan's decision and the supporting coverage or clinical reasons and the enrollee's right to request independent review of the carrier's decision under RCW 48.43.535.

(6) Written notice required by subsection (3) of this section must explain:

(a) The carrier's and health plan's decision and the supporting coverage or clinical reasons; and

(b) The carrier's and grandfathered plan's appeal or for plans that are not grandfathered, adverse benefit determination review process, including information, as appropriate, about how to exercise the enrollee's rights to obtain a second opinion, and how to continue receiving services as provided in this section.

(7) When an enrollee requests that the carrier or health plan reconsider its decision to modify, reduce, or terminate an otherwise covered health service that an enrollee is receiving through the health plan and the carrier's or health plan's decision is based upon a finding that the health service, or level of health service, is no longer medically necessary or appropriate, the carrier and health plan must continue to provide that health service until the appeal, or for health plans that are not grandfathered, the review of an adverse benefit determination, is resolved. If the resolution of the appeal, review of an adverse benefit determination, or any review sought by the enrollee under RCW 48.43.535 affirms the carrier's or health plan's decision, the enrollee may be responsible for the cost of this continued health service.

(8) Each carrier and health plan must provide a clear explanation of the grievance and appeal, or for plans that are not grandfathered, the process for review of an adverse benefit determination process upon request, upon enrollment to new enrollees, and annually to enrollees and subcontractors.

(9) Each carrier and health plan must ensure that each grievance, appeal, and for plans that are not grandfathered, grievance and review of adverse benefit determinations, 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 a grievance, appeal or review of an adverse benefit determination.

(10)(a) Each plan that is not grandfathered and the carrier that offers it must: Track each appeal until final resolution; maintain, and make accessible to the commissioner for a period of three years, a log of all appeals; and identify and evaluate trends in appeals.

(b) Each grandfathered plan and the carrier that offers it must: Track each review of an adverse benefit determination until final resolution; maintain and make accessible to the commissioner, for a period of six years, a log of all such determinations; and identify and evaluate trends in requests for and resolution of review of adverse benefit determinations.

(11) In complying with this section, plans that are not grandfathered and the carriers offering them must treat a rescission of coverage, whether or not the rescission has an adverse effect on any particular benefit at that time, and any decision to deny coverage in an initial eligibility determination as an adverse benefit determination. [2019 c 56 s 6; 2012 c 211 s 20; 2011 c 314 s 4; 2000 c 5 s 10.]

Findings—Declarations—Effective date—2019 c 56: See notes following RCW 48.43.5051.

Application—Short title—Captions not law—Construction—Severability—Application to contracts—Effective dates—2000 c 5: See notes following RCW 48.43.500.

RCW 48.43.535 Independent review of health care disputes—System for using certified independent review organizations—Rules. ***(Effective until January 1, 2027.)*** (1) There is a need for a process for the fair consideration of disputes relating to decisions by carriers that offer a health plan to deny, modify, reduce, or terminate coverage of or payment for health care services for an enrollee. For purposes of this section, "carrier" also applies to a health plan if the health plan administers the appeal process directly or through a third party.

(2) An enrollee may seek review by a certified independent review organization of a carrier's decision to deny, modify, reduce, or terminate coverage of or payment for a health care service or of any adverse determination made by a carrier under RCW 48.49.020, 48.49.030, or sections 2799A-1 or 2799A-2 of the public health service act (42 U.S.C. Secs. 300gg-111 or 300gg-112) and implementing federal regulations in effect as of March 31, 2022, after exhausting the carrier's grievance process and receiving a decision that is unfavorable to the enrollee, or after the carrier has exceeded the timelines for grievances provided in RCW 48.43.530, without good cause and without reaching a decision. Any requirements that the enrollee must first engage in, exhaust, or wait for any timelines related to the carrier's grievance process do not apply to review sought pursuant to RCW 48.43.525.

(3) The commissioner must establish and use a rotational registry system for the assignment of a certified independent review organization to each dispute. The system should be flexible enough to ensure that an independent review organization has the expertise necessary to review the particular medical condition or service at issue in the dispute, and that any approved independent review organization does not have a conflict of interest that will influence its independence.

(4) Carriers must provide to the appropriate certified independent review organization, not later than the third business day after the date the carrier receives a request for review, a copy of:

(a) Any medical records of the enrollee that are relevant to the review;

(b) Any documents used by the carrier in making the determination to be reviewed by the certified independent review organization;

(c) Any documentation and written information submitted to the carrier in support of the appeal; and

(d) A list of each physician or health care provider who has provided care to the enrollee and who may have medical records relevant to the appeal. Health information or other confidential or proprietary information in the custody of a carrier may be provided to an independent review organization, subject to rules adopted by the commissioner.

(5) Enrollees must be provided with at least five business days to submit to the independent review organization in writing additional information that the independent review organization must consider when conducting the external review. The independent review organization must forward any additional information submitted by an enrollee to the plan or carrier within one business day of receipt by the independent review organization.

(6) The medical reviewers from a certified independent review organization will make determinations regarding the medical necessity or appropriateness of, and the application of health plan coverage provisions to, health care services for an enrollee. The medical reviewers' determinations must be based upon their expert medical judgment, after consideration of relevant medical, scientific, and cost-effectiveness evidence, and medical standards of practice in the state of Washington. Except as provided in this subsection, the certified independent review organization must ensure that determinations are consistent with the scope of covered benefits as outlined in the medical coverage agreement. Medical reviewers may override the health plan's medical necessity or appropriateness standards if the standards are determined upon review to be unreasonable or inconsistent with sound, evidence-based medical practice.

(7) Once a request for an independent review determination has been made, the independent review organization must proceed to a final determination, unless requested otherwise by both the carrier and the enrollee or the enrollee's representative.

(a) An enrollee or carrier may request an expedited external review if the adverse benefit determination or internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care service for which the claimant received emergency services but has not been discharged from a facility; or involves a medical condition for which the standard external review time frame would seriously jeopardize the life or health of the enrollee or jeopardize the enrollee's ability to regain maximum

function. The independent review organization must make its decision to uphold or reverse the adverse benefit determination or final internal adverse benefit determination and notify the enrollee and the carrier or health plan of the determination as expeditiously as possible but within not more than seventy-two hours after the receipt of the request for expedited external review. If the notice is not in writing, the independent review organization must provide written confirmation of the decision within forty-eight hours after the date of the notice of the decision.

(b) For claims involving experimental or investigational treatments, the independent review organization must ensure that adequate clinical and scientific experience and protocols are taken into account as part of the external review process.

(8) Carriers must timely implement the certified independent review organization's determination, and must pay the certified independent review organization's charges.

(9) When an enrollee requests independent review of a dispute under this section, and the dispute involves a carrier's decision to modify, reduce, or terminate an otherwise covered health service that an enrollee is receiving at the time the request for review is submitted and the carrier's decision is based upon a finding that the health service, or level of health service, is no longer medically necessary or appropriate, the carrier must continue to provide the health service if requested by the enrollee until a determination is made under this section. If the determination affirms the carrier's decision, the enrollee may be responsible for the cost of the continued health service.

(10) Each certified independent review organization must maintain written records and make them available upon request to the commissioner.

(11) A certified independent review organization may notify the office of the insurance commissioner if, based upon its review of disputes under this section, it finds a pattern of substandard or egregious conduct by a carrier.

(12)(a) The commissioner shall adopt rules to implement this section after considering relevant standards adopted by national managed care accreditation organizations and the national association of insurance commissioners.

(b) This section is not intended to supplant any existing authority of the office of the insurance commissioner under this title to oversee and enforce carrier compliance with applicable statutes and rules. [2026 c 157 s 6; 2022 c 263 s 4; 2012 c 211 s 21; 2011 c 314 s 5; 2000 c 5 s 11.]

Expiration date—2026 c 157 ss 2 and 6: See note following RCW 48.43.830.

Finding—Intent—2026 c 157: See note following RCW 48.43.830.

Effective date—2022 c 263: See note following RCW 43.371.100.

Application—Short title—Captions not law—Construction—Severability—Application to contracts—Effective dates—2000 c 5: See notes following RCW 48.43.500.

RCW 48.43.535 Independent review of health care disputes—System for using certified independent review organizations—Rules. ***(Effective January 1, 2027.)*** (1) There is a need for a process for the fair consideration of disputes relating to decisions by carriers that offer a health plan to deny, modify, reduce, or terminate coverage of or payment for health care services for an enrollee. For purposes of this section, "carrier" also applies to a health plan if the health plan administers the appeal process directly or through a third party.

(2) An enrollee may seek review by a certified independent review organization of a carrier's decision to deny, modify, reduce, or terminate coverage of or payment for a health care service or of any adverse determination made by a carrier under RCW 48.49.020, 48.49.030, or sections 2799A-1 or 2799A-2 of the public health service act (42 U.S.C. Secs. 300gg-111 or 300gg-112) and implementing federal regulations in effect as of March 31, 2022, after exhausting the carrier's grievance process and receiving a decision that is unfavorable to the enrollee, or after the carrier has exceeded the timelines for grievances provided in RCW 48.43.530, without good cause and without reaching a decision. Any requirements that the enrollee must first engage in, exhaust, or wait for any timelines related to the carrier's grievance process do not apply to review sought pursuant to RCW 48.43.525.

(3) The commissioner must establish and use a rotational registry system for the assignment of a certified independent review organization to each dispute. The system should be flexible enough to ensure that an independent review organization has the expertise necessary to review the particular medical condition or service at issue in the dispute, and that any approved independent review organization does not have a conflict of interest that will influence its independence.

(4) Carriers must provide to the appropriate certified independent review organization, not later than the third business day after the date the carrier receives a request for review, a copy of:

(a) Any medical records of the enrollee that are relevant to the review;

(b) Any documents used by the carrier in making the determination to be reviewed by the certified independent review organization;

(c) Any documentation and written information submitted to the carrier in support of the appeal; and

(d) A list of each physician or health care provider who has provided care to the enrollee and who may have medical records relevant to the appeal. Health information or other confidential or proprietary information in the custody of a carrier may be provided to an independent review organization, subject to rules adopted by the commissioner.

(5) Enrollees must be provided with at least five business days to submit to the independent review organization in writing additional information that the independent review organization must consider when conducting the external review. The independent review organization must forward any additional information submitted by an enrollee to the plan or carrier within one business day of receipt by the independent review organization.

(6) The medical reviewers from a certified independent review organization will make determinations regarding the medical necessity or appropriateness of, and the application of health plan coverage

provisions to, health care services for an enrollee. The medical reviewers' determinations must be based upon their expert medical judgment, after consideration of relevant medical, scientific, and cost-effectiveness evidence, and medical standards of practice in the state of Washington. Except as provided in this subsection, the certified independent review organization must ensure that determinations are consistent with the scope of covered benefits as outlined in the medical coverage agreement. Medical reviewers may override the health plan's medical necessity or appropriateness standards if the standards are determined upon review to be unreasonable or inconsistent with sound, evidence-based medical practice. For reviews of mental health and substance use disorder services, as defined in RCW 48.43.766, the medical reviewers must conduct reviews and make determinations in a manner consistent with the requirements of RCW 48.43.766.

(7) Once a request for an independent review determination has been made, the independent review organization must proceed to a final determination, unless requested otherwise by both the carrier and the enrollee or the enrollee's representative.

(a) An enrollee or carrier may request an expedited external review if the adverse benefit determination or internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care service for which the claimant received emergency services but has not been discharged from a facility; or involves a medical condition for which the standard external review time frame would seriously jeopardize the life or health of the enrollee or jeopardize the enrollee's ability to regain maximum function. The independent review organization must make its decision to uphold or reverse the adverse benefit determination or final internal adverse benefit determination and notify the enrollee and the carrier or health plan of the determination as expeditiously as possible but within not more than seventy-two hours after the receipt of the request for expedited external review. If the notice is not in writing, the independent review organization must provide written confirmation of the decision within forty-eight hours after the date of the notice of the decision.

(b) For claims involving experimental or investigational treatments, the independent review organization must ensure that adequate clinical and scientific experience and protocols are taken into account as part of the external review process.

(8) Carriers must timely implement the certified independent review organization's determination, and must pay the certified independent review organization's charges.

(9) When an enrollee requests independent review of a dispute under this section, and the dispute involves a carrier's decision to modify, reduce, or terminate an otherwise covered health service that an enrollee is receiving at the time the request for review is submitted and the carrier's decision is based upon a finding that the health service, or level of health service, is no longer medically necessary or appropriate, the carrier must continue to provide the health service if requested by the enrollee until a determination is made under this section. If the determination affirms the carrier's decision, the enrollee may be responsible for the cost of the continued health service.

(10) Each certified independent review organization must maintain written records and make them available upon request to the commissioner.

(11) A certified independent review organization may notify the office of the insurance commissioner if, based upon its review of disputes under this section, it finds a pattern of substandard or egregious conduct by a carrier.

(12)(a) The commissioner shall adopt rules to implement this section after considering relevant standards adopted by national managed care accreditation organizations and the national association of insurance commissioners.

(b) This section is not intended to supplant any existing authority of the office of the insurance commissioner under this title to oversee and enforce carrier compliance with applicable statutes and rules. [2026 c 157 s 7; 2025 c 227 s 6; 2022 c 263 s 4; 2012 c 211 s 21; 2011 c 314 s 5; 2000 c 5 s 11.]

Effective date—2026 c 157 ss 3 and 7: See note following RCW 48.43.830.

Finding—Intent—2026 c 157: See note following RCW 48.43.830.

Effective date—2025 c 227 ss 1-8: See note following RCW 48.43.766.

Findings—Intent—Rules—2025 c 227: See notes following RCW 48.43.766.

Effective date—2022 c 263: See note following RCW 43.371.100.

Application—Short title—Captions not law—Construction—Severability—Application to contracts—Effective dates—2000 c 5: See notes following RCW 48.43.500.

RCW 48.43.537 Health care disputes—Certifying independent review organizations—Application—Restrictions—Maximum fee schedule for conducting reviews—Rules. (1) No later than January 1, 2017, the insurance commissioner shall adopt rules providing a procedure and criteria for certifying one or more organizations to perform independent review of health care disputes described in RCW 48.43.535.

(2) The rules must require that the organization ensure:

(a) The confidentiality of medical records transmitted to an independent review organization for use in independent reviews;

(b) That each health care provider, physician, or contract specialist making review determinations for an independent review organization is qualified. Physicians, other health care providers, and, if applicable, contract specialists must be appropriately licensed, certified, or registered as required in Washington state or in at least one state with standards substantially comparable to Washington state. Reviewers may be drawn from nationally recognized centers of excellence, academic institutions, and recognized leading practice sites. Expert medical reviewers should have substantial, recent clinical experience dealing with the same or similar health conditions. The organization must have demonstrated expertise and a history of reviewing health care in terms of medical necessity, appropriateness, and the application of other health plan coverage provisions;

(c) That any physician, health care provider, or contract specialist making a review determination in a specific review is free of any actual or potential conflict of interest or bias. Neither the expert reviewer, nor the independent review organization, nor any officer, director, or management employee of the independent review organization may have any material professional, familial, or financial affiliation with any of the following: The health carrier; professional associations of carriers and providers; the provider; the provider's medical or practice group; the health facility at which the service would be provided; the developer or manufacturer of a drug or device under review; or the enrollee;

(d) The fairness of the procedures used by the independent review organization in making the determinations;

(e) That each independent review organization make its determination:

(i) Not later than the earlier of:

(A) The fifteenth day after the date the independent review organization receives the information necessary to make the determination; or

(B) The twentieth day after the date the independent review organization receives the request that the determination be made. In exceptional circumstances, when the independent review organization has not obtained information necessary to make a determination, a determination may be made by the twenty-fifth day after the date the organization received the request for the determination; and

(ii) In requests for expedited review under RCW 48.43.535(7)(a), as expeditiously as possible but within not more than seventy-two hours after the date the independent review organization receives the request for expedited review;

(f) That timely notice is provided to enrollees of the results of the independent review, including the clinical basis for the determination;

(g) That the independent review organization has a quality assurance mechanism in place that ensures the timeliness and quality of review and communication of determinations to enrollees and carriers, and the qualifications, impartiality, and freedom from conflict of interest of the organization, its staff, and expert reviewers; and

(h) That the independent review organization meets any other reasonable requirements of the insurance commissioner directly related to the functions the organization is to perform under this section and RCW 48.43.535, and related to assessing fees to carriers in a manner consistent with the maximum fee schedule developed under this section.

