

# Chapter 284-44 WAC

## HEALTH CARE SERVICES CONTRACTORS—AGENTS— CONTRACT FORMATS—STANDARDS

### WAC

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### DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

284-44-020	Agents, licensing or appointment required. [Order R-74-1, § 284-44-020, filed 6/4/74, effective 8/1/74.] Repealed by WSR 84-08-001 (Order R 84-1), filed 3/22/84. Statutory Authority: RCW 48.44.050.	284-44-180
284-44-060	Minimum filing requirements. [Order R-74-1, § 284-44-060, filed 6/4/74, effective 8/1/74.] Repealed by WSR 81-15-070 (Order R 81-3), filed 7/21/81, effective 10/1/81. Statutory Authority: RCW 48.44.050.	284-44-190
284-44-100	Authority and purpose. [Statutory Authority: RCW 48.44.050. WSR 81-15-070 (Order R 81-3), § 284-44-100, filed 7/21/81, effective 10/1/81.] Repealed by WSR 98-04-011 (Matter No. R 97-2), filed 1/23/98, effective 3/1/98. Statutory Authority: RCW 48.02.060, 48.44-050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066.	284-44-200
284-44-110	Applicability and scope. [Statutory Authority: RCW 48.44.050. WSR 81-15-070 (Order R 81-3), § 284-44-110, filed 7/21/81, effective 10/1/81.] Repealed by WSR 98-04-011 (Matter No. R 97-2), filed 1/23/98, effective 3/1/98. Statutory Authority: RCW 48.02.060, 48.44-050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066.	284-44-210
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284-44-140	General contents of all filings. [Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.18.100, 48.19.040, 48.19.050, 48.19.070, 48.20.012, 48.21-	

- Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243.
- 284-44-345 Requirement to file annual statement—Form of annual statement—Requirement to file quarterly statements—Authority to require filing of monthly financial statements—Compliance with NAIC instructions required. [Statutory Authority: RCW 48.02.060 (3)(a) and 48.44.050. WSR 92-22-095 (Order R 92-20), § 284-44-345, filed 11/3/92, effective 12/4/92.] Repealed by WSR 96-17-079 (Matter No. R 95-18), filed 8/21/96, effective 9/21/96. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200.
- 284-44-360 Effective date. [Statutory Authority: RCW 48.44.050. WSR 82-23-010 (Order R 82-6), § 284-44-360, filed 11/5/82, effective 1/1/83.] Repealed by WSR 98-11-088 (Matter No. R 98-5), filed 5/20/98, effective 6/20/98. Statutory Authority: RCW 48.02.060.
- 284-44-400 Assessments for examination costs. [Statutory Authority: RCW 48.44.050. WSR 84-08-001 (Order R 84-1), § 284-44-400, filed 3/22/84.] Repealed by WSR 91-07-053 (Order R 91-1), filed 3/19/91, effective 4/19/91. Statutory Authority: RCW 48.02.060.
- 284-44-410 Form for reporting number of persons entitled to services. [Statutory Authority: RCW 48.44.050. WSR 84-08-001 (Order R 84-1), § 284-44-410, filed 3/22/84.] Repealed by WSR 98-04-005 (Matter No. R 97-3), filed 1/22/98, effective 2/22/98. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.-200 and 48.46.243.

**WAC 284-44-010 Title and application.** (1) This regulation, WAC 284-44-010 through 284-44-070, is promulgated pursuant to RCW 48.44.050 and 48.44.020, and may be cited as the "Washington state health care service contractor regulation."

(2) This regulation, chapter 284-44 WAC, shall apply to every health care service contractor (hereinafter referred to as "contractor") registered pursuant to RCW 48.44.015.

[Order R-74-1, § 284-44-010, filed 6/4/74, effective 8/1/74.]