(3) To be certified as an independent review organization under this chapter, an organization must submit to the insurance commissioner an application in the form required by the insurance commissioner. The application must include:

(a) For an applicant that is publicly held, the name of each stockholder or owner of more than five percent of any stock or options;

(b) The name of any holder of bonds or notes of the applicant that exceed one hundred thousand dollars;

(c) The name and type of business of each corporation or other organization that the applicant controls or is affiliated with and the nature and extent of the affiliation or control;

(d) The name and a biographical sketch of each director, officer, and executive of the applicant and any entity listed under (c) of this

subsection and a description of any relationship the named individual has with:

(i) A carrier;

(ii) A utilization review agent;

(iii) A nonprofit or for-profit health corporation;

(iv) A health care provider;

(v) A drug or device manufacturer; or

(vi) A group representing any of the entities described by (d)(i) through (v) of this subsection;

(e) The percentage of the applicant's revenues that are anticipated to be derived from reviews conducted under RCW 48.43.535;

(f) A description of the areas of expertise of the health care professionals and contract specialists making review determinations for the applicant; and

(g) The procedures to be used by the independent review organization in making review determinations regarding reviews conducted under RCW 48.43.535.

(4) If at any time there is a material change in the information included in the application under subsection (3) of this section, the independent review organization shall submit updated information to the insurance commissioner.

(5) An independent review organization may not be a subsidiary of, or in any way owned or controlled by, a carrier or a trade or professional association of health care providers or carriers.

(6) An independent review organization, and individuals acting on its behalf, are immune from suit in a civil action when performing functions under chapter 5, Laws of 2000. However, this immunity does not apply to an act or omission made in bad faith or that involves gross negligence.

(7) Independent review organizations must be free from interference by state government in its functioning except as provided in subsection (8) of this section.

(8) The rules adopted under this section shall include provisions for terminating the certification of an independent review organization for failure to comply with the requirements for certification. The insurance commissioner may review the operation and performance of an independent review organization in response to complaints or other concerns about compliance. The rules adopted under this section must include a reasonable maximum fee schedule that independent review organizations shall use to assess carriers for conducting reviews authorized under RCW 48.43.535.

(9) In adopting rules for this section, the insurance commissioner shall take into consideration rules adopted by the department of health that regulate independent review organizations and standards for independent review organizations adopted by national accreditation organizations. The insurance commissioner may accept national accreditation or certification by another state as evidence that an organization satisfies some or all of the requirements for certification by the insurance commissioner as an independent review organization.

(10) The rules adopted under this section must require independent review organizations to report decisions and associated information directly to the insurance commissioner. [2016 c 139 s 1; 2012 c 211 s 14; 2005 c 54 s 1; 2000 c 5 s 12. Formerly RCW 43.70.235.]

Savings clause—Automatic certification—2016 c 139: "(1) Independent review organizations remain subject to RCW 48.43.537, as it existed on January 1, 2016, and the rules adopted by the department of health under that section through December 31, 2016. Beginning on January 1, 2017, the insurance commissioner is the sole certifying authority for independent review organizations under RCW 48.43.537.

(2) On January 1, 2017, the insurance commissioner shall automatically certify each independent review organization that was certified in good standing by the department of health on December 31, 2016." [2016 c 139 s 2.]

Intent—Purpose—2000 c 5: See RCW 48.43.500.

Application—Short title—Captions not law—Construction—Severability—Application to contracts—Effective dates—2000 c 5: See notes following RCW 48.43.500.

RCW 48.43.540 Requirement to designate a licensed medical director—Exemption. Any carrier that offers a health plan and any self-insured health plan subject to the jurisdiction of Washington state shall designate a medical director who is licensed under chapter 18.57 or 18.71 RCW. However, a naturopathic or complementary alternative health plan, which provides solely complementary alternative health care to individuals, groups, or health plans, may have a medical director licensed under chapter 18.36A RCW. A carrier that offers dental only coverage shall designate a dental director who is licensed under chapter 18.32 RCW, or licensed in a state that has been determined by the dental quality assurance commission to have substantially equivalent licensing standards to those of Washington. A health plan or self-insured health plan that offers only religious nonmedical treatment or religious nonmedical nursing care shall not be required to have a medical director. [2002 c 103 s 1; 2000 c 5 s 13.]

Application—Short title—Captions not law—Construction—Severability—Application to contracts—Effective dates—2000 c 5: See notes following RCW 48.43.500.

RCW 48.43.545 Standard of care—Liability—Causes of action—Defense—Exception. (1)(a) A health carrier shall adhere to the accepted standard of care for health care providers under chapter 7.70 RCW when arranging for the provision of medically necessary health care services to its enrollees. A health carrier shall be liable for any and all harm proximately caused by its failure to follow that standard of care when the failure resulted in the denial, delay, or modification of the health care service recommended for, or furnished to, an enrollee.

(b) A health carrier is also liable for damages under (a) of this subsection for harm to an enrollee proximately caused by health care treatment decisions that result from a failure to follow the accepted standard of care made by its:

(i) Employees;

(ii) Agents; or

(iii) Ostensible agents who are acting on its behalf and over whom it has the right to exercise influence or control or has actually exercised influence or control.

(2) The provisions of this section may not be waived, shifted, or modified by contract or agreement and responsibility for the provisions shall be a duty that cannot be delegated. Any effort to waive, modify, delegate, or shift liability for a breach of the duty established by this section, through a contract for indemnification or otherwise, is invalid.

(3) This section does not create any new cause of action, or eliminate any presently existing cause of action, with respect to health care providers and health care facilities that are included in and subject to the provisions of chapter 7.70 RCW.

(4) It is a defense to any action or liability asserted under this section against a health carrier that:

(a) The health care service in question is not a benefit provided under the plan or the service is subject to limitations under the plan that have been exhausted;

(b) Neither the health carrier, nor any employee, agent, or ostensible agent for whose conduct the health carrier is liable under subsection (1)(b) of this section, controlled, influenced, or participated in the health care decision; or

(c) The health carrier did not deny or unreasonably delay payment for treatment prescribed or recommended by a participating health care provider for the enrollee.

(5) This section does not create any liability on the part of an employer, an employer group purchasing organization that purchases coverage or assumes risk on behalf of its employers, or a governmental agency that purchases coverage on behalf of individuals and families. The governmental entity established to offer and provide health insurance to public employees, public retirees, and their covered dependents under RCW 41.05.140 is subject to liability under this section.

(6) Nothing in any law of this state prohibiting a health carrier from practicing medicine or being licensed to practice medicine may be asserted as a defense by the health carrier in an action brought against it under this section.

(7)(a) A person may not maintain a cause of action under this section against a health carrier unless:

(i) The affected enrollee has suffered substantial harm. As used in this subsection, "substantial harm" means loss of life, loss or significant impairment of limb, bodily or cognitive function, significant disfigurement, or severe or chronic physical pain; and

(ii) The affected enrollee or the enrollee's representative has exercised the opportunity established in RCW 48.43.535 to seek independent review of the health care treatment decision.

(b) This subsection (7) does not prohibit an enrollee from pursuing other appropriate remedies, including injunctive relief, a declaratory judgment, or other relief available under law, if its requirements place the enrollee's health in serious jeopardy.

(8) In an action against a health carrier, a finding that a health care provider is an employee, agent, or ostensible agent of such a health carrier shall not be based solely on proof that the person's name appears in a listing of approved physicians or health care providers made available to enrollees under a health plan.

(9) Any action under this section shall be commenced within three years of the completion of the independent review process.

(10) This section does not apply to workers' compensation insurance under Title 51 RCW. [2000 c 5 s 17.]

Application—Short title—Captions not law—Construction—Severability—Application to contracts—Effective dates—2000 c 5: See notes following RCW 48.43.500.

RCW 48.43.550 Delegation of duties—Carrier accountability. Each carrier is accountable for and must oversee any activities required by chapter 5, Laws of 2000 that it delegates to any subcontractor. No contract with a subcontractor executed by the health carrier or the subcontractor may relieve the health carrier of its obligations to any enrollee for the provision of health care services or of its responsibility for compliance with statutes or rules. [2000 c 5 s 18.]

Application—Short title—Captions not law—Construction—Severability—Application to contracts—Effective dates—2000 c 5: See notes following RCW 48.43.500.

MISCELLANEOUS

RCW 48.43.600 Overpayment recovery—Carrier. ***(Effective until January 1, 2027.)*** (1) Except in the case of fraud, or as provided in subsections (2) and (3) of this section, a carrier may not: (a) Request a refund from a health care provider of a payment previously made to satisfy a claim unless it does so in writing to the provider within twenty-four months after the date that the payment was made; or (b) request that a contested refund be paid any sooner than six months after receipt of the request. Any such request must specify why the carrier believes the provider owes the refund. If a provider fails to contest the request in writing to the carrier within thirty days of its receipt, the request is deemed accepted and the refund must be paid.

(2) A carrier may not, if doing so for reasons related to coordination of benefits with another carrier or entity responsible for payment of a claim: (a) Request a refund from a health care provider of a payment previously made to satisfy a claim unless it does so in writing to the provider within thirty months after the date that the payment was made; or (b) request that a contested refund be paid any sooner than six months after receipt of the request. Any such request must specify why the carrier believes the provider owes the refund, and include the name and mailing address of the entity that has primary responsibility for payment of the claim. If a provider fails to contest the request in writing to the carrier within thirty days of its receipt, the request is deemed accepted and the refund must be paid.

(3) A carrier may at any time request a refund from a health care provider of a payment previously made to satisfy a claim if: (a) A third party, including a government entity, is found responsible for satisfaction of the claim as a consequence of liability imposed by law, such as tort liability; and (b) the carrier is unable to recover directly from the third party because the third party has either

already paid or will pay the provider for the health services covered by the claim.

(4) If a contract between a carrier and a health care provider conflicts with this section, this section shall prevail. However, nothing in this section prohibits a health care provider from choosing at any time to refund to a carrier any payment previously made to satisfy a claim.

(5) For purposes of this section, "refund" means the return, either directly or through an offset to a future claim, of some or all of a payment already received by a health care provider.

(6) This section neither permits nor precludes a carrier from recovering from a subscriber, enrollee, or beneficiary any amounts paid to a health care provider for benefits to which the subscriber, enrollee, or beneficiary was not entitled under the terms and conditions of the health plan, insurance policy, or other benefit agreement.

(7) This section does not apply to claims for health care services provided through dental only health carriers, health care services provided under Title XVIII (medicare) of the social security act, or medicare supplemental plans regulated under chapter 48.66 RCW. [2005 c 278 s 1.]

Application—2005 c 278: "This act applies to contracts issued or renewed on or after January 1, 2006." [2005 c 278 s 3.]

RCW 48.43.600 Overpayment recovery—Carrier. ***(Effective January 1, 2027, until January 1, 2028.)*** (1) Except in the case of fraud, or as provided in subsections (2) and (3) of this section, a carrier may not: (a) Request a refund from a health care provider of a payment previously made to satisfy a claim unless it does so in writing to the provider within twenty-four months after the date that the payment was made or, in the case of mental health and substance use disorder services as defined in RCW 48.43.766, within six months after the date the payment was made; or (b) request that a contested refund be paid any sooner than six months after receipt of the request. Any such request must specify why the carrier believes the provider owes the refund. If a provider fails to contest the request in writing to the carrier within thirty days of its receipt, the request is deemed accepted and the refund must be paid.

(2) A carrier may not, if doing so for reasons related to coordination of benefits with another carrier or entity responsible for payment of a claim: (a) Request a refund from a health care provider of a payment previously made to satisfy a claim unless it does so in writing to the provider within thirty months after the date that the payment was made or, in the case of mental health and substance use disorder services as defined in RCW 48.43.766, within nine months after the date the payment was made; or (b) request that a contested refund be paid any sooner than six months after receipt of the request. Any such request must specify why the carrier believes the provider owes the refund, and include the name and mailing address of the entity that has primary responsibility for payment of the claim. If a provider fails to contest the request in writing to the carrier within thirty days of its receipt, the request is deemed accepted and the refund must be paid.

(3) A carrier may at any time request a refund from a health care provider of a payment previously made to satisfy a claim if: (a) A third party, including a government entity, is found responsible for satisfaction of the claim as a consequence of liability imposed by law, such as tort liability; and (b) the carrier is unable to recover directly from the third party because the third party has either already paid or will pay the provider for the health services covered by the claim.

(4) If a contract between a carrier and a health care provider conflicts with this section, this section shall prevail. However, nothing in this section prohibits a health care provider from choosing at any time to refund to a carrier any payment previously made to satisfy a claim.

(5) For purposes of this section, "refund" means the return, either directly or through an offset to a future claim, of some or all of a payment already received by a health care provider.

(6) This section neither permits nor precludes a carrier from recovering from a subscriber, enrollee, or beneficiary any amounts paid to a health care provider for benefits to which the subscriber, enrollee, or beneficiary was not entitled under the terms and conditions of the health plan, insurance policy, or other benefit agreement.

(7) This section does not apply to claims for health care services provided through dental only health carriers, health care services provided under Title XVIII (medicare) of the social security act, or medicare supplemental plans regulated under chapter 48.66 RCW. [2025 c 227 s 7; 2005 c 278 s 1.]

Effective date—2025 c 227 ss 1-8: See note following RCW 48.43.766.

Findings—Intent—Rules—2025 c 227: See notes following RCW 48.43.766.

Application—2005 c 278: "This act applies to contracts issued or renewed on or after January 1, 2006." [2005 c 278 s 3.]

RCW 48.43.600 Overpayment recovery—Carrier. *(Effective January 1, 2028.)* (1) Except in the case of fraud, or as provided in subsections (2) and (3) of this section, a carrier may not: (a) Request a refund from a health care provider of a payment previously made to satisfy a claim unless it does so in writing to the provider within 12 months after the date that the original payment was made or, in the case of mental health and substance use disorder services as defined in RCW 48.43.766, within six months after the date the original payment was made; or (b) request that a contested refund be paid any sooner than six months after receipt of the request. Any such request must specify why the carrier believes the provider owes the refund. If a provider fails to contest the request in writing to the carrier within thirty days of its receipt, the request is deemed accepted and the refund must be paid.

(2) A carrier may not, if doing so for reasons related to coordination of benefits with another carrier or entity responsible for payment of a claim: (a) Request a refund from a health care provider of a payment previously made to satisfy a claim unless it

does so in writing to the provider within 18 months after the date that the original payment was made or, in the case of mental health and substance use disorder services as defined in RCW 48.43.766, within nine months after the date the original payment was made; or (b) request that a contested refund be paid any sooner than six months after receipt of the request. Any such request must specify why the carrier believes the provider owes the refund, and include the name and mailing address of the entity that has primary responsibility for payment of the claim. If a provider fails to contest the request in writing to the carrier within thirty days of its receipt, the request is deemed accepted and the refund must be paid.

(3) A carrier may at any time request a refund from a health care provider of a payment previously made to satisfy a claim if: (a) A third party, including a government entity, is found responsible for satisfaction of the claim as a consequence of liability imposed by law, such as tort liability; and (b) the carrier is unable to recover directly from the third party because the third party has either already paid or will pay the provider for the health services covered by the claim.

(4) If a contract between a carrier and a health care provider conflicts with this section, this section prevails. However, nothing in this section prohibits a health care provider from choosing at any time to refund to a carrier any payment previously made to satisfy a claim.

(5) For purposes of this section, "refund" means the return, either directly or through an offset to a future claim, of some or all of a payment already received by a health care provider.

(6) This section neither permits nor precludes a carrier from recovering from a subscriber, enrollee, or beneficiary any amounts paid to a health care provider for benefits to which the subscriber, enrollee, or beneficiary was not entitled under the terms and conditions of the health plan, insurance policy, or other benefit agreement.

(7) This section does not apply to claims for health care services provided through dental only health carriers, health care services provided under Title XVIII (medicare) of the social security act, or medicare supplemental plans regulated under chapter 48.66 RCW. [2026 c 158 s 4; 2025 c 227 s 7; 2005 c 278 s 1.]

Effective date—2026 c 158 s 4: "Section 4 of this act takes effect January 1, 2028." [2026 c 158 s 5.]

Finding—Intent—2026 c 158: See note following RCW 48.43.013.

Effective date—2025 c 227 ss 1-8: See note following RCW 48.43.766.

Findings—Intent—Rules—2025 c 227: See notes following RCW 48.43.766.

Application—2005 c 278: "This act applies to contracts issued or renewed on or after January 1, 2006." [2005 c 278 s 3.]

RCW 48.43.605 Overpayment recovery—Health care provider. (1) Except in the case of fraud, or as provided in subsection (2) of this

section, a health care provider may not: (a) Request additional payment from a carrier to satisfy a claim unless he or she does so in writing to the carrier within twenty-four months after the date that the claim was denied or payment intended to satisfy the claim was made; or (b) request that the additional payment be made any sooner than six months after receipt of the request. Any such request must specify why the provider believes the carrier owes the additional payment.