**WAC 284-44-015 Discretionary clauses prohibited.**

(1) No contract may contain a discretionary clause. "Discretionary clause" means a provision that purports to reserve discretion to a carrier, its agents, officers, employees, or designees in interpreting the terms of a contract or deciding eligibility for benefits, or requires deference to such interpretations or decisions, including a provision that provides for any of the following results:

- (a) That the carrier's interpretation of the terms of the contract is binding;
- (b) That the carrier's decision regarding eligibility or continued receipt of benefits is binding;
- (c) That the carrier's decision to deny, modify, reduce or terminate payment, coverage, authorization, or provision of health care service or benefits, is binding;
- (d) That there is no appeal or judicial remedy from a denial of a claim;
- (e) That deference must be given to the carrier's interpretation of the contract or claim decision; and
- (f) That the standard of review of a carrier's interpretation of the contract or claim decision is other than a de novo review.

(2) Nothing in this section prohibits a carrier from including a provision in a contract that informs an insured that as part of its routine operations the carrier applies the terms of its contracts for making decisions, including making

determination regarding eligibility, receipt of benefits and claims, or explaining its policies, procedures, and processes.

[Statutory Authority: RCW 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.200, 48.02.060, 48.18.110, 48.44.020, and 48.46.060. WSR 09-16-128 (Matter No. R 2008-25), § 284-44-015, filed 8/5/09, effective 9/5/09.]

**WAC 284-44-030 Contract format required.** Every health care service contract issued or renewed after December 31, 1974 shall conform to the following format standards:

(1) The style, arrangement and over-all appearance of the contract shall give no undue prominence to any portion of the text, and every printed portion of the text of the contract and of any endorsements or attached papers shall be plainly printed in type of a style in general use, the size of which shall be uniform and not less than eight-point with a lower-case unspaced alphabet length not less than one hundred and twenty-point. The "text" shall include all printed matter except the name and address of the contractor, name or title of the policy, a brief description if any, and captions and sub-captions.

(2) The exceptions, reductions, and limitations (as those terms are defined in WAC 284-50-030) shall be set forth in the contract either included with the benefit provisions to which they apply, or under an appropriate caption such as "exclusions," "exceptions," or "exceptions and limitations," except that if an exception, reduction, or limitation specifically applies only to a particular benefit under the contract, a statement of such exception, reduction, or limitation shall be included with the benefit provision to which it applies.

(3) Each form, including riders and endorsements, shall be identified by a form number in the lower left hand corner of the first page thereof.

(4) It shall contain no provision purporting to make any portion of the contractor's charter, rules, constitution, articles of incorporation, or bylaws a part of the contract if the effect of such provision would be to incorporate into the contract exceptions, reductions, limitations or additional charges not otherwise set forth in the contract, unless such portion is set forth in full in the contract, or is attached thereto.

[Order R-74-1, § 284-44-030, filed 6/4/74, effective 8/1/74.]

**WAC 284-44-040 Contract standards required.**

Every health care service contract issued or renewed after December 31, 1974, shall conform to the following standards:

(1) A contract shall not unreasonably limit benefits to a specified period of time. For example, a provision that services for a particular condition will be covered only for one year without regard to the amount of the benefits paid or provided, is not acceptable. Contracts may, however, limit major medical benefits, supplemental accident benefits, and diagnostic X-ray and laboratory benefits to a reasonable period of time. Benefits may also be limited to a reasonable maximum dollar amount, and, in the case of doctor calls, to a reasonable number of calls over a stated period of time.

(2) A contract must provide that reasonable benefits will be restored upon each renewal of the contract or upon a calendar year basis or that such benefits be reasonably continuous. It is not required that a major medical contract with a lifetime maximum benefit be renewed or restored.

(3) A contract shall not contain any provision which gives or purports to give the contractor, its agent, officer, employee, or designee the authority to make a decision relative to the contract, or coverage or claims thereunder, which is final and binding on the subscriber or beneficiary. That is, in the case of controversy arising out of the contract, a subscriber shall not be denied the right to have the controversy determined by legal or arbitration proceedings.

(4) A contract shall not contain any provision which requires a subscriber to purchase a "monthly treatment order." This prohibits provisions that require a subscriber to pay a special charge, distinct from the pre-payment fees required of all subscribers and coinsurance deductible amounts, in order to obtain advance authorization for treatment or services.

(5) If a contract restricts treatment to services by the contractor's participants or agents, a reasonable provision shall be included to allow emergency treatment consistent with the scope of the benefits regularly provided by the contract.

(6) If a contract provides maternity benefits, there shall be no waiting period for maternity benefits in advance of a conception occurring while the contract is in force.

(7) No contract shall contain any provision that unreasonably restricts or delays the payment of benefits payable under the contract. Delays are not justified because the expenses incurred, or the services received, resulted from an act or omission of a third party.

(8) Every contract shall provide for a grace period of not less than ten days following the due date for the payment of the subscriber's dues, fees, or premium, during which grace period the contract shall continue in force. If payment is not made within the grace period, the contract may be terminated as of the due date of payment rather than at the end of the grace period.

(9) No contract other than a conversion contract issued pursuant to chapter 284-52 WAC shall contain any provision having the effect of coordinating benefits with other health care service contracts, health maintenance agreements, or disability insurance policies, except that group contracts may provide for coordination of benefits pursuant to chapter 284-51 WAC, and except that any contract may provide for coordination with respect to governmental programs.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. WSR 84-19-055 (Order R 84-4), § 284-44-040, filed 9/19/84; Order R-74-1, § 284-44-040, filed 6/4/74, effective 8/1/74.]

**WAC 284-44-042 Temporomandibular joint disorders—Specified offer of coverage required—Terms of specified offer defined—Proof of offer must be maintained—Discrimination prohibited—Terms defined.** (1) Pursuant to RCW 48.44.460, each offer of new or renewal group coverage made on or after January 1, 1993, must include one or more offers of optional coverage for the treatment of temporomandibular joint disorders. Health care service contractors are encouraged to exercise broad flexibility in designing benefits for these optional temporomandibular joint disorder coverage offerings. However, compliance with the statute shall be demonstrated only when one of the optional temporomandibular joint disorder coverage offerings provides benefits as follows:

(9/11/17)

(a) Offers limited to only medical coverage shall provide coverage for medical services related to the treatment of temporomandibular joint disorders in the amount of one thousand dollars per covered individual, after the application of deductibles, coinsurance, and copayments, in any calendar year, and a lifetime benefit of five thousand dollars per covered individual, after the application of deductibles, coinsurance, and copayments. Other than the benefit amount, coverage for medical services shall be the same as are generally provided in the health care service contract for other injuries or musculoskeletal disorders. The coverage provisions may require:

(i) That services either be rendered or referred by the covered individual's primary care physician; and

(ii) A second opinion, provided that the covered individual shall not be financially responsible for any costs relating to this second opinion and that such costs shall be in excess of the required benefit levels; and

(iii) Prenotification or preauthorization.

Except that the coverage provisions shall not require either a second opinion or prenotification or preauthorization for treatment commencing within forty-eight hours, or as soon as is reasonably possible, after the occurrence of an accident or trauma to the temporomandibular joint.

(b) Offers limited to only dental coverage shall provide coverage for dental services related to the treatment of temporomandibular joint disorders in the amount of one thousand dollars per covered individual, after the application of deductibles, coinsurance, and copayments, in any calendar year, and a lifetime benefit of five thousand dollars per covered individual, after the application of deductibles, coinsurance, and copayments. Other than the benefit amount, coverage for dental services shall be the same as are generally provided in the health care service contract for other injuries or dental conditions. The coverage provisions may require:

(i) That services either be rendered or referred by the covered individual's primary care dentist; and

(ii) A second opinion, provided that the covered individual shall not be financially responsible for any costs relating to this second opinion and that such costs shall be in excess of the required benefit levels; and

(iii) Prenotification or preauthorization.