(2) A health care provider may not, if doing so for reasons related to coordination of benefits with another carrier or entity responsible for payment of a claim: (a) Request additional payment from a carrier to satisfy a claim unless he or she does so in writing to the carrier within thirty months after the date the claim was denied or payment intended to satisfy the claim was made; or (b) request that the additional payment be made any sooner than six months after receipt of the request. Any such request must specify why the provider believes the carrier owes the additional payment, and include the name and mailing address of any entity that has disclaimed responsibility for payment of the claim.

(3) If a contract between a carrier and a health care provider conflicts with this section, this section shall prevail. However, nothing in this section prohibits a carrier from choosing at any time to make additional payments to a provider to satisfy a claim.

(4) This section does not apply to claims for health care services provided through dental only health carriers, health care services provided under Title XVIII (medicare) of the social security act, or medicare supplemental plans regulated under chapter 48.66 RCW. [2005 c 278 s 2.]

Application—2005 c 278: See note following RCW 48.43.600.

RCW 48.43.670 Plan or contract renewal—Modification of wellness program. Upon the renewal date of an individual or group health benefit plan or contract containing health benefits, the modification of a wellness program, as defined in 45 C.F.R. 146.121(f), included in such a plan or contract shall not be considered a cancellation or nonrenewal of such plan or contract. [2009 c 329 s 3.]

RCW 48.43.680 Lifetime limit on transplants—Definition. (1) A health benefit plan that is issued or renewed on or after January 1, 2010, and that provides coverage for organ and tissue transplants, may not permit a separate lifetime limit on transplants of any less than three hundred fifty thousand dollars. The lifetime limit on transplants shall apply from one day prior to the date of the transplant or the date of hospital admission, for a patient who receives a transplant during the course of a longer hospital stay, through one hundred days after the transplant. Donor-related services may apply to the lifetime limit on transplants any time. The major medical lifetime limit shall apply to health care services provided before and after this time period. Benefits provided are subject to all other terms and conditions of the health benefit plan, including but not limited to any applicable coinsurances, deductibles, and copayments.

(2) "Organ and tissue transplant" means the same as defined under the applicable health benefit plan. [2009 c 487 s 1.]

RCW 48.43.690 Assessments under RCW 70.290.040 considered medical expenses. Assessments paid by carriers under RCW 70.290.040 may be considered medical expenses for purposes of rate setting and regulatory filings. [2010 c 174 s 15.]

Effective date—2010 c 174: See RCW 70.290.900.

RCW 48.43.700 Exchange—Plans that a carrier must offer—Review—Rules. (1) For plan or policy years beginning January 1, 2014, a carrier offering a health benefit plan that meets the definition of bronze level in section 1302 of P.L. 111-148 of 2010, as amended, in the individual market outside of the exchange must also offer plans that meet the definition of silver and gold level plans in section 1302 of P.L. 111-148 of 2010, as amended, in the individual market outside of the exchange.

(2) For plan or policy years beginning January 1, 2014, a carrier offering a health benefit plan that meets the definition of bronze level in section 1302 of P.L. 111-148 of 2010, as amended, in the small group market outside of the exchange must also offer plans that meet the definition of silver and gold level plans in section 1302 of P.L. 111-148 of 2010, as amended, in the small group market outside of the exchange.

(3) A health benefit plan meeting the definition of a catastrophic plan in *RCW 48.43.005(8)(c)(i) may only be sold through the exchange.

(4) By December 1, 2016, the exchange board, in consultation with the commissioner, must complete a review of the impact of this section on the health and viability of the markets inside and outside the exchange and submit the recommendations to the legislature on whether to maintain the market rules or let them expire.

(5) The commissioner shall evaluate plans offered at each actuarial value defined in section 1302 of P.L. 111-148 of 2010, as amended, and determine whether variation in prescription drug benefit cost-sharing, both inside and outside the exchange in both the individual and small group markets results in adverse selection. If so, the commissioner may adopt rules to assure substantial equivalence of prescription drug cost-sharing. [2014 c 31 s 1; 2012 c 87 s 6.]

***Reviser's note:** RCW 48.43.005 was alphabetized pursuant to RCW 1.08.015(2)(k), changing subsection (8) to subsection (10). RCW 48.43.005 was alphabetized pursuant to RCW 1.08.015(2)(k), changing subsection (10) to subsection (12).

Spiritual care services—2012 c 87: See RCW 43.71.901.

RCW 48.43.705 Plans offered outside of exchange. All nongrandfathered individual and small group health plans, other than catastrophic health plans, offered outside of the exchange must conform with the actuarial value tiers specified in section 1302 of P.L. 111-148 of 2010, as amended, as bronze, silver, gold, or platinum. [2014 c 31 s 2; 2012 c 87 s 7.]

Spiritual care services—2012 c 87: See RCW 43.71.901.

RCW 48.43.710 Certification as qualified health plan not an exemption. Certification by the Washington health benefit exchange of a plan as a qualified health plan, or of a carrier as a qualified issuer, does not exempt the plan or carrier from any of the requirements of this title or rules adopted by the commissioner pursuant to chapter 34.05 RCW to implement this title. [2012 c 87 s 12.]

Spiritual care services—2012 c 87: See RCW 43.71.901.

RCW 48.43.715 Individual and small group market—Selection of benchmark plan—Minimum requirements—Criteria—List of state-mandated health benefits. (1) Until the effective date of an updated essential health benefits benchmark plan submitted under section 1, chapter 87, Laws of 2023, the commissioner, in consultation with the board and the health care authority, shall, by rule, select the largest small group plan in the state by enrollment as the benchmark plan for the individual and small group market for purposes of establishing the essential health benefits in Washington state.

(2) If the essential health benefits benchmark plan for the individual and small group market does not include all of the 10 essential health benefits categories, the commissioner, in consultation with the board and the health care authority, shall, by rule, supplement the benchmark plan benefits as needed.

(3) All individual and small group health plans must cover the 10 essential health benefits categories, other than a health plan offered through the federal basic health program, a grandfathered health plan, or medicaid. Such a health plan may not be offered in the state unless the commissioner finds that it is substantially equal to the benchmark plan. When making this determination, the commissioner:

(a) Must ensure that the plan covers the 10 essential health benefits categories;

(b) May consider whether the health plan has a benefit design that would create a risk of biased selection based on health status and whether the health plan contains meaningful scope and level of benefits in each of the ten essential health benefits categories;

(c) Notwithstanding (a) and (b) of this subsection, for benefit years beginning January 1, 2015, must establish by rule the review and approval requirements and procedures for pediatric oral services when offered in stand-alone dental plans in the nongrandfathered individual and small group markets outside of the exchange; and

(d) Must allow health carriers to also offer pediatric oral services within the health benefit plan in the nongrandfathered individual and small group markets outside of the exchange.

(4) Beginning December 15, 2012, and every year thereafter, the commissioner shall submit to the legislature a list of state-mandated health benefits, the enforcement of which will result in federally imposed costs to the state related to the plans sold through the exchange because the benefits are not included in the essential health benefits designated under federal law. The list must include the anticipated costs to the state of each state-mandated health benefit on the list and any statutory changes needed if funds are not

appropriated to defray the state costs for the listed mandate. The commissioner may enforce a mandate on the list for the entire market only if funds are appropriated in an omnibus appropriations act specifically to pay the state portion of the identified costs.

(5) The commissioner shall include coverage for donor human milk as provided in RCW 48.43.815 and hearing instruments and associated services as described in RCW 48.43.135, in any update of the state's essential health benefits benchmark plan submitted to the centers for medicare and medicaid services under section 1, chapter 87, Laws of 2023. [2023 c 87 s 2; 2022 c 236 s 2; 2019 c 33 s 9; 2013 c 325 s 1; 2012 c 87 s 13.]

Effective date—2023 c 87: "This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately [April 13, 2023]." [2023 c 87 s 3.]

Effective date—2019 c 33: See note following RCW 48.43.005.

Spiritual care services—2012 c 87: See RCW 43.71.901.

RCW 48.43.720 Reinsurance and risk adjustment programs—Affordable care act—Rules. (1)(a) The commissioner, in consultation with the board, shall adopt rules establishing the reinsurance and risk adjustment programs required by P.L. 111-148 of 2010, as amended.

(b) The commissioner must include in deliberations related to reinsurance rule making an analysis of an invisible high risk pool option, in which the full premium and risk associated with certain high-risk or high-cost enrollees would be ceded to the transitional reinsurance program. The analysis must include a determination as to whether that option is authorized under the federal reinsurance program regulations, whether the option would provide sufficiently comprehensive coverage for current nonmedicare high risk pool enrollees, and how an invisible high risk pool option could be designed to ensure that carriers ceding risk provide effective care management to high-risk or high-cost enrollees.

(2) Consistent with federal law, the rules for the reinsurance program must, at a minimum, establish:

(a) A mechanism to collect reinsurance contribution funds;

(b) A reinsurance payment formula; and

(c) A mechanism to disburse reinsurance payments.

(3)(a) The commissioner may adjust the rules adopted under this section as needed to preserve a healthy market both inside and outside of the exchange.

(b) The rules adopted under this section must identify and may require submission of the data needed to support operation of the reinsurance and risk adjustment programs established under this section. The commissioner must identify by rule the sources of the data, and other requirements related to the collection, validation, correction, interpretation, transmission or exchange, and retention of the data.

(4) The commissioner shall contract with one or more nonprofit entities to administer the risk adjustment and reinsurance programs.

(5) Contribution amounts for the transitional reinsurance program under section 1341 of P.L. 111-148 of 2010, as amended, may be

increased to include amounts sufficient to cover the costs of administration of the reinsurance program including reasonable costs incurred for preoperational and planning activities related to the reinsurance program. [2012 c 87 s 16.]

Effective date—2012 c 87 ss 4, 16, 18, and 19-23: See note following RCW 43.71.030.

Spiritual care services—2012 c 87: See RCW 43.71.901.

RCW 48.43.725 Exclusion of mandated benefits from health plan—Carrier requirements—Notice—Fees—Commissioner's duties. (1) A health carrier that excludes, under state or federal law, any benefit required or mandated by this title or rules adopted by the commissioner from any health plan or student health plan shall:

(a) Notify each enrollee in writing of the following:

(i) Which benefits the health plan or student health plan does not cover; and

(ii) Alternate ways in which the enrollees may access excluded benefits in a timely manner;

(b) Ensure that enrollees have prompt access to the information required under this subsection; and

(c) Clearly and legibly include the information specified in (a)(i) and (ii) of this subsection in any of its marketing materials that include a list of benefits covered under the plan. The information must also be listed in the benefit booklet and posted on the carrier's health plan or student health plan website.

(2) For the purpose of mitigating inequity in the health insurance market, unless waived by the commissioner pursuant to (c) of this subsection, the commissioner must assess a fee on any health carrier offering a health plan or student health plan if the health plan or student health plan excludes, under state or federal law, any essential health benefit or coverage that is otherwise required or mandated by this title or rules adopted by the commissioner.

(a) The commissioner shall set the fee in an amount that is the actuarial equivalent of costs attributed to the provision and administration of the excluded benefit. As part of its rate filing, a health carrier subject to this subsection (2) must submit to the commissioner an estimate of the amount of the fee, including supporting documentation of its methods for estimating the fee. The carrier must include in its supporting documentation a certification by a member of the American academy of actuaries that the estimated fee is the actuarial equivalent of costs attributed to the provision and administration of the excluded benefit.

(b) Fees paid under this section must be deposited into the general fund.

(c) The commissioner may waive the fee assessed under this subsection (2) if he or she finds that the carrier excluding a mandated benefit for a health plan or student health plan provides health plan enrollees or student health plan enrollees alternative access to all excluded mandated benefits.

(3) Beginning July 1, 2021, the commissioner shall provide on its website written notice of the carrier requirements in this section and information on alternate ways in which enrollees may access excluded benefits in a timely manner.

(4) Nothing in this section limits the authority of the commissioner to take enforcement action if a health carrier unlawfully fails to comply with the provisions of this title.

(5) The commissioner shall adopt any rules necessary to implement this section. [2020 c 283 s 1.]

RCW 48.43.730 Carrier must file provider contracts and compensation agreements with commissioner—Approval or disapproval—Confidentiality—Hearings—Rules—Definitions. (1) For the purposes of this section:

(a) "Carrier" means a:

(i) Health carrier as defined in RCW 48.43.005; and

(ii) Limited health care service contractor that offers limited health care service as defined in RCW 48.44.035.

(b) "Provider" means:

(i) A health care provider as defined in RCW 48.43.005;

(ii) A participating provider as defined in RCW 48.44.010;

(iii) A health care facility, as defined in RCW 48.43.005; and

(iv) Intermediaries that have agreed in writing with a carrier to provide access to providers under this subsection (1)(b) who render covered services to enrollees of a carrier.

(c) "Provider compensation agreement" means any written agreement that includes specific information about payment methodology, payment rates, and other terms that determine the remuneration a carrier will pay to a provider.

(d) "Provider contract" means a written contract between a carrier and a provider for any health care services rendered to an enrollee.

(2) A carrier must file all provider contracts and provider compensation agreements with the commissioner thirty calendar days before use. When a carrier and provider negotiate a provider contract or provider compensation agreement that deviates from a filed agreement, the carrier must also file that specific contract or agreement with the commissioner thirty calendar days before use.

(a) Any provider contract and related provider compensation agreements not affirmatively disapproved by the commissioner are deemed approved, except the commissioner may extend the approval date an additional fifteen calendar days upon giving notice before the expiration of the initial thirty-day period.

(b) Changes to previously filed and approved provider compensation agreements modifying the compensation amount or related terms that help determine the compensation amount must be filed and are deemed approved upon filing if no other changes are made to the previously approved provider contract or compensation agreement.

(3) The commissioner may not base a disapproval of a provider compensation agreement on the amount of compensation or other financial arrangements between the carrier and the provider, unless that compensation amount causes the underlying health benefit plan to otherwise be in violation of state or federal law. This subsection does not grant the commissioner the authority to regulate provider reimbursement amounts.

(4) The commissioner may withdraw approval of a provider contract or provider compensation agreement at any time for cause.

(5) Provider compensation agreements are confidential and not subject to public inspection under RCW 48.02.120(2), or public

disclosure under chapter 42.56 RCW, if filed in accordance with the procedures for submitting confidential filings through the system for electronic rate and form filings and the general filing instructions as set forth by the commissioner. In the event the referenced filing fails to comply with the filing instructions setting forth the process to withhold the compensation agreement from public inspection, and the carrier indicates that the compensation agreement is to be withheld from public inspection, the commissioner shall reject the filing and notify the carrier through the system for electronic rate and form filings to amend its filing to comply with the confidentiality filing instructions.

(6) In the event a provider contract or provider compensation agreement is disapproved or withdrawn from use by the commissioner, the carrier has the right to demand and receive a hearing under chapters 48.04 and 34.05 RCW.

(7) Provider contracts filed pursuant to subsection (2) of this section shall identify the network or networks to which the contract applies.

(8) The commissioner may adopt rules to implement this section. [2019 c 427 s 30; 2013 c 277 s 1.]

Findings—Intent—Effective date—2019 c 427: See RCW 48.49.003 and 48.49.900.

RCW 48.43.731 Health care benefit management contracts—Carrier filing requirements—Notice to enrollees—Confidentiality of filings. (1) A carrier must file with the commissioner in the form and manner prescribed by the commissioner every contract and contract amendment between the carrier and any health care benefit manager registered under RCW 48.200.030, within thirty days following the effective date of the contract or contract amendment.

(2) For health plans issued or renewed on or after January 1, 2022, carriers must notify health plan enrollees in writing of each health care benefit manager contracted with the carrier to provide any benefit management services in the administration of the health plan.

(3) Contracts filed under this section are confidential and not subject to public inspection under RCW 48.02.120(2), or public disclosure under chapter 42.56 RCW, if filed in accordance with the procedures for submitting confidential filings through the system for electronic rate and form filings and the general filing instructions as set forth by the commissioner. In the event the referenced filing fails to comply with the filing instructions setting forth the process to withhold the contract from public inspection, and the carrier indicates that the contract is to be withheld from public inspection, the commissioner must reject the filing and notify the carrier through the system for electronic rate and form filings to amend its filing to comply with the confidentiality filing instructions.

(4) For purposes of this section, "health care benefit manager" has the same meaning as in RCW 48.200.020. [2020 c 240 s 6.]

Rule making—Effective date—2020 c 240: See RCW 48.200.900 and 48.200.901.

RCW 48.43.732 Provider contracts—Public statements—Language.

(1) In the case of a provider contract that is expiring by its own terms or for which one party has given notice to the other party of an intended termination without cause in accordance with the terms of the provider contract, neither the health care provider, the health care facility, any health care provider employed by, contracted with, or otherwise affiliated with the facility, nor the carrier may make or cause to be made public statements, including by directly communicating with impacted health plan enrollees and patients, regarding such expiration or termination until 45 days prior to the termination date, unless: (a) The disclosure is required to satisfy a specific legal obligation; or (b) the expiration or termination has already been disclosed publicly because of a legal obligation. Communications exclusively with the governor, legislators, or state agency staff regarding a potential or intended contract termination do not constitute a public statement.

(2) Nothing in this section requires a carrier, health care facility, or health care provider to provide notice of a potential termination to enrollees, unless required to do so as a regulatory or legal requirement.

(3) Public statements or communication with health plan enrollees or patients by a carrier, health care facility, or health care provider may not occur prior to the date the carrier, health care facility, or health care provider has given written notice of the termination to the other party, unless agreed upon by both parties.

(4)(a) By December 1, 2025, the commissioner, in consultation with health carriers, health care providers, health care facilities, and consumers, must develop standard template language for notices sent to health plan enrollees and patients by health carriers, health care providers, or health care facilities pursuant to this section. The standard template language must be posted on the commissioner's website.

(b) Notices developed pursuant to this section must include, at a minimum:

(i) A reference to the specific facility or facilities by name that would be affected by the potential contract termination or expiration and an indication of whether the potential termination or expiration would apply to hospital-based providers;

(ii) Direction to enrollees related to appointments that are scheduled past the date of the potential contract termination or expiration date; and

(iii) Information concerning the enrollee's continuity of care rights pursuant to the federal no surprises act, 42 U.S.C. Sec. 300gg-111.

(c) Notices sent to enrollees or patients that solely utilize the template language developed pursuant to this section are not subject to review or approval. Notices to enrollees or patients that do not utilize the template language in full, or add to or revise the language of the template developed pursuant to this section, must be reviewed and approved by the commissioner before being used in any manner.

(5) By January 1, 2027, the requirements of this section must be included in all provider contracts. The commissioner must develop template language for inclusion in provider contracts by rule.

(6)(a) The commissioner is authorized to enforce the provisions of chapter 389, Laws of 2025 related to carriers on or after January

1, 2026. In addition to the enforcement actions authorized under RCW 48.02.080, the commissioner may impose a civil monetary penalty in an amount not to exceed $100 for each day that a notice has been sent to enrollees in advance of the 45-day period established in subsection (1) of this section for each enrollee to whom the notice has been sent.

(b) If the commissioner has cause to believe that any health care provider or health care facility has violated this section, the commissioner may submit information to the department of health, another appropriate health care facility licensing entity, or the appropriate health profession disciplining authority for action. The commissioner may provide the health care provider or health care facility with an opportunity to explain why the actions in question did not violate this section.

(c) If any health care provider or health care facility violates this section, the department of health, other appropriate health care facility licensing entity, or the appropriate health profession disciplining authority may levy a fine or cost recovery upon the health care provider or health care facility in an amount not to exceed the applicable statutory amount per violation and take other action as permitted under the authority of the department of health or disciplining authority. Upon completion of its review of any potential violation submitted by the commissioner, the department of health or the disciplining authority shall notify the commissioner of the results of the review, including whether the violation was substantiated and any enforcement action taken as a result of a finding of a substantiated violation.

(7) For the purposes of this section, "provider contract" means a written contract between a carrier and a health care provider or health care facility, as they are defined in RCW 48.43.005, for any health care services rendered to an enrollee.

(8) This section does not apply to a provider contract that is expiring or being terminated by an independent individual provider or an independent single-specialty or multispecialty group practice of five or fewer providers, whether due to a provider's retirement or some other reason. For purposes of this subsection, "independent" means a provider that is not employed by or affiliated with a hospital or multihospital health system. [2025 c 389 s 2.]

Finding—Intent—2025 c 389: "The legislature finds that public communications and notices to health plan members by carriers, health care providers, or health care facilities during contract negotiations have created concerns for enrollees, patients, and affected communities. Therefore, the legislature intends to provide consistent policies for communication with enrollees and affected communities regarding potential contract terminations." [2025 c 389 s 1.]

RCW 48.43.733 Rates and forms of group health benefit plans—Timing of filings—Exceptions—Rules. (1) All rates and forms of group health benefit plans other than small group plans, and all stand-alone dental and all stand-alone vision plans offered by a health carrier or limited health care service contractor as defined in RCW 48.44.035 and modification of a contract form or rate must be filed before the contract form is offered for sale to the public and before the rate schedule is used.

(2) Filings of negotiated health benefit plans, stand-alone dental, and stand-alone vision contract forms for groups other than small groups, 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) 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) For purposes of this section, a negotiated contract form is a health benefit plan, stand-alone dental plan, or stand-alone vision plan where benefits, and other terms and conditions, including the applicable rate schedules are negotiated and agreed to by the carrier or limited health care service contractor and the policy or contract holder. The negotiated policy form and associated rate schedule must otherwise comply with state and federal laws governing the content and schedule of rates for the negotiated plans.

(4) Stand-alone dental and stand-alone vision plans offered by a disability insurer to out-of-state groups specified by RCW 48.21.010(2) may be negotiated, but may not be offered in this state before the commissioner finds that the stand-alone dental or stand-alone vision plan otherwise meets the standards set forth in RCW 48.21.010(2) (a) and (b).

(5) The commissioner may, subject to a carrier's or limited health care service contractor's right to demand and receive a hearing under chapters 48.04 and 34.05 RCW, disapprove filings submitted under this section, as permitted under RCW 48.18.110, 48.44.020, and 48.46.060.

(6) The commissioner shall amend existing rules to standardize the rate and form filing process as well as regulatory review standards for the rates and forms of the plans submitted under this section. The commissioner may amend the rules previously adopted under RCW 48.43.733 and shall amend any additional rating requirements established by existing rule, that are not applied to health care service contractors and health maintenance organizations.

(7) The requirements of this section apply to all group health benefit plans other than small group plans, all stand-alone dental plans, and all stand-alone vision plans issued or renewed on or after March 31, 2016. [2016 c 156 s 2; 2015 c 19 s 3.]

Effective date—2016 c 156: "This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately [March 31, 2016]." [2016 c 156 s 3.]

Intent—2016 c 156: "It is the intent of the legislature to enhance competition among all health carriers and limited health care service contractors by having the office of the insurance commissioner establish regulatory uniformity for the rate and form filing process and the rate and form filing content and regulatory review standards for group health benefit plans other than small group health benefit plans, as well as all stand-alone dental plans and all stand-alone vision plans." [2016 c 156 s 1.]

Intent—2015 c 19: See note following RCW 48.18.100.

RCW 48.43.734 Health carrier rate filings—Review of surplus, capital, and profit levels. (1) For individual and small group rate filings with an effective date on or after January 1, 2021, submitted by a health carrier for either the individual or small group markets, the commissioner may review the carrier's surplus, capital, or profit levels as an element in determining the reasonableness of the proposed rate.

(2) In reviewing the surplus, capital, or profit levels, the commissioner must take into consideration the current capital facility needs for carriers, including those maintaining and operating hospital and clinical facilities.

(3) Except as provided in subsection (1) of this section, this section does not affect the rate review authority granted to the commissioner by chapter 48.19, 48.44, or 48.46 RCW.

(4) Nothing in this section affects the requirement that all approved individual and small group rates be actuarially sound according to chapter 48.19, 48.44, or 48.46 RCW.

(5) The commissioner may adopt rules to implement this section. [2020 c 247 s 1.]

RCW 48.43.735 Reimbursement of health care services provided through telemedicine or store and forward technology—Audio-only telemedicine. (1)(a) For health plans issued or renewed on or after January 1, 2017, a health carrier shall reimburse a provider for a health care service provided to a covered person through telemedicine or store and forward technology if:

(i) The plan provides coverage of the health care service when provided in person by the provider;

(ii) The health care service is medically necessary;

(iii) The health care service is a service recognized as an essential health benefit under section 1302(b) of the federal patient protection and affordable care act in effect on January 1, 2015;

(iv) The health care service is determined to be safely and effectively provided through telemedicine or store and forward technology according to generally accepted health care practices and standards, and the technology used to provide the health care service meets the standards required by state and federal laws governing the privacy and security of protected health information; and

(v) Beginning January 1, 2023, for audio-only telemedicine, the covered person has an established relationship with the provider.

(b)(i) Except as provided in (b)(ii) of this subsection, for health plans issued or renewed on or after January 1, 2021, a health carrier shall reimburse a provider for a health care service provided to a covered person through telemedicine the same amount of compensation the carrier would pay the provider if the health care service was provided in person by the provider.

(ii) Hospitals, hospital systems, telemedicine companies, and provider groups consisting of eleven or more providers may elect to negotiate an amount of compensation for telemedicine services that differs from the amount of compensation for in-person services.

(iii) For purposes of this subsection (1)(b), the number of providers in a provider group refers to all providers within the group, regardless of a provider's location.

(2) For purposes of this section, reimbursement of store and forward technology is available only for those covered services

specified in the negotiated agreement between the health carrier and the health care provider.

(3) An originating site for a telemedicine health care service subject to subsection (1) of this section includes a:

(a) Hospital;

(b) Rural health clinic;

(c) Federally qualified health center;

(d) Physician's or other health care provider's office;

(e) Licensed or certified behavioral health agency;

(f) Skilled nursing facility;

(g) Home or any location determined by the individual receiving the service; or

(h) Renal dialysis center, except an independent renal dialysis center.

(4) Except for subsection (3)(g) of this section, any originating site under subsection (3) of this section may charge a facility fee for infrastructure and preparation of the patient. Reimbursement for a facility fee must be subject to a negotiated agreement between the originating site and the health carrier. A distant site, a hospital that is an originating site for audio-only telemedicine, or any other site not identified in subsection (3) of this section may not charge a facility fee.

(5) A health carrier may not distinguish between originating sites that are rural and urban in providing the coverage required in subsection (1) of this section.

(6) A health carrier may subject coverage of a telemedicine or store and forward technology health service under subsection (1) of this section to all terms and conditions of the plan in which the covered person is enrolled including, but not limited to, utilization review, prior authorization, deductible, copayment, or coinsurance requirements that are applicable to coverage of a comparable health care service provided in person.

(7) This section does not require a health carrier to reimburse:

(a) An originating site for professional fees;

(b) A provider for a health care service that is not a covered benefit under the plan; or

(c) An originating site or health care provider when the site or provider is not a contracted provider under the plan.

(8)(a) If a provider intends to bill a patient or the patient's health plan for an audio-only telemedicine service, the provider must obtain patient consent for the billing in advance of the service being delivered.

(b) If the commissioner has cause to believe that a provider has engaged in a pattern of unresolved violations of this subsection (8), the commissioner may submit information to the appropriate disciplining authority, as defined in RCW 18.130.020, for action. Prior to submitting information to the appropriate disciplining authority, the commissioner may provide the provider with an opportunity to cure the alleged violations or explain why the actions in question did not violate this subsection (8).

(c) If the provider has engaged in a pattern of unresolved violations of this subsection (8), the appropriate disciplining authority may levy a fine or cost recovery upon the provider in an amount not to exceed the applicable statutory amount per violation and take other action as permitted under the authority of the disciplining authority. Upon completion of its review of any potential violation submitted by the commissioner or initiated directly by an enrollee,

the disciplining authority shall notify the commissioner of the results of the review, including whether the violation was substantiated and any enforcement action taken as a result of a finding of a substantiated violation.

(9) For purposes of this section:

(a)(i) "Audio-only telemedicine" means the delivery of health care services through the use of audio-only technology, permitting real-time communication between the patient at the originating site and the provider, for the purpose of diagnosis, consultation, or treatment.

(ii) For purposes of this section only, "audio-only telemedicine" does not include:

(A) The use of facsimile or email; or

(B) The delivery of health care services that are customarily delivered by audio-only technology and customarily not billed as separate services by the provider, such as the sharing of laboratory results;

(b) "Disciplining authority" has the same meaning as in RCW 18.130.020;

(c) "Distant site" means the site at which a physician or other licensed provider, delivering a professional service, is physically located at the time the service is provided through telemedicine;

(d) "Established relationship" means the provider providing audio-only telemedicine has access to sufficient health records to ensure safe, effective, and appropriate care services and:

(i) The covered person has had, within the past three years, at least one in-person appointment, or at least one real-time interactive appointment using both audio and video technology, with the provider providing audio-only telemedicine or with a provider employed at the same medical group, at the same clinic, or by the same integrated delivery system operated by a carrier licensed under chapter 48.44 or 48.46 RCW as the provider providing audio-only telemedicine; or

(ii) The covered person was referred to the provider providing audio-only telemedicine by another provider who has had, within the past three years, at least one in-person appointment, or at least one real-time interactive appointment using both audio and video technology, with the covered person and has provided relevant medical information to the provider providing audio-only telemedicine;

(e) "Health care service" has the same meaning as in RCW 48.43.005;

(f) "Hospital" means a facility licensed under chapter 70.41, 71.12, or 72.23 RCW;

(g) "Originating site" means the physical location of a patient receiving health care services through telemedicine;

(h) "Provider" has the same meaning as in RCW 48.43.005;

(i) "Store and forward technology" means use of an asynchronous transmission of a covered person's medical information from an originating site to the health care provider at a distant site which results in medical diagnosis and management of the covered person, and does not include the use of audio-only telephone, facsimile, or email; and

(j) "Telemedicine" means the delivery of health care services through the use of interactive audio and video technology, permitting real-time communication between the patient at the originating site and the provider, for the purpose of diagnosis, consultation, or treatment. For purposes of this section only, "telemedicine" includes audio-only telemedicine, but does not include facsimile or email.

(10) The commissioner may adopt any rules necessary to implement this section. [2024 c 215 s 2; 2023 c 8 s 2; 2022 c 213 s 2; 2021 c 157 s 2; 2020 c 92 s 1; 2017 c 219 s 1; 2016 c 68 s 3; 2015 c 23 s 3.]

Conflict with federal requirements—2022 c 213: See note following RCW 41.05.700.

Conflict with federal requirements—2021 c 157: See note following RCW 74.09.327.

Effective date—2020 c 92: "This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately [March 19, 2020]." [2020 c 92 s 5.]

Effective date—2017 c 219: "Sections 1 through 3 of this act take effect January 1, 2018." [2017 c 219 s 4.]

Effective date—2016 c 68: "Sections 3 through 5 of this act take effect January 1, 2018." [2016 c 68 s 7.]

Intent—2016 c 68: "The legislature recognizes telemedicine will play an increasingly important role in the health care system. Telemedicine is a meaningful and efficient way to treat patients and control costs while improving access to care. The expansion of the use of telemedicine should be thoughtfully and systematically considered in Washington state in order to maximize its application and expand access to care. Therefore, it is the intent of the legislature to broaden the reimbursement opportunities for health care services and establish a collaborative for the advancement of telemedicine to provide guidance, research, and recommendations for the benefit of professionals providing care through telemedicine." [2016 c 68 s 1.]

Effective date—Adoption of sections—2015 c 23 ss 2-4: See notes following RCW 41.05.700.

Intent—2015 c 23: See note following RCW 41.05.700.

RCW 48.43.740 Dental only plan—Emergency dental conditions—Definitions. (1) A health carrier offering a dental only plan may not deny coverage for treatment of emergency dental conditions that would otherwise be considered a covered service of an existing benefit contract on the basis that the services were provided on the same day the covered person was examined and diagnosed for the emergency dental condition.

(2) For purposes of this section:

(a) "Emergency dental condition" means a dental condition manifesting itself by acute symptoms of sufficient severity, including severe pain or infection such that a prudent layperson, who possesses an average knowledge of health and dentistry, could reasonably expect the absence of immediate dental attention to result in:

(i) 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;

(ii) Serious impairment to bodily functions; or

(iii) Serious dysfunction of any bodily organ or part.

(b) "Health carrier," in addition to the definition in RCW 48.43.005, also includes health care service contractors, limited health care service contractors, and disability insurers offering dental only coverage. [2015 c 9 s 1.]

Effective date—2015 c 9: "This act takes effect January 1, 2017." [2015 c 9 s 3.]

RCW 48.43.743 Dental only plan—Annual data statement—Contents—Public use—Definition. (1) Each health carrier offering a dental only plan in Washington shall submit to the commissioner on or before April 1st of each year as part of the additional data statement, or as a supplemental data statement, Washington specific data for the preceding year that is derived from the carrier's annual statement, including the exhibit of premiums, enrollments, and utilization for the company at an aggregate level and the additional data to the annual statement, which must be based on Washington data and may not include data from other states:

(a) The total number of dental members;

(b) The total amount of dental revenue;

(c) The total amount of dental payments;

(d) The dental loss ratio that is computed by dividing the total amount of dental payments by the total amount of dental revenues;

(e) The average amount of premiums per member per month; and

(f) The percentage change in the average premium per member per month, measured from the previous year.