Except that the coverage provisions shall not require either a second opinion or prenotification or preauthorization for treatment commencing within forty-eight hours, or as soon as is reasonably possible, after the occurrence of an accident or trauma to the temporomandibular joint.

(c) Offers of both medical and dental coverage shall provide coverage for medical and dental services related to the treatment of temporomandibular joint disorders in the amount of one thousand dollars per covered individual, after the application of deductibles, coinsurance, and copayments, in any calendar year and a lifetime benefit of five thousand dollars per covered individual, after the application of deductibles, coinsurance, and copayments. Other than the benefit amount, coverage for medical and dental services shall be the same as are generally provided in the health care service contract for other injuries, musculoskeletal disorders, or dental conditions. The coverage provisions may require:

(i) That services either be rendered or referred by the covered individual's primary care physician or dentist; and

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(ii) A second opinion, provided that the covered individual shall not be financially responsible for any costs relating to this second opinion and that such costs shall be in excess of the required benefit levels; and

(iii) Prenotification or preauthorization.

Except that the coverage provisions shall not require either a second opinion or prenotification or preauthorization for treatment commencing within forty-eight hours or as soon as is reasonably possible, after the occurrence of an accident or trauma to the temporomandibular joint.

(2) Offers of the optional coverage required by subsection (1) of this section shall be included on the health care service contractor's application form(s) and retained by the health care service contractor for five years or until the completion of the next examination of the health care service contractor by the insurance commissioner, whichever occurs first. In those cases where there is no written application form, the health care service contractor shall retain other written evidence of the offer of this optional coverage for temporomandibular joint disorders for the same period of time as required for application forms. This subsection applies only in those cases where the offeree has accepted any coverage.

(3) With respect to both medical and dental optional coverage of disorders of the temporomandibular joint, health care service contractors shall not engage in discriminatory practices against persons submitting claims for that coverage, nor shall they engage in discriminatory practices against licensed health care providers providing services within the scope of their licensure, for the treatment of disorders of the temporomandibular joint. This shall not prejudice the ability of the health care service contractor to limit its coverage to its participating providers.

(4) For the purposes of the optional coverage for disorders of the temporomandibular joint required by subsections (1) through (3) of this section, the following definitions shall apply and shall be contained in the coverage contract:

(a) "Temporomandibular joint disorders" shall include those disorders which have one or more of the following characteristics: Pain in the musculature associated with the temporomandibular joint, internal derangements of the temporomandibular joint, arthritic problems with the temporomandibular joint, or an abnormal range of motion or limitation of motion of the temporomandibular joint.

(b) "Medical services" are those which are:

(i) Reasonable and appropriate for the treatment of a disorder of the temporomandibular joint, under all the factual circumstances of the case; and

(ii) Effective for the control or elimination of one or more of the following, caused by a disorder of the temporomandibular joint: Pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food; and

(iii) Recognized as effective, according to the professional standards of good medical practice; and

(iv) Not experimental or primarily for cosmetic purposes.

(c) "Dental services" are those which are:

(i) Reasonable and appropriate for the treatment of a disorder of the temporomandibular joint, under all the factual circumstances of the case; and

(ii) Effective for the control or elimination of one or more of the following, caused by a disorder of the temporomandibular joint: Pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food; and

(iii) Recognized as effective, according to the professional standards of good dental practice; and

(iv) Not experimental or primarily for cosmetic purposes.

(5) The requirements listed in the preceding subparagraphs of this section do not apply to those health care service contracts exempted by RCW 48.44.023 or 48.44.460(3), or other applicable law.

[Statutory Authority: RCW 48.44.460, 48.02.060 (3)(a) and 48.44.050. WSR 92-24-043 (Order R 92-21), § 284-44-042, filed 11/25/92, effective 12/26/92.]

**WAC 284-44-043 Experimental and investigational prescriptions, treatments, procedures, or services—Definition required—Standard for definition—Written notice of denial required—Appeal process required.** (1)

Every health care service contract which excludes or limits, or reserves the right to exclude or limit, benefits for any treatment, procedure, facility, equipment, drug, drug usage, medical device, or supply (hereinafter individually and collectively referred to as services) for one or more medical condition or illness because such services are deemed to be experimental or investigational must include within the contract and any certificate of coverage issued thereunder, a definition of experimental or investigational.

(2) The definition of experimental or investigational services must include an identification of the authority or authorities which will make a determination of which services will be considered to be experimental or investigational. If the health care service contractor specifies that it, or an affiliated entity, is the authority making the determination, the criteria it will utilize to determine whether a service is experimental or investigational must be set forth in the contract and any certificate of coverage issued thereunder. As an example, and not by way of limitation, the requirement to set forth criteria in the contract and any certificate of coverage issued thereunder may be satisfied by using one or more of the following statements, or other similar statements:

(a) "In determining whether services are experimental or investigational, the plan will consider whether the services are in general use in the medical community in the state of Washington, whether the services are under continued scientific testing and research, whether the services show a demonstrable benefit for a particular illness or disease, and whether they are proven to be safe and efficacious."

(b) "In determining whether services are experimental or investigational, the plan will consider whether the services result in greater benefits for a particular illness or disease than other generally available services, and do not pose a significant risk to health or safety of the patient."

The supporting documentation upon which the criteria are established must be made available for inspection upon written request in all instances and may not be withheld as proprietary.

(3) Every health care service contractor that denies a request for benefits or that refuses to approve a request to preauthorize services, whether made in writing or through other

claim presentation or preauthorization procedures set out in the contract and any certificate of coverage thereunder, because of an experimental or investigational exclusion or limitation, must do so in writing within twenty working days of receipt of a fully documented request. The health care service contractor may extend the review period beyond twenty days only with the informed written consent of the covered individual. The denial letter must identify by name and job title the individual making the decision and fully disclose:

(a) The basis for the denial of benefits or refusal to preauthorize services;

(b) The procedure through which the decision to deny benefits or to refuse to preauthorize services may be appealed;

(c) What information the appellant is required to submit with the appeal; and

(d) The specific time period within which the company will reconsider its decision.

(4)(a) Every health care service contractor must establish a reasonable procedure under which denials of benefits or refusals to preauthorize services because of an experimental or investigational exclusion or limitation may be appealed. The appeals procedure may be considered reasonable if it provides that:

(i) A final determination must be made and provided to the appellant in writing within twenty working days of receipt of the fully documented appeal. The health care service contractor may extend the review period beyond twenty days only with the informed written consent of the covered individual;

(ii) The appeal must be reviewed by a person or persons qualified by reasons of training, experience and medical expertise to evaluate it; and

(iii) The appeal must be reviewed by a person or persons other than the person or persons making the initial decision to deny benefits or to refuse to preauthorize services.

(b) When the initial decision to deny benefits or to refuse to preauthorize services is upheld upon appeal, the written notice shall set forth:

(i) The basis for the denial of benefits or refusal to preauthorize services; and

(ii) The name and professional qualifications of the person or persons reviewing the appeal.

(c) Disclosure of the existence of an appeal procedure shall be made by the health care service contractor in each contract and any certificate of coverage issued thereunder which contains an experimental or investigational exclusion or limitation.

(5) Whenever a covered person appeals the health care service contractor's decision and delay would jeopardize the covered person's life or health, the health care service contractor must follow the appeal procedures and time frames in WAC 284-43-4040(2).

[Statutory Authority: RCW 48.02.060. WSR 16-14-106 (Matter No. R 2016-11), § 284-44-043, filed 7/6/16, effective 8/6/16. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.43.055, 48.44-050, 48.46.100 and 48.46.200. WSR 99-24-075 (Matter No. R 98-17), § 284-44-043, filed 11/29/99, effective 12/30/99. Statutory Authority: RCW 48.02.060 (3)(a) and 48.44.050. WSR 92-21-099 (Order 92-15), § 284-44-043, filed 10/21/92, effective 11/21/92.]