(2) A carrier shall electronically submit the information described in subsection (1) of this section in a format and according to instructions prescribed by the commissioner.

(3) The commissioner shall make the information reported under this section available to the public on the commissioner's public website on the internet.

(4) For the purposes of licensed disability insurers and health care service contractors, the commissioner shall work collaboratively with insurers to develop an additional or supplemental data statement that utilizes to the maximum extent possible information from the annual statement forms that are currently filed by these entities.

(5) For purposes of this section, "health carrier," in addition to the definition in RCW 48.43.005, also includes health care service contractors, limited health care service contractors, and disability insurers offering dental only coverage.

(6) Nothing in this section is intended to establish a minimum dental loss ratio. [2025 c 243 s 10; 2025 c 219 s 5; 2015 c 9 s 2.]

Reviser's note: This section was amended by 2025 c 219 s 5 and by 2025 c 243 s 10, each without reference to the other. Both amendments are incorporated in the publication of this section under RCW 1.12.025(2). For rule of construction, see RCW 1.12.025(1).

Effective date—2015 c 9: See note following RCW 48.43.740.

RCW 48.43.745 Dental only plan—Denturist services. (1) Every health carrier offering dental only coverage and every health carrier offering dental only coverage in addition to a health plan delivered,

issued for delivery, or renewed by a health carrier on and after January 1, 2024, shall permit denturists licensed under chapter 18.30 RCW to provide dental services or care included in their benefits package, to the extent that:

(a) The provision of such dental services or care is within the health care providers' permitted scope of practice; and

(b) The providers agree to abide by standards related to:

(i) Provision, utilization review, and cost containment of dental services;

(ii) Management and administrative procedures; and

(iii) Provision of cost-effective and clinically efficacious dental services.

(2) The requirements of subsection (1) of this section do not apply to a licensed health care profession regulated under Title 18 RCW when the licensing statute for the profession states that such requirements do not apply.

(3) For purposes of this section, "health carrier," in addition to the definition in RCW 48.43.005, also includes health care service contractors, limited health care service contractors, and disability insurers offering dental only coverage.

(4) Chapter 216, Laws of 2023 does not apply to a plan that offers dental only coverage when the plan relies solely on employees of the health carrier for provision of the benefits. [2023 c 216 s 1.]

RCW 48.43.747 Dental only plan—Coverage for same day procedures. (1) A dental only plan offered by a carrier or limited health care service contractor, as defined in RCW 48.44.035, may not deny coverage for procedures solely on the basis that the procedures were performed on the same day.

(2) Nothing in this section shall prevent a dental only plan offered by a carrier or limited health care service contractor from denying a claim for coverage where such denial relates in whole or in part to any of the following:

(a) Limitations intended to prevent fraud, waste, and abuse;

(b) A claim indicating unbundling of procedure elements where payment for a service bundles multiple procedure elements;

(c) Clinical appropriateness;

(d) Medical necessity;

(e) A final benefit decision that has been pended due to the need for further documentation or provider narrative; or

(f) Plan benefit limitations. [2025 c 219 s 1.]

Rules—2025 c 219 ss 1 and 2: "The insurance commissioner may adopt any rules necessary to implement sections 1 and 2 of this act." [2025 c 219 s 3.]

RCW 48.43.748 Dental only plan—Payments by credit card. (1) A dental only plan offered by a carrier or limited health care service contractor, as defined in RCW 48.44.035, may pay a claim for reimbursement made by a dental care provider using a credit card if:

(a) The carrier or limited health care service contractor notifies the provider, in advance, of any fees associated with the use of the credit card;

(b) The carrier or limited health care service contractor offers the provider an alternative payment method that does not impose fees or similar charges on the provider; and

(c) The carrier or limited health care service contractor advises the provider of available methods of payment and provides clear instructions to the provider as to how to select an alternative payment method.

(2) If a carrier or limited health care service contractor contracts with a vendor to process payments of dental providers' claims, the carrier or limited health care service contractor shall require the vendor to comply with the provisions of subsection (1)(a) of this section. [2025 c 219 s 2.]

Rules—2025 c 219 ss 1 and 2: See note following RCW 48.43.747.

RCW 48.43.750 Health care provider credentialing applications—Use of electronic database by health carriers. (1)(a) A health carrier must use the database selected pursuant to RCW 48.165.035 to accept and manage credentialing applications from health care providers. A health carrier may not require a health care provider to submit credentialing information in any format other than through the database selected pursuant to RCW 48.165.035.

(b) Effective June 1, 2018, a health carrier shall make a determination approving or denying a credentialing application submitted to the carrier no later than ninety days after receiving a complete application from a health care provider.

(c) Effective June 1, 2020, a health carrier shall make a determination approving or denying a credentialing application submitted to the carrier no later than ninety days after receiving a complete application from a health care provider. All determinations made by a health carrier in approving or denying credentialing applications must average no more than sixty days.

(d) This section does not require health carriers to approve a credentialing application or to place providers into a network.

(2) This section does not apply to health care entities that utilize credentialing delegation arrangements in the credentialing of their health care providers with health carriers.

(3) For purposes of this section, "credentialing" means the collection, verification, and assessment of whether a health care provider meets relevant licensing, education, and training requirements.

(4) Nothing in this section creates an oversight or enforcement duty on behalf of the office of the insurance commissioner against a health carrier for failure to comply with the terms of this section. [2020 c 4 s 1; 2016 c 123 s 1.]

Effective date—2016 c 123: "This act takes effect June 1, 2018." [2016 c 123 s 3.]

RCW 48.43.755 Health care provider credentialing applications—Use of electronic database by providers. (1) When submitting a credentialing application to a health carrier, a health care provider shall submit the application to health carriers using the database selected pursuant to RCW 48.165.035.

(2) A health care provider shall update credentialing information as necessary to provide for the purposes of recredentialing.

(3) This section does not apply to providers practicing at entities that utilize credentialing delegation arrangements in the credentialing of their health care providers with health carriers.

(4) The definitions in this subsection apply throughout this section unless the context clearly requires otherwise.

(a) "Credentialing" has the same meaning as in RCW 48.43.750.

(b) "Health care provider" has the same meaning as in *RCW 48.43.005(23)(a).

(c) "Health carrier" has the same meaning as in RCW 48.43.005. [2016 c 123 s 2.]

***Reviser's note:** RCW 48.43.005 was alphabetized pursuant to RCW 1.08.015(2)(k), changing subsection (23) to subsection (24), and effective January 1, 2020, changing subsection (23) to subsection (26). RCW 48.43.005 was alphabetized pursuant to RCW 1.08.015(2)(k), changing subsection (26) to subsection (28). Subsequently, RCW 48.43.005 was amended by 2024 c 218 s 1, changing subsection (28) to subsection (30).

Effective date—2016 c 123: See note following RCW 48.43.750.

RCW 48.43.757 Health care provider credentialing applications—Reimbursement requirements. (1) If a carrier approves a health care provider's credentialing application, upon completion of the credentialing process, the carrier must reimburse a health care provider under the following circumstances:

(a) When credentialing a new health care provider through a new provider contract, the carrier must reimburse the health care provider for covered services provided to the carrier's enrollee retroactively to the date of contract effectiveness if the credentialing process extends beyond the effective date of the new contract.

(b) When credentialing a provider to be added to an approved and in-use provider contract where a relationship existed between the carrier and the health care provider or the entity for whom the health care provider is employed or engaged at the time the health care provider submitted the completed credentialing application, the carrier must reimburse the health care provider for covered health care services provided to the carrier's enrollees during the credentialing process beginning when the health care provider submitted a completed credentialing application to the carrier.

(2) The health carrier must reimburse the health care provider at the contracted rate for the applicable health benefit plan that the health care provider would have been paid at the time the services were provided if the health care provider were fully credentialed by the carrier.

(3) Nothing in this section requires reimbursement of health care provider-rendered services that are not benefits or services covered by the health carrier's health benefit plan.

(4) Nothing in this section requires a health carrier to pay reimbursement for any covered medical services provided by a health care provider applicant if the health care provider's credentialing application is not approved or if the carrier and health care provider do not enter into a contractual relationship. [2020 c 4 s 2.]

RCW 48.43.760 Opioid use disorder—Coverage without prior authorization. For health plans issued or renewed on or after January 1, 2020, a health carrier shall provide coverage without prior authorization of at least one federal food and drug administration approved product for the treatment of opioid use disorder in the drug classes opioid agonists, opioid antagonists, and opioid partial agonists. [2019 c 314 s 37.]

Declaration—2019 c 314: See note following RCW 18.22.810.

RCW 48.43.761 Withdrawal management services—Substance use disorder treatment services—Prior authorization—Utilization review—Medical necessity review. (1) Except as provided in subsection (2) of this section, a health plan issued or renewed on or after January 1, 2021, may not require an enrollee to obtain prior authorization for withdrawal management services or inpatient or residential substance use disorder treatment services in a behavioral health agency licensed or certified under RCW 71.24.037.

(2)(a) A health plan issued or renewed on or after January 1, 2021, must:

(i) Provide coverage for no less than two business days, excluding weekends and holidays, in a behavioral health agency that provides inpatient or residential substance use disorder treatment prior to conducting a utilization review; and

(ii) Provide coverage for no less than three days in a behavioral health agency that provides withdrawal management services prior to conducting a utilization review.

(b)(i) The health plan may not require an enrollee to obtain prior authorization for the services specified in (a) of this subsection as a condition for payment of services prior to the times specified in (a) of this subsection.

(ii) Once the times specified in (a) of this subsection have passed, the health plan may initiate utilization management review procedures if the behavioral health agency continues to provide services or is in the process of arranging for a seamless transfer to an appropriate facility or lower level of care under subsection (6) of this section. For a health plan issued or renewed on or after January 1, 2025, if a health plan authorizes inpatient or residential substance use disorder treatment services pursuant to (a)(i) of this subsection following the initial medical necessity review process under (c)(iii) of this subsection, the length of the initial authorization may not be less than 14 days from the date that the patient was admitted to the behavioral health agency. Any subsequent reauthorization that the health plan approves after the first 14 days must continue for no less than seven days prior to requiring further reauthorization. Nothing prohibits a health plan from requesting information to assist with a seamless transfer under this subsection.

(c)(i) The behavioral health agency under (a) of this subsection must notify an enrollee's health plan as soon as practicable after admitting the enrollee, but not later than twenty-four hours after admitting the enrollee. The time of notification does not reduce the requirements established in (a) of this subsection.

(ii) The behavioral health agency under (a) of this subsection must provide the health plan with its initial assessment and initial treatment plan for the enrollee within two business days of admission,

excluding weekends and holidays, or within three days in the case of a behavioral health agency that provides withdrawal management services.

(iii) After the time period in (a) of this subsection and receipt of the material provided under (c)(ii) of this subsection, the plan may initiate a medical necessity review process. Medical necessity review must be based on the standard set of criteria established under RCW 41.05.528. In a review for inpatient or residential substance use disorder treatment services, a health plan may not make a determination that a patient does not meet medical necessity criteria based primarily on the patient's length of abstinence. If the patient's abstinence from substance use was due to incarceration, hospitalization, or inpatient treatment, a health plan may not consider the patient's length of abstinence in determining medical necessity. If the health plan determines within one business day from the start of the medical necessity review period and receipt of the material provided under (c)(ii) of this subsection that the admission to the facility was not medically necessary and advises the agency of the decision in writing, the health plan is not required to pay the facility for services delivered after the start of the medical necessity review period, subject to the conclusion of a filed appeal of the adverse benefit determination. If the health plan's medical necessity review is completed more than one business day after the start of the medical necessity review period and receipt of the material provided under (c)(ii) of this subsection, the health plan must pay for the services delivered from the time of admission until the time at which the medical necessity review is completed and the agency is advised of the decision in writing.

(3)(a) The behavioral health agency shall document to the health plan the patient's need for continuing care and justification for level of care placement following the current treatment period, based on the standard set of criteria established under RCW 41.05.528, with documentation recorded in the patient's medical record.

(b) For a health plan issued or renewed on or after January 1, 2025, for inpatient or residential substance use disorder treatment services, the health plan may not consider the patient's length of stay at the behavioral health agency when making decisions regarding the authorization to continue care at the behavioral health agency.

(4) Nothing in this section prevents a health carrier from denying coverage based on insurance fraud.

(5) If the behavioral health agency under subsection (2)(a) of this section is not in the enrollee's network:

(a) The health plan is not responsible for reimbursing the behavioral health agency at a greater rate than would be paid had the agency been in the enrollee's network; and

(b) The behavioral health agency may not balance bill, as defined in RCW 48.43.005.

(6) When the treatment plan approved by the health plan involves transfer of the enrollee to a different facility or to a lower level of care, the care coordination unit of the health plan shall work with the current agency to make arrangements for a seamless transfer as soon as possible to an appropriate and available facility or level of care. The health plan shall pay the agency for the cost of care at the current facility until the seamless transfer to the different facility or lower level of care is complete. A seamless transfer to a lower level of care may include same day or next day appointments for outpatient care, and does not include payment for nontreatment services, such as housing services. If placement with an agency in the

health plan's network is not available, the health plan shall pay the current agency until a seamless transfer arrangement is made.

(7) The requirements of this section do not apply to treatment provided in out-of-state facilities.

(8) For the purposes of this section "withdrawal management services" means twenty-four hour medically managed or medically monitored detoxification and assessment and treatment referral for adults or adolescents withdrawing from alcohol or drugs, which may include induction on medications for addiction recovery. [2024 c 366 s 7; 2020 c 345 s 3.]

Findings—Intent—2024 c 366: See note following RCW 71.24.847.

Findings—Intent—2020 c 345: See note following RCW 41.05.526.

RCW 48.43.762 Opioid overdose reversal medication bulk purchasing and distribution program. (1) For health plans issued or renewed on or after January 1, 2023, health carriers must participate in the opioid overdose reversal medication bulk purchasing and distribution program established in RCW 70.14.170 once the program is operational. A health plan may not impose enrollee cost sharing related to opioid overdose reversal medication provided through the bulk purchasing and distribution program established in RCW 70.14.170.

(2) For health plans issued or renewed on or after January 1, 2025, a health carrier must reimburse a hospital or psychiatric hospital that bills for the following outpatient services:

(a) For opioid overdose reversal medication dispensed or distributed to a patient under RCW 70.41.485 as a separate reimbursable expense; and

(b) For the administration of long-acting injectable buprenorphine as a separate reimbursable expense.

(3) Reimbursements provided under subsection (2) of this section must be separate from any bundled payment for outpatient hospital or emergency department services. [2024 c 366 s 17; 2021 c 273 s 11.]

Findings—Intent—2024 c 366: See note following RCW 71.24.847.

Rules—2021 c 273 ss 7-12: See note following RCW 70.14.170.

Findings—Intent—2021 c 273: See note following RCW 70.41.480.

RCW 48.43.764 Standard set of criteria—Authority review. When updated versions of the ASAM Criteria, treatment criteria for addictive, substance related, and co-occurring conditions, inclusive of adolescent and transition age youth versions, are published by the American society of addiction medicine, the health care authority and the office of the insurance commissioner shall jointly determine whether to use the updated version, and, if so, the date upon which the updated version must begin to be used by medicaid managed care organizations, carriers, and other relevant entities. Both agencies shall post notice of their decision on their websites. For purposes of the ASAM Criteria, 4th edition, medicaid managed care organizations and carriers shall begin to use the updated criteria no later than January 1, 2028, unless the health care authority and the office of

the insurance commissioner jointly determine that it should not be used. [2025 c 335 s 2; 2024 c 366 s 11.]

Findings—Intent—2024 c 366: See note following RCW 71.24.847.

RCW 48.43.765 Health carrier network adequacy—Mental health and substance abuse treatment. (1) The commissioner shall amend his or her rules on electronic provider directories to require health carriers to include a notation when any mental health provider or substance abuse provider is closed to new patients.

(2) Beginning January 1, 2020, a health carrier shall prominently post the information listed in (a) through (e) of this subsection on its website in an easily understandable format and in a manner that any interested party may obtain the information:

(a) Whether the health carrier classifies mental health treatment and substance abuse treatment as primary care or specialty care and the number of business days within which an enrollee must have access to covered mental health treatment services and substance abuse treatment services under network access standards pertaining to primary care or specialty care, as applicable, adopted by the commissioner;

(b) Information on actions an enrollee may take if he or she is unable to access covered mental health treatment services or substance abuse treatment services within the requisite number of business days, including any tools or resources the carrier makes available to enrollees to assist them in finding available providers and information on how to file a complaint with the office of the insurance commissioner;

(c) Any instances where the commissioner has taken disciplinary action against the health carrier for failing to comply with network access standards for covered mental health treatment services or substance abuse treatment services;

(d) A link to the commissioner's report published under subsection (5) of this section; and

(e) Resources for persons who are experiencing a mental health crisis including, but not limited to, information on the national suicide prevention lifeline.