(9/11/17)

**WAC 284-44-045 Benefits for registered nurses' services.** (1) Every health care service contractor agreement which is entered into initially or renewed after the effective date of this rule, and which provides benefits for any health care service to be performed by doctors of medicine, and every certificate issued thereunder, shall contain the following provision, or a provision which is the substantial equivalent of it:

"Benefits under this contract will not be denied for any health care service performed by a registered nurse licensed to practice under chapter 18.88 RCW, if first, the service performed was within the lawful scope of such nurse's license, and second, this contract would have provided benefits if such service had been performed by a doctor of medicine licensed to practice under chapter 18.71 RCW."

(2) The provisions of subsection (1) shall apply to all health care service agreements, whether they expressly provide for indemnification benefits for services rendered by health care providers who are not "participants" as defined in RCW 48.44.010(4), or whether they provide only for benefits in the form of services rendered by health care providers who are "participants" for the purpose of such contracts.

(3) To comply with RCW 48.44.290, benefits must not be denied to a person covered by a health care service agreement by reason of his choice to obtain health care services from a registered nurse. A unilaterally imposed contract provision which requires or permits an artificial reduction in the level of an indemnification benefit based on such a choice to obtain health care services from a registered nurse will be held to violate RCW 48.44.290, and will be the basis for disapproval of such agreement pursuant to RCW 48.44.020 (2)(f). An example of such an impermissible provision would be one which unilaterally sets the level of reimbursement for nurse-provided service at a fixed, less-than-100% percentage of the benefit which would be paid for participant-doctor-provided services, if any, or other doctor-provided services, if the contractor has no participant doctors. An example of a permissible provision would be one which was based on some percentage of the usual, customary, and reasonable (UCR) fee charged by the particular provider of health care service, and which applied the same percentage to the UCR fees of medical doctors and registered nurses alike. The latter provision would be permissible even if it resulted in lower actual dollar amounts for benefits for nurse-provided services than for doctor-provided services, since the difference would result from the disparity of fees actually charged by medical doctors and registered nurses rather than from an arbitrary formula based on assumptions concerning the relative worth of doctor-provided services versus nurse-provided services. A contract provision is not unilaterally imposed and is permissible, if it sets the benefit level in accord with an agreement between the health care service contractor and the particular registered nurse for whose services the benefits are provided.

(4) To comply with RCW 48.44.290, no health care service contractor agreement may contain a provision which places restrictions or limitations on benefits for nurse-provided health care services which are not also placed on benefits for doctor-provided health care services. An example of an impermissible provision would be one which limited the number of office calls made to a registered nurse to a number

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less than the limit for office calls made to a medical doctor. A contract provision which places such a limitation or restriction on benefits for nurse-provided health care services will be held to violate RCW 48.44.290, and will be the basis for disapproval of such agreement pursuant to RCW 48.44.020 (2)(f).

[Statutory Authority: RCW 48.44.050. WSR 82-02-004 (Order R 81-8), § 284-44-045, filed 12/28/81.]

**WAC 284-44-046 Mammograms—Coverage requirements and exceptions.** (1) The purpose of this regulation is to effectuate the provisions of RCW 48.44.325 by establishing definitions for the exceptions to coverage for mammograms. This regulation shall apply to every group and individual health care service contract which is delivered or issued for delivery or renewed in this state on or after September 1, 1992, that provides for hospital or medical care.

(2) For the purposes of RCW 48.44.325 and this regulation, supplemental contracts covering specified disease shall be defined to mean and include only those contracts which provide benefits to a member only in the event that the member contracts the disease or diseases specifically named in the contract. Also for the purposes of RCW 48.44.325 and this regulation, supplemental contracts covering limited benefits shall be defined to mean and include only those contracts providing only one of the following benefits: Hospital indemnity, accident only coverage, dental care, vision care, mental health care, chemical dependency care, pharmaceutical care, and podiatric care.