(3) The commissioner shall, by rule, specify a model format for the information required to be posted on a health carrier's website under subsection (2) of this section.

(4) The commissioner may audit the information a health carrier provides under this section for accuracy.

(5) The commissioner shall annually publish on the commissioner's website a report on the number of consumer complaints per licensed health carrier the commissioner received in the previous calendar year regarding consumers who were not able to access covered mental health treatment services or substance abuse treatment services within the time limits established by the commissioner for primary care or specialty care. [2019 c 11 s 1.]

Short title—2019 c 11: "This act may be known and cited as Brennen's law." [2019 c 11 s 2.]

RCW 48.43.766 Mental health and substance use disorder services ——Coverage——Utilization reviews. *(Effective January 1, 2027.)* (1) For the purposes of this section:

(a) "Clinical review criteria" means written guidelines, standards, protocols, or decision rules used by a health carrier, or health care benefit manager on behalf of a health carrier, during utilization review to evaluate the medical necessity of a patient's requested health care services.

(b) "Core treatment" means a standard treatment or course of treatment, therapy, service, or intervention indicated by generally accepted standards of mental health and substance use disorder care for a condition or disorder.

(c) "Generally accepted standards of mental health and substance use disorder care" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, social work, addiction medicine and counseling, and behavioral health treatment.

(d) "Health plan" or "health benefit plan" means:

(i) A health plan as defined by RCW 48.43.005; or

(ii) A plan deemed by the commissioner to have a short-term limited purpose or duration, or to be a student-only health plan that is guaranteed renewable while the covered person is enrolled as a regular, full-time undergraduate student at an accredited higher education institution.

(e) "Medically necessary" means a service or product addressing the specific needs of a patient, for the purpose of screening, preventing, diagnosing, managing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is:

(i) In accordance with generally accepted standards of mental health and substance use disorder care;

(ii) Clinically appropriate in terms of type, frequency, extent, site, and duration of a service or product; and

(iii) Not primarily for the economic benefit of the insurer or purchaser or for the convenience of the patient, treating physician, or other health care provider.

(f) "Mental health and substance use disorder services" means:

(i) For health benefit plans issued or renewed before January 1, 2021, medically necessary outpatient and inpatient services provided to treat mental disorders covered by the diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental disorders, published by the American psychiatric association, on June 11, 2020, or such subsequent date as may be provided by the insurance commissioner by rule, consistent with the purposes of chapter 6, Laws of 2005, with the exception of the following categories, codes, and services: (A) Substance-related disorders; (B) life transition problems, currently referred to as "V" codes, and diagnostic codes 302 through 302.9 as found in the diagnostic and statistical manual of mental disorders, 4th edition, published by the American psychiatric association; (C) skilled nursing facility services, home health care, residential treatment, and custodial care; and (D) court-ordered treatment, unless the insurer's medical director or designee determines the treatment to be medically necessary;

(ii) For a health benefit plan or a plan deemed by the commissioner to have a short-term limited purpose or duration, or to be a student-only health plan that is guaranteed renewable while the covered person is enrolled as a regular, full-time undergraduate student at an accredited higher education institution, issued or renewed on or after January 1, 2021, medically necessary outpatient services, residential care, partial hospitalization services, and inpatient services provided to treat mental health and substance use disorders covered by the diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental disorders, published by the American psychiatric association, on June 11, 2020, or such subsequent date as may be provided by the insurance commissioner by rule, consistent with the purposes of chapter 6, Laws of 2005; and

(iii) For a health plan issued or renewed on or after January 1, 2027, medically necessary outpatient services, residential care, partial hospitalization services, inpatient services, and prescription drugs provided to treat mental health or substance use disorders covered by:

(A) The diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental disorders, published by the American psychiatric association, on June 11, 2020, or any subsequent version as determined by the insurance commissioner in rule consistent with this section and the goals listed in section 1, chapter 227, Laws of 2025;

(B) The diagnostic categories listed in the mental, behavioral, and neurodevelopmental chapters of the version available on January 13, 2025, of the international classification of diseases adopted by the federal department of health and human services through 42 C.F.R. Sec. 162.002 or any subsequent version as determined by the insurance commissioner in rule consistent with this section and the goals listed in section 1, chapter 227, Laws of 2025; or

(C) The diagnostic categories listed in the DC:0-5 diagnostic classification of mental health and developmental disorders of infancy and early childhood available on January 13, 2025, or any subsequent version as determined by the insurance commissioner in rule consistent with this section and the goals listed in section 1, chapter 227, Laws of 2025.

(g) "Nonprofit professional association" means a not-for-profit health care provider professional association or specialty society that is generally recognized by clinicians practicing in the relevant clinical specialty and issues peer-reviewed guidelines, criteria, or other clinical recommendations developed through a transparent process.

(h) "Utilization review" has the same meaning as in RCW 48.43.005.

(2) Each health plan providing coverage for medical and surgical services shall provide coverage for mental health and substance use disorder services. Any cost sharing for mental health and substance use disorder services and any treatment limitations related to mental health and substance use disorder services must comply with the quantitative and nonquantitative treatment limitation requirements in the provisions of 89 Fed. Reg. 77586 et seq., as published on September 23, 2024.

(3) Utilization review and clinical review criteria may not deviate from generally accepted standards of mental health and substance use disorder care.

(4)(a) Except as otherwise provided in (c) of this subsection, in conducting utilization reviews relating to service intensity or level of care placement, continued stay, or transfer or discharge, the health carrier shall apply relevant age-appropriate patient placement criteria from nonprofit professional associations and shall authorize placement at the service intensity and level of care consistent with that criteria. The health carrier may not apply conflicting or more restrictive criteria. A carrier may continue to use software-based clinical decision support tools, including those developed by commercial entities, so long as such tools incorporate and apply with fidelity the relevant age-appropriate patient placement criteria consistent with the requirements of this subsection.

(b) If the carrier's application of the relevant age-appropriate patient placement criteria under (a) of this subsection is not consistent with the service intensity or level of care placement requested by the covered person or their provider, any adverse benefit determination notice must include full details of the carrier's assessment under the relevant criteria to the provider and the covered person.

(c) A carrier may use patient placement criteria in addition to the relevant age-appropriate placement criteria under (a) of this subsection only to approve requested services and may not rely on additional patient placement criteria to issue an adverse benefit determination or otherwise deny, restrict, or limit access to requested services.

(d) For utilization review not relating to service intensity or level of care placement, continued stay, or transfer or discharge, a carrier may use clinical review criteria from either for-profit or nonprofit sources provided that the clinical review criteria meet the requirements of subsection (3) of this section.

(e) To ensure appropriate use of all clinical review criteria used by a carrier to conduct utilization reviews, carriers must comply with any oversight measures deemed appropriate by the commissioner.

(5) A health carrier may not limit benefits or coverage for medically necessary mental health and substance use disorder services on the basis that those services should or could be covered by a public entitlement program including, but not limited to, special education or an individualized education program, medicaid, medicare, supplemental security income, or social security disability insurance, and may not include or enforce a contract term that excludes otherwise covered benefits on the basis that those services should or could be covered by a public entitlement program. Nothing in this subsection may be construed to require a carrier to cover benefits that have been authorized and provided for a covered person by a public entitlement program, except as otherwise required by state or federal law.

(6) This section applies to any health care benefit manager, as defined in RCW 48.200.020[,] or contracted provider that performs utilization review functions directly or indirectly on a health carrier's behalf.

(7) A health carrier may not adopt, impose, or enforce terms in its policies or provider agreements, in writing or in operation, in a manner that undermines, alters, or conflicts with the requirements of this section.

(8) If a health carrier provides any benefits for a mental health condition or substance use disorder in any classification of benefits, it shall provide meaningful benefits for that mental health condition or substance use disorder in every classification in which medical or

surgical benefits are provided. For purposes of this subsection, whether the benefits provided are considered "meaningful benefits" is determined in comparison to the benefits provided for medical conditions and surgical procedures in the classification and requires, at a minimum, coverage of benefits for that condition or disorder in each classification in which the health carrier provides benefits for one or more medical conditions or surgical procedures. A health carrier does not provide meaningful benefits under this subsection unless it provides benefits for a core treatment for that condition or disorder in each classification in which the health carrier provides benefits for a core treatment for one or more medical conditions or surgical procedures. If there is no core treatment for a covered mental health condition or substance use disorder with respect to a classification, the health carrier is not required to provide benefits for a core treatment for such condition or disorder in that classification, but shall provide benefits for such condition or disorder in every classification in which medical or surgical benefits are provided.

(9) The provisions of 89 Fed. Reg. 77586 et seq., as published on September 23, 2024, and any guidance issued by federal departments of health and human services, labor, and the treasury to implement the rules adopted in September 2024 are incorporated in this section in their entirety.

(10) If, following an adverse benefit determination, a covered person requests one or more nonquantitative treatment limitation parity compliance analyses that the health carrier is required to have completed by 29 U.S.C. Sec. 1185a or 42 U.S.C. Sec. 300gg-26, the health carrier shall provide the requested analyses free of charge within 30 days.

(11) This section does not prohibit a requirement that mental health and substance use disorder services be medically necessary, if a comparable requirement is applicable to medical and surgical services. [2025 c 227 s 2.]

Effective date—2025 c 227 ss 1-8: "Sections 1 through 8 of this act take effect January 1, 2027." [2025 c 227 s 10.]

Findings—Intent—2025 c 227: "(1) The legislature finds that:

(a) Access to mental health and substance use disorder treatment is critical to the health and well-being of individuals with these conditions and that access to appropriate care is important to reducing preventable emergency department visits, hospitalizations, and physical health care costs associated with significant comorbidities;

(b) Health insurance coverage is essential to ensuring that individuals can access needed mental health and substance use disorder treatment and that health carriers should make medical necessity determinations based on the objective needs of the patient; and

(c) The mental health and substance use disorder workforce faces a number of administrative barriers and undue financial risks with respect to participation in health carriers' provider networks that should be alleviated.

(2) Therefore, it is the intent of the legislature to increase access to mental health and substance use disorder treatment by updating Washington's mental health parity requirements, requiring that medical necessity determinations be consistent with generally

accepted standards of care and recommendations from nonprofit health care provider associations, requiring consistent rules for both mental health and substance use disorders, and eliminating harmful barriers to care." [2025 c 227 s 1.]

Rules—2025 c 227: "The insurance commissioner may adopt rules necessary to implement this act, including requiring submission of quantitative data to determine in-operation parity compliance." [2025 c 227 s 9.]

RCW 48.43.767 Behavioral health services—Network access. By July 1, 2025, every carrier shall provide access to services provided by behavioral health support specialists in a manner sufficient to meet the network access standards set forth in rules established by the office of the insurance commissioner. [2023 c 270 s 12.]

RCW 48.43.770 Individual market health plan availability—Annual report. The commissioner shall submit an annual report to the appropriate committees of the legislature on the number of health plans available per county in the individual market. [2019 c 364 s 7.]

RCW 48.43.775 Qualified health plan participation—Reimbursement rate for other health plans. A carrier may not require a provider or facility participating in a qualified health plan under RCW 41.05.410 to, as a condition of participation in a qualified health plan under RCW 41.05.410, accept a reimbursement rate for other health plans offered by the carrier at the same rate as the provider or facility is reimbursed for a qualified health plan under RCW 41.05.410. [2019 c 364 s 8.]

RCW 48.43.780 Cap on enrollee's required payment amount for specific drugs and equipment—Cost-sharing requirements. (1)(a) Except as required in (b) of this subsection, a health plan issued or renewed on or after January 1, 2023, that provides coverage for prescription insulin drugs for the treatment of diabetes must cap the total amount that an enrollee is required to pay for a covered insulin drug at an amount not to exceed $35 per 30-day supply of the drug. Prescription insulin drugs must be covered without being subject to a deductible, and any cost sharing paid by an enrollee must be applied toward the enrollee's deductible obligation.

(b) If the federal internal revenue service removes insulin from the list of preventive care services which can be covered by a qualifying health plan for a health savings account before the deductible is satisfied, for a health plan that provides coverage for prescription insulin drugs for the treatment of diabetes and is offered as a qualifying health plan for a health savings account, the carrier must establish the plan's cost sharing for the coverage of prescription insulin for diabetes at the minimum level necessary to preserve the enrollee's ability to claim tax exempt contributions from his or her health savings account under internal revenue service laws and regulations.

(2)(a) Except as provided in (b) of this subsection, a health plan issued or renewed on or after January 1, 2025, that provides coverage for prescription asthma inhalers for the treatment of asthma shall cap the total amount that an enrollee is required to pay for at least one covered inhaled corticosteroid and at least one covered inhaled corticosteroid combination that is federal food and drug administration approved for the treatment of asthma at an amount not to exceed $35 per 30-day supply of the drug. A health plan must ensure that a covered inhaled corticosteroid and a covered inhaled corticosteroid combination is always available to a patient at the amount required by this subsection. Except as provided in (b) of this subsection, prescription asthma inhalers must be covered without being subject to a deductible, and any cost sharing paid by an enrollee must be applied toward the enrollee's deductible obligation.

(b) For a health plan that is offered as a qualifying health plan for a health savings account, the health carrier shall establish the plan's cost sharing for asthma inhalers that are not on the federal internal revenue service's list of preventive care services at the minimum level necessary to preserve the enrollee's ability to claim tax exempt contributions and withdrawals from the enrollee's health savings account under internal revenue service laws and regulations. If the federal internal revenue service removes asthma inhalers from the list of preventive care services which can be covered by a qualifying health plan for a health savings account before the deductible is satisfied, for a health plan that provides coverage for prescription asthma inhalers for the treatment of asthma and is offered as a qualifying health plan for a health savings account, the carrier shall establish the plan's cost sharing for the coverage of prescription asthma inhalers at the minimum level necessary to preserve the enrollee's ability to claim tax exempt contributions from the enrollee's health savings account under internal revenue service laws and regulations.

(3)(a) Except as provided in (b) of this subsection, a health plan issued or renewed on or after January 1, 2025, that provides coverage for prescription epinephrine autoinjectors for the treatment of allergic reaction shall cap the total amount that an enrollee is required to pay for at least one covered epinephrine autoinjector product containing at least two autoinjectors at an amount not to exceed $35. A health plan must ensure that a covered epinephrine autoinjector is always available to a patient at the amount required by this subsection. Except as provided in (b) of this subsection, prescription epinephrine autoinjectors must be covered without being subject to a deductible, and any cost sharing paid by an enrollee must be applied toward the enrollee's deductible obligation.

(b) For a health plan that is offered as a qualifying health plan for a health savings account, the health carrier shall establish the plan's cost sharing for epinephrine autoinjectors at the minimum level necessary to preserve the enrollee's ability to claim tax exempt contributions and withdrawals from the enrollee's health savings account under internal revenue service laws and regulations. If the federal internal revenue service adds epinephrine autoinjectors to the list of preventive care services which can be covered by a qualifying health plan for a health savings account before the deductible is satisfied, coverage must be provided as described in (a) of this subsection without being subject to the deductible.

(4) The office of the insurance commissioner must provide written notice of any changes in internal revenue service guidance regarding

any prescription drug covered in this section to affected parties, the chief clerk of the house of representatives, the secretary of the senate, the office of the code reviser, and others as deemed appropriate by the office.

(5) To the extent not prohibited under this section, health plans may apply drug utilization management strategies to prescription drugs covered under subsections (2) and (3) of this section. [2024 c 226 s 1; 2023 c 16 s 1; 2022 c 10 s 1. Prior: 2020 c 346 s 5; 2020 c 245 s 1.]

Effective date—2022 c 10 s 1: "Section 1 of this act takes effect January 1, 2023." [2022 c 10 s 3.]

Intent—2020 c 346: See note following RCW 70.14.165.

RCW 48.43.790 Behavioral services—Next-day appointments. Health plans issued or renewed on or after January 1, 2023, must make next-day appointments available to enrollees experiencing urgent, symptomatic behavioral health conditions to receive covered behavioral health services. The appointment may be with a licensed provider other than a licensed behavioral health professional, as long as that provider is acting within their scope of practice, and may be provided through telemedicine consistent with RCW 48.43.735. Need for urgent symptomatic care is associated with the presentation of behavioral health signs or symptoms that require immediate attention, but are not emergent. [2021 c 302 s 106.]

Findings—Intent—2021 c 302: See note following RCW 71.24.890.

RCW 48.43.795 Qualified health plans—Acceptance of premium and cost-sharing assistance. For qualified health plans offered on the exchange, a carrier shall:

(1) Accept payments for enrollee premiums or cost-sharing assistance under RCW 43.71.110 or as part of a sponsorship program under RCW 43.71.030(4). Nothing in this subsection expands or restricts the types of sponsorship programs authorized under state and federal law;

(2) Clearly communicate premium assistance amounts to enrollees as part of the invoicing and payment process; and

(3) Accept and process enrollment and payment data transferred by the exchange in a timely manner. [2021 c 246 s 4.]

RCW 48.43.800 Primary care expenditures reporting—Review. (1) The commissioner may require health carriers to annually report primary care expenditures in previous calendar years or anticipated for upcoming calendar years.

(2) The commissioner may determine the form and content of carrier primary care expenditure reporting. In developing the form and content for reporting, the commissioner shall consider the definition of primary care expenditures and any primary care expenditure targets established under RCW 70.390.080 as well as primary care expenditure reporting systems implemented by the health care authority for medical

assistance and employee benefits coverage administered under chapter 41.05 or 74.09 RCW.

(3) Primary care expenditure reports submitted by carriers under this section are public information. [2025 c 6 s 1; 2022 c 155 s 2.]

RCW 48.43.805 Prescription drug upper payment limit—Rules. (1) For health plans issued or renewed on or after January 1, 2024, if the prescription drug affordability board, as established in chapter 70.405 RCW, establishes an upper payment limit for a prescription drug pursuant to RCW 70.405.050, a carrier must provide sufficient information, as determined by the commissioner, to indicate that reimbursement for a claim for that prescription drug will not exceed the upper payment limit for the drug established by the board.

(2) The commissioner may adopt any rules necessary to implement this section. [2022 c 153 s 10.]

RCW 48.43.810 Biomarker testing—Standards—Construction. (1) Health plans issued or renewed on or after January 1, 2023, shall exempt an enrollee from prior authorization requirements for coverage of biomarker testing for either of the following:

(a) Stage 3 or 4 cancer; or

(b) Recurrent, relapsed, refractory, or metastatic cancer.

(2) For purposes of this section, "biomarker test" means a single or multigene diagnostic test of the cancer patient's biospecimen, such as tissue, blood, or other bodily fluids, for DNA, RNA, or protein alterations, including phenotypic characteristics of a malignancy, to identify an individual with a subtype of cancer, in order to guide patient treatment.

(3) For purposes of this section, biomarker testing must be:

(a) Recommended in the latest version of nationally recognized guidelines or biomarker compendia, such as those published by the national comprehensive cancer network;

(b) Approved by the United States food and drug administration or a validated clinical laboratory test performed in a clinical laboratory certified under the clinical laboratory improvement amendments or in an alternative laboratory program approved by the centers for medicare and medicaid services;

(c) A covered service; and

(d) Prescribed by an in-network provider.

(4) This section does not limit, prohibit, or modify an enrollee's rights to biomarker testing as part of an approved clinical trial under chapter 69.77 RCW.

(5) Nothing in this section may be construed to mandate coverage of a health care service.

(6) Nothing in this section prohibits a health plan from requiring a biomarker test prior to approving a drug or treatment.

(7) This section does not limit an enrollee's rights to access individual gene tests. [2022 c 123 s 1.]

RCW 48.43.815 Donor human milk—Standards. (1) For group health plans other than small group health plans issued or renewed on or after January 1, 2023, a health carrier shall provide coverage for medically necessary donor human milk for inpatient use when ordered by

a licensed health care provider with prescriptive authority or an international board certified lactation consultant certified by the international board of lactation consultant examiners for an infant who is medically or physically unable to receive maternal human milk or participate in chest feeding or whose parent is medically or physically unable to produce maternal human milk in sufficient quantities or caloric density or participate in chest feeding, if the infant meets at least one of the following criteria:

(a) An infant birth weight of below 2,500 grams;

(b) An infant gestational age equal to or less than 34 weeks;

(c) Infant hypoglycemia;

(d) A high risk for development of necrotizing enterocolitis, bronchopulmonary dysplasia, or retinopathy of prematurity;

(e) A congenital or acquired gastrointestinal condition with long-term feeding or malabsorption complications;

(f) Congenital heart disease requiring surgery in the first year of life;

(g) An organ or bone marrow transplant;

(h) Sepsis;

(i) Congenital hypotonias associated with feeding difficulty or malabsorption;

(j) Renal disease requiring dialysis in the first year of life;

(k) Craniofacial anomalies;

(l) An immunologic deficiency;

(m) Neonatal abstinence syndrome;

(n) Any other serious congenital or acquired condition for which the use of pasteurized donor human milk and donor human milk derived products is medically necessary and supports the treatment and recovery of the child; or

(o) Any baby still inpatient within 72 hours of birth without sufficient human milk available.

(2) Donor human milk covered under this section must be obtained from a milk bank that meets minimum standards adopted by the department of health pursuant to RCW 43.70.645.

(3) For purposes of this section:

(a) "Donor human milk" means human milk that has been contributed to a milk bank by one or more donors.

(b) "Milk bank" means an organization that engages in the procurement, processing, storage, distribution, or use of human milk contributed by donors.

(4) The commissioner may adopt any rules necessary to implement this section. [2022 c 236 s 1.]

RCW 48.43.820 Consolidated appropriations act enforcement—Implementation of federal regulations. The commissioner is authorized to enforce provisions of P.L. 116-260 (enacted December 27, 2020, as the consolidated appropriations act of 2021) and implementing federal regulations in effect on March 31, 2022, that are applicable to or regulate the conduct of carriers issuing health plans or grandfathered health plans to residents of Washington state on or after January 1, 2022. In addition to the enforcement actions authorized under RCW 48.02.080, the commissioner may impose a civil monetary penalty in an amount not to exceed $100 for each day for each individual with respect to which a failure to comply with these provisions occurs. [2022 c 263 s 5.]

Effective date—2022 c 263: See note following RCW 43.371.100.

RCW 48.43.825 Certified peer support specialist services—Network access standards. By July 1, 2026, each carrier shall provide access to services provided by certified peer support specialists and certified peer support specialist trainees in a manner sufficient to meet the network access standards set forth in rules established by the office of the insurance commissioner. [2025 c 360 s 16; 2023 c 469 s 16.]

RCW 48.43.830 Prior authorization—Standards—Denials—Application—Rules. ***(Effective until January 1, 2027.)*** (1) Each carrier offering a health plan issued or renewed on or after January 1, 2024, shall comply with the following standards related to prior authorization for health care services and prescription drugs:

(a) The carrier shall meet the following time frames for prior authorization determinations and notifications to a participating provider or facility that submits the prior authorization request through an electronic prior authorization process, as designated by each carrier:

(i) For electronic standard prior authorization requests, the carrier shall make a decision and notify the provider or facility of the results of the decision within three calendar days, excluding holidays, of submission of an electronic prior authorization request by the provider or facility that contains the necessary information to make a determination. If insufficient information has been provided to the carrier to make a decision, the carrier shall request any additional information from the provider or facility within one calendar day of submission of the electronic prior authorization request.

(ii) For electronic expedited prior authorization requests, the carrier shall make a decision and notify the provider or facility of the results of the decision within one calendar day of submission of an electronic prior authorization request by the provider or facility that contains the necessary information to make a determination. If insufficient information has been provided to the carrier to make a decision, the carrier shall request any additional information from the provider or facility within one calendar day of submission of the electronic prior authorization request.

(b) The carrier shall meet the following time frames for prior authorization determinations and notifications to a participating provider or facility that submits the prior authorization request through a process other than an electronic prior authorization process:

(i) For nonelectronic standard prior authorization requests, the carrier shall make a decision and notify the provider or facility of the results of the decision within five calendar days of submission of a nonelectronic prior authorization request by the provider or facility that contains the necessary information to make a determination. If insufficient information has been provided to the carrier to make a decision, the carrier shall request any additional information from the provider or facility within five calendar days of submission of the nonelectronic prior authorization request.

(ii) For nonelectronic expedited prior authorization requests, the carrier shall make a decision and notify the provider or facility of the results of the decision within two calendar days of submission of a nonelectronic prior authorization request by the provider or facility that contains the necessary information to make a determination. If insufficient information has been provided to the carrier to make a decision, the carrier shall request any additional information from the provider or facility within one calendar day of submission of the nonelectronic prior authorization request.

(c) In any instance in which a carrier has determined that a provider or facility has not provided sufficient information for making a determination under (a) and (b) of this subsection, a carrier may establish a specific reasonable time frame for submission of the additional information. This time frame must be communicated to the provider and enrollee with a carrier's request for additional information.

(d) The carrier's prior authorization requirements must be described in detail and written in easily understandable language. The carrier shall make its most current prior authorization requirements and restrictions, including the written clinical review criteria, available to providers and facilities in an electronic format upon request. The prior authorization requirements must be based on peer-reviewed clinical review criteria. The clinical review criteria must be evidence-based criteria and must accommodate new and emerging information related to the appropriateness of clinical criteria with respect to black and indigenous people, other people of color, gender, and underserved populations. The clinical review criteria must be evaluated and updated, if necessary, at least annually.

(e) When denying a prior authorization determination, the carrier shall include the credentials, board certifications, and areas of specialty of the provider who had clinical oversight over the determination in any notification sent to the health plan enrollee and provider requesting or referring the service.

(2) Carriers must post any adjustments to policies and procedures that impact the applicability of their prior authorization requirements for health care services or prescription drugs, including new applications of prior authorization, in a single location on the carrier's website. After December 30, 2030, any new application of prior authorization for health care services must be available to providers on the electronic prior authorization system or application programming interface system referenced in subsection (4) of this section.

(3)(a) Only a licensed physician or a licensed health professional working within their scope of practice may deny a prior authorization request based on medical necessity. The licensed physician or licensed health professional shall evaluate the specific clinical issues involved in the health care services requested by the requesting provider by reviewing and considering the requesting provider's recommendation, the enrollee's medical or other clinical history, as applicable, and individual clinical circumstances. Artificial intelligence shall not be the sole means used to deny, delay, or modify health care services. Algorithms may be used to process and approve prior authorization requests, but may not be used without human review to deny care based on a determination of medical necessity.

(b) A carrier that uses artificial intelligence for the purpose of prior authorization or prior authorization functions, based in

whole or in part on medical necessity, or that contracts with or otherwise works through an entity that uses artificial intelligence for the purpose of prior authorization or prior authorization functions, based in whole or in part on medical necessity, shall ensure all of the following:

(i) The artificial intelligence bases its determination on the following information, as applicable:

(A) An enrollee's medical or other clinical history, including demographic data; and

(B) Individual clinical circumstances as presented by the requesting provider;

(ii) The artificial intelligence does not base its determination solely on a group data set;

(iii) The artificial intelligence's criteria and guidelines comply with this chapter and applicable state and federal law;

(iv) The use of the artificial intelligence does not discriminate, directly or indirectly, against an enrollee in violation of state or federal law;

(v) The artificial intelligence is fairly and equitably applied, including in accordance with any applicable regulations and guidance issued by the federal department of health and human services;

(vi) The policies and procedures for using artificial intelligence are open to audit by the office of the insurance commissioner under chapter 48.37 RCW;

(vii) The artificial intelligence's performance, use, and outcomes are periodically reviewed by the carrier to maximize accuracy and reliability; and

(viii) Patient data is not used beyond its intended and stated purpose, consistent with chapter 70.02 RCW and the federal health insurance portability and accountability act of 1996, 42 U.S.C. Sec. 1320d et al., as applicable.

(4)(a) Each carrier shall establish and maintain a prior authorization application programming interface that is consistent with final rules issued by the federal centers for medicare and medicaid services and published in the federal register, and that indicates that a prior authorization denial or authorization of a service less intensive than that included in the original request is an adverse benefit determination and is subject to the carrier's grievance and appeal process under RCW 48.43.535.

(b) Each carrier shall establish and maintain an interoperable electronic process or application programming interface that automates the process for in-network providers to determine whether a prior authorization is required for a covered prescription drug. The interoperable electronic process or application programming interface must support the exchange of prior authorization requests and determinations for prescription drugs, including information on covered alternative prescription drugs, beginning January 1, 2027, and must:

(i) Allow providers to identify prior authorization information and documentation requirements;

(ii) Facilitate the exchange of prior authorization requests and determinations from its electronic health records or practice management system; and

(iii) Indicate that a prior authorization denial or authorization of a drug other than the one included in the original prior authorization request is an adverse benefit determination and is

subject to the carrier's grievance and appeal process under RCW 48.43.535.

(c) Regardless of whether federal rules related to standards for using an application programming interface to communicate prior authorization status to providers are revoked, delayed, suspended, or not finalized by the federal centers for medicare and medicaid services after February 8, 2024, the requirements of (a) of this subsection shall be enforced beginning January 1, 2027.

(d) By September 13, 2023, and at least every six months thereafter until September 13, 2026, the commissioner shall provide an update to the health care policy committees of the legislature on the development of rules and implementation guidance from the federal centers for medicare and medicaid services regarding the standards for development of application programming interfaces and interoperable electronic processes related to prior authorization functions. The updates should include recommendations, as appropriate, on whether the status of the federal rule development aligns with the provisions of chapter 382, Laws of 2023. The commissioner also shall report on any actions by the federal centers for medicare and medicaid services to exercise enforcement discretion related to the implementation and maintenance of an application programming interface for prior authorization functions. The commissioner shall consult with the health care authority, carriers, providers, and consumers on the development of these updates and any recommendations.

(5) Nothing in this section applies to prior authorization determinations made pursuant to RCW 48.43.761.

(6) This section applies to prior authorization functions carried out by health care benefit managers, as defined in RCW 48.200.020, under direct or indirect contract with a carrier.

(7) The commissioner may adopt any rules necessary to implement this section.

(8) For the purposes of this section:

(a) "Artificial intelligence" means the use of machine learning and related technologies that use data to train statistical models for the purpose of enabling computer systems to perform tasks normally associated with human intelligence or perception, such as computer vision, speech or natural language processing, and content generation. "Artificial intelligence" includes generative artificial intelligence.

(b) "Expedited prior authorization request" means a request by a provider or facility for approval of a health care service or prescription drug where:

(i) The passage of time:

(A) Could seriously jeopardize the life or health of the enrollee;

(B) Could seriously jeopardize the enrollee's ability to regain maximum function; or

(C) In the opinion of a provider or facility with knowledge of the enrollee's medical condition, would subject the enrollee to severe pain that cannot be adequately managed without the health care service or prescription drug that is the subject of the request; or

(ii) The enrollee is undergoing a current course of treatment using a nonformulary drug.

(c) "Generative artificial intelligence" means an artificial intelligence system that generates novel data or content based on a foundation model.

(d) "Machine learning" means the process by which artificial intelligence is developed using data and algorithms to draw inferences

therefrom to automatically adapt or improve its accuracy without explicit programming.

(e) "Standard prior authorization request" means a request by a provider or facility for approval of a health care service or prescription drug where the request is made in advance of the enrollee obtaining a health care service or prescription drug that is not required to be expedited. [2026 c 157 s 2; 2025 c 25 s 1; 2023 c 382 s 1.]

Expiration date—2026 c 157 ss 2 and 6: "Sections 2 and 6 of this act expire January 1, 2027." [2026 c 157 s 9.]

Finding—Intent—2026 c 157: "(1) The legislature finds that health carriers are the decision makers for the type and level of care covered for an enrollee's health care benefits and are not responsible for determining or altering an enrollee's diagnosis or treatment plan. It is not always transparent who the decision maker is or how decisions are made in determining enrollee coverage for treatment, prescription drugs, or services. Artificial intelligence is being increasingly utilized by health carriers to make or aid in decisions about medical necessity and coverage of provider-recommended treatment.

(2) It is the intent of the legislature to increase transparency in the prior authorization process for health care coverage decisions and to ensure licensed physicians and licensed health professionals remain responsible for making determinations regarding treatments, prescription drugs, and other health care services. If artificial intelligence is used to aid in the decision-making process, standards must be put in place to ensure artificial intelligence is not used to make inappropriate determinations that could impact the health of an enrollee.

(3) It is the intent of the legislature to update the protections of this act for enrollees to include managed care organizations as soon as feasible, recognizing that low-income, publicly insured Washingtonians deserve the same patient protections as higher-income, commercially insured Washingtonians." [2026 c 157 s 1.]

RCW 48.43.830 Prior authorization—Standards—Denials—Application—Rules. ***(Effective January 1, 2027.)*** (1) Each carrier offering a health plan issued or renewed on or after January 1, 2024, shall comply with the following standards related to prior authorization for health care services and prescription drugs:

(a) The carrier shall meet the following time frames for prior authorization determinations and notifications to a participating provider or facility that submits the prior authorization request through an electronic prior authorization process, as designated by each carrier:

(i) For electronic standard prior authorization requests, the carrier shall make a decision and notify the provider or facility of the results of the decision within three calendar days, excluding holidays, of submission of an electronic prior authorization request by the provider or facility that contains the necessary information to make a determination. If insufficient information has been provided to the carrier to make a decision, the carrier shall request any additional information from the provider or facility within one

calendar day of submission of the electronic prior authorization request.

(ii) For electronic expedited prior authorization requests, the carrier shall make a decision and notify the provider or facility of the results of the decision within one calendar day of submission of an electronic prior authorization request by the provider or facility that contains the necessary information to make a determination. If insufficient information has been provided to the carrier to make a decision, the carrier shall request any additional information from the provider or facility within one calendar day of submission of the electronic prior authorization request.

(b) The carrier shall meet the following time frames for prior authorization determinations and notifications to a participating provider or facility that submits the prior authorization request through a process other than an electronic prior authorization process:

(i) For nonelectronic standard prior authorization requests, the carrier shall make a decision and notify the provider or facility of the results of the decision within five calendar days of submission of a nonelectronic prior authorization request by the provider or facility that contains the necessary information to make a determination. If insufficient information has been provided to the carrier to make a decision, the carrier shall request any additional information from the provider or facility within five calendar days of submission of the nonelectronic prior authorization request.

(ii) For nonelectronic expedited prior authorization requests, the carrier shall make a decision and notify the provider or facility of the results of the decision within two calendar days of submission of a nonelectronic prior authorization request by the provider or facility that contains the necessary information to make a determination. If insufficient information has been provided to the carrier to make a decision, the carrier shall request any additional information from the provider or facility within one calendar day of submission of the nonelectronic prior authorization request.

(c) In any instance in which a carrier has determined that a provider or facility has not provided sufficient information for making a determination under (a) and (b) of this subsection, a carrier may establish a specific reasonable time frame for submission of the additional information. This time frame must be communicated to the provider and enrollee with a carrier's request for additional information.

(d) The carrier's prior authorization requirements must be described in detail and written in easily understandable language. The carrier shall make its most current prior authorization requirements and restrictions, including the written clinical review criteria, available to providers and facilities in an electronic format upon request. The prior authorization requirements must be based on peer-reviewed clinical review criteria. The clinical review criteria must be evidence-based criteria and must accommodate new and emerging information related to the appropriateness of clinical criteria with respect to black and indigenous people, other people of color, gender, and underserved populations. The clinical review criteria must be evaluated and updated, if necessary, at least annually. Clinical review criteria used for purposes of reviewing and decided upon prior authorization requests related to mental health and substance use disorder services, as defined in RCW 48.43.766, must meet the requirements of RCW 48.43.766.

(e) When denying a prior authorization determination, the carrier shall include the credentials, board certifications, and areas of specialty of the provider who had clinical oversight over the determination in any notification sent to the health plan enrollee and provider requesting or referring the service.

(2) Carriers must post any adjustments to policies and procedures that impact the applicability of their prior authorization requirements for health care services or prescription drugs, including new applications of prior authorization, in a single location on the carrier's website. After December 30, 2030, any new application of prior authorization for health care services must be available to providers on the electronic prior authorization system or application programming interface system.

(3)(a) Only a licensed physician or a licensed health professional working within their scope of practice may deny a prior authorization request based on medical necessity. The licensed physician or licensed health professional shall evaluate the specific clinical issues involved in the health care services requested by the requesting provider by reviewing and considering the requesting provider's recommendation, the enrollee's medical or other clinical history, as applicable, and individual clinical circumstances. Artificial intelligence shall not be the sole means used to deny, delay, or modify health care services. Algorithms may be used to process and approve prior authorization requests, but may not be used without human review to deny care based on a determination of medical necessity.

(b) A carrier that uses artificial intelligence for the purpose of prior authorization or prior authorization functions, based in whole or in part on medical necessity, or that contracts with or otherwise works through an entity that uses artificial intelligence for the purpose of prior authorization or prior authorization functions, based in whole or in part on medical necessity, shall ensure all of the following:

(i) The artificial intelligence bases its determination on the following information, as applicable:

(A) An enrollee's medical or other clinical history, including demographic data; and

(B) Individual clinical circumstances as presented by the requesting provider;

(ii) The artificial intelligence does not base its determination solely on a group data set;

(iii) The artificial intelligence's criteria and guidelines comply with this chapter and applicable state and federal law;

(iv) The use of the artificial intelligence does not discriminate, directly or indirectly, against an enrollee in violation of state or federal law;

(v) The artificial intelligence is fairly and equitably applied, including in accordance with any applicable regulations and guidance issued by the federal department of health and human services;

(vi) The policies and procedures for using artificial intelligence are open to audit by the office of the insurance commissioner under chapter 48.37 RCW;

(vii) The artificial intelligence's performance, use, and outcomes are periodically reviewed by the carrier to maximize accuracy and reliability; and

(viii) Patient data is not used beyond its intended and stated purpose, consistent with chapter 70.02 RCW and the federal health

insurance portability and accountability act of 1996, 42 U.S.C. Sec. 1320d et al., as applicable.

(4)(a) Each carrier shall establish and maintain a prior authorization application programming interface that is consistent with final rules issued by the federal centers for medicare and medicaid services and published in the federal register, and that indicates that a prior authorization denial or authorization of a service less intensive than that included in the original request is an adverse benefit determination and is subject to the carrier's grievance and appeal process under RCW 48.43.535.

(b) Each carrier shall establish and maintain an interoperable electronic process or application programming interface that automates the process for in-network providers to determine whether a prior authorization is required for a covered prescription drug. The interoperable electronic process or application programming interface must support the exchange of prior authorization requests and determinations for prescription drugs, including information on covered alternative prescription drugs, beginning January 1, 2027, and must:

(i) Allow providers to identify prior authorization information and documentation requirements;

(ii) Facilitate the exchange of prior authorization requests and determinations from its electronic health records or practice management system; and

(iii) Indicate that a prior authorization denial or authorization of a drug other than the one included in the original prior authorization request is an adverse benefit determination and is subject to the carrier's grievance and appeal process under RCW 48.43.535.

(c) Regardless of whether federal rules related to standards for using an application programming interface to communicate prior authorization status to providers are revoked, delayed, suspended, or not finalized by the federal centers for medicare and medicaid services after February 8, 2024, the requirements of (a) of this subsection shall be enforced beginning January 1, 2027.

(d) By September 13, 2023, and at least every six months thereafter until September 13, 2026, the commissioner shall provide an update to the health care policy committees of the legislature on the development of rules and implementation guidance from the federal centers for medicare and medicaid services regarding the standards for development of application programming interfaces and interoperable electronic processes related to prior authorization functions. The updates should include recommendations, as appropriate, on whether the status of the federal rule development aligns with the provisions of chapter 382, Laws of 2023. The commissioner also shall report on any actions by the federal centers for medicare and medicaid services to exercise enforcement discretion related to the implementation and maintenance of an application programming interface for prior authorization functions. The commissioner shall consult with the health care authority, carriers, providers, and consumers on the development of these updates and any recommendations.

(5) Nothing in this section applies to prior authorization determinations made pursuant to RCW 48.43.761.

(6) This section applies to prior authorization functions carried out by health care benefit managers, as defined in RCW 48.200.020, under direct or indirect contract with a carrier.

(7) The commissioner may adopt any rules necessary to implement this section.

(8) For the purposes of this section:

(a) "Artificial intelligence" means the use of machine learning and related technologies that use data to train statistical models for the purpose of enabling computer systems to perform tasks normally associated with human intelligence or perception, such as computer vision, speech or natural language processing, and content generation. "Artificial intelligence" includes generative artificial intelligence.

(b) "Expedited prior authorization request" means a request by a provider or facility for approval of a health care service or prescription drug where:

(i) The passage of time:

(A) Could seriously jeopardize the life or health of the enrollee;

(B) Could seriously jeopardize the enrollee's ability to regain maximum function; or

(C) In the opinion of a provider or facility with knowledge of the enrollee's medical condition, would subject the enrollee to severe pain that cannot be adequately managed without the health care service or prescription drug that is the subject of the request; or

(ii) The enrollee is undergoing a current course of treatment using a nonformulary drug.

(c) "Generative artificial intelligence" means an artificial intelligence system that generates novel data or content based on a foundation model.

(d) "Machine learning" means the process by which artificial intelligence is developed using data and algorithms to draw inferences therefrom to automatically adapt or improve its accuracy without explicit programming.

(e) "Standard prior authorization request" means a request by a provider or facility for approval of a health care service or prescription drug where the request is made in advance of the enrollee obtaining a health care service or prescription drug that is not required to be expedited. [2026 c 157 s 3. Prior: 2025 c 227 s 8; 2025 c 25 s 1; 2023 c 382 s 1.]

Effective date—2026 c 157 ss 3 and 7: "Sections 3 and 7 of this act take effect January 1, 2027." [2026 c 157 s 10.]

Finding—Intent—2026 c 157: See note following RCW 48.43.830.

Effective date—2025 c 227 ss 1-8: See note following RCW 48.43.766.

Findings—Intent—Rules—2025 c 227: See notes following RCW 48.43.766.

RCW 48.43.835 Physician assistants—Coverage. This chapter authorizes carriers to reimburse employers of physician assistants for covered services rendered by licensed physician assistants. Payment for services within the physician assistant's scope of practice must be made when ordered or performed by a physician assistant if the same services would have been covered if ordered or performed by a physician. Physician assistants or their employers, who are billing on

behalf of the physician assistant, are authorized to bill for and receive direct payment for the services delivered by physician assistants. A carrier may not impose a practice, education, or collaboration requirement that is inconsistent with or more restrictive than state laws or regulations governing physician assistants. [2024 c 62 s 11.]

Effective date—2024 c 62 ss 1-8, 10-18, 20-26, 28, and 30-32: See note following RCW 18.71A.010.

Intent—2024 c 62: See note following RCW 18.71A.020.

RCW 48.43.840 Prosthetic limbs and custom orthotic braces—Coverage—Reporting. (1) Except as provided in subsection (9) of this section, a health plan offered in the large group or small group market that is issued or renewed on or after January 1, 2026, must include coverage for one or more prostheses per limb and custom orthotic braces per limb when medically necessary for the enrollee to participate in any of the following:

(a) Completing activities of daily living or essential job-related activities; and

(b) Performing physical activities, including but not limited to running, biking, swimming, and strength training, for maximizing the enrollee's lower limb function, upper limb function, or both.

(2) The coverage required under this section must also include coverage for:

(a) Materials, components, and related services necessary to use the devices for their intended purposes;

(b) Instruction to the enrollee on using the devices; and

(c) Reasonable repair or replacement of the devices.

(3)(a) Coverage under this section includes coverage for the replacement or repair of a prosthetic limb or custom orthotic brace or for the replacement or repair of any part of such devices, without regard to continuous use or useful lifetime restrictions, if medically necessary because:

(i) Of a change in the physiological condition of the patient;

(ii) Of an irreparable change in the condition of the device or a part of the device; or

(iii) The device, or any part of the device, requires repairs and the cost of such repairs would be more than 60 percent of the cost of a replacement device or of the part being replaced.

(b) Confirmation from the prescribing health care provider may be required if the prosthetic limb or custom orthotic brace or part being replaced is less than three years old.

(4) A health plan offered in the large group or small group market may not deny coverage for a prosthetic limb or custom orthotic brace for an enrollee with a disability if health care services would otherwise be covered for a nondisabled person seeking medical or surgical intervention to restore or maintain the ability to perform the same physical activity.

(5) For coverage under this section, a health plan offered in the large group or small group market may apply normal utilization management and prior authorization practices. Any denial of coverage must be issued in writing with an explanation for determining coverage was not medically necessary.

(6) A health plan offered in the large group or small group market shall provide payment for coverage under this section that is at least equal to the payment and coverage for prosthetic limbs and custom orthotic braces provided under federal laws and regulations for the aged and disabled pursuant to 42 U.S.C. Sec. 1395k, 1395l, and 1395m and 42 C.F.R. Sec. 414.202, 414.210, 414.228, and 410.100.

(7) No later than July 1, 2028, each carrier that issues a health plan subject to this section shall report to the office of the insurance commissioner, in a form and manner determined by the commissioner, the number of claims and the total amount of claims paid in the state for the services required by this section for plan years 2026 and 2027. The commissioner shall aggregate this data by plan year in a report and submit the report to the relevant committees of the legislature by December 1, 2028.

(8) For the purposes of this section:

(a) "Prosthetic limb" or "prosthesis" means an external medical device that is used to replace or restore a missing limb or portion of a limb and is deemed medically necessary for an individual with a mobility impairing health condition or disability.

(b) "Custom orthotic brace" means an external medical device that is custom-fabricated or custom-fitted to support, correct, or alleviate neuromuscular or musculoskeletal dysfunction, disease, injury, or deformity, is needed to improve the safety and efficiency of functional mobility, is patient-specific based on the patient's unique physical condition, and is deemed medically necessary for individuals with a mobility impairing health condition or disability.

(9) This section does not apply to health plans offered in the individual market or to self-insured or fully insured large group health plans offered to public employees and school employees under chapter 41.05 RCW. [2025 c 96 s 1.]

RCW 48.43.845 Prescription hormone therapy—Coverage. (1) A health plan issued or renewed on or after January 1, 2026, that includes coverage for prescription hormone therapy must provide reimbursement for a 12-month refill of covered prescription hormone therapy obtained at one time by the enrollee, unless the enrollee requests a smaller supply, the prescribing provider instructs that the enrollee must receive a smaller supply, or the prescription hormone therapy is a controlled substance. The 12-month refill requirement only applies to prescription hormone therapy that is able to be safely stored at room temperature without refrigeration. If the prescription hormone therapy is a controlled substance, the health plan must provide reimbursement for the maximum refill allowed under state and federal law to be obtained at one time by the enrollee. Any dispensing practices required by the health plan must follow clinical guidelines for appropriate prescribing and dispensing to ensure the health of the patient while maximizing access to effective prescription hormone therapy.

(2) Nothing in this section prohibits a health plan from limiting refills that may be obtained in the last quarter of the plan year if a 12-month supply of the prescription hormone therapy has already been dispensed during the plan year.

(3) Nothing in this section prohibits a prescribing provider from temporarily limiting refills that may be obtained to a 90-day supply at one time if the prescription hormone therapy is experiencing an

acute dispensing shortage during the plan year provided limits must be rescinded at first opportunity of a regularly reinstated, sustainable supply.

(4) To the extent not otherwise prohibited under this section or state or federal law, health plans may apply drug utilization management strategies to prescription drugs covered under subsection (1) of this section.

(5) For purposes of this section, "prescription hormone therapy" means all drugs approved by the United States food and drug administration that are used to medically suppress, increase, or replace hormones that the body is not producing at intended levels. Prescription hormone therapy does not include glucagon-like peptide-1 and glucagon-like peptide-1 receptor agonists. [2025 c 171 s 1.]

RCW 48.43.850 HIV antiviral drugs—Prior authorization. (1) For health plans issued or renewed on or after January 1, 2027, except as provided in subsection (2) of this section, a health carrier shall provide coverage for all federal food and drug administration approved HIV antiviral drugs without prior authorization, step therapy, or any other utilization management protocols.

(2) If the United States food and drug administration has approved one or more therapeutic equivalents of a drug, device, or product for the prevention or treatment of HIV, this section does not require a health plan to cover all of the therapeutically equivalent versions without prior authorization, step therapy, or any other utilization management protocols, if at least one therapeutically equivalent version is covered without prior authorization, step therapy, or any other utilization management protocols. [2026 c 48 s 1.]

CONSTRUCTION

RCW 48.43.902 Effective date—1996 c 312. This act shall take effect July 1, 1996. [1996 c 312 s 8.]

RCW 48.43.904 Construction—Chapter applicable to state registered domestic partnerships—2009 c 521. For the purposes of this chapter, the terms spouse, marriage, marital, husband, wife, widow, widower, next of kin, and family shall be interpreted as applying equally to state registered domestic partnerships or individuals in state registered domestic partnerships as well as to marital relationships and married persons, and references to dissolution of marriage shall apply equally to state registered domestic partnerships that have been terminated, dissolved, or invalidated, to the extent that such interpretation does not conflict with federal law. Where necessary to implement chapter 521, Laws of 2009, gender-specific terms such as husband and wife used in any statute, rule, or other law shall be construed to be gender neutral, and applicable to individuals in state registered domestic partnerships. [2009 c 521 s 125.]