(3) Coverage of mammograms may be subject to standard contract provisions applicable to other diagnostic X-ray benefits such as deductible or copayment provisions.

(4) For purposes of RCW 48.44.325 and this regulation, a contract is "renewed" when it is continued beyond the earliest date, after September 1, 1992, upon which, at the health care service contractor's sole option:

(a) The contract's termination could have been effectuated, for other than nonpayment of premium; or

(b) The contract could have been amended to add the mammogram coverage, with, if justified, an appropriate rate increase for any increased cost in providing mammogram coverage under the contract.

The failure of the health care service contractor to take any such steps does not prevent the contract from being "renewed." The intent of this section is to bring the mammogram coverage under the maximum number of contracts possible at the earliest possible time, by permitting the health care service contractor to exclude such coverage from only those contracts as to which there exists a right of renewal on the part of the contractholder without any change in any provision of the contract.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.44.050. WSR 92-16-009 (Order R 92-4), § 284-44-046, filed 7/23/92, effective 8/23/92.]

**WAC 284-44-050 Group certificates to be furnished.** Every contractor shall issue to the employer, a contract holder, or other person or association in whose name a contract is issued, for delivery to each person covered by a group contract, a certificate setting forth in summary form a statement of the essential features of the contract coverage, and to or for whom the benefits thereunder are payable. If family

members are covered, only one certificate need be issued for each family. In the event that contracts are changed or amended, new certificates or a clearly understandable amendment to existing certificates shall be promptly furnished. The style, arrangement, and over-all appearance of the certificate shall not be less favorable than the requirements imposed by WAC 284-44-030. Such "certificate" may be in the form of a comprehensive booklet or brochure. The form of such certificate shall be filed with the insurance commissioner.

[Order R-74-1, § 284-44-050, filed 6/4/74, effective 8/1/74.]

**WAC 284-44-070 Effective date.** The effective date of this regulation shall be August 1, 1974.

[Order R-74-1, § 284-44-070, filed 6/4/74, effective 8/1/74.]

**WAC 284-44-250 Accounting method.** Beginning January 1, 1983, to aid in the administration of chapter 48.44 RCW, every health care service contractor shall account for its business on the accrual basis, and any annual financial statement filed after December 31, 1983, pursuant to RCW 48.44.095, shall be reported on such accrual basis.

[Statutory Authority: RCW 48.44.050. WSR 82-23-010 (Order R 82-6), § 284-44-250, filed 11/5/82, effective 1/1/83.]

**WAC 284-44-300 Purpose and applicability.** (1) The purpose of this regulation, WAC 284-44-300 through 284-44-360, is to establish indemnity requirement rules and procedures for the effectuation of RCW 48.44.030 and to aid in the administration thereof.

(2) This regulation applies to every health care service contractor registered pursuant to chapter 48.44 RCW.

[Statutory Authority: RCW 48.44.050. WSR 82-23-010 (Order R 82-6), § 284-44-300, filed 11/5/82, effective 1/1/83.]

**WAC 284-44-310 Agreement underwritten by insurance.** (1) If, pursuant to RCW 48.44.030, the agreement is underwritten by a contract or policy of insurance, such contract or policy shall:

(a) Have a continuous term;

(b) Fully insure the benefits of the persons who have paid for or contracted for covered health care services, which persons shall be designated as beneficiaries, when such services are not performed by the health care service contractor or a participant;

(c) Contain a provision that, in the event of cancellation, the coverage shall continue with respect to services provided prior to the effective date of such cancellation;

(d) Contain a provision that it may not be cancelled without ninety days advance written notice to the insured or insurer by the cancelling party; and

(e) Contain a provision requiring not less than sixty days advance notice to the insurance commissioner, health care services division, by the insurer of any cancellation.

(2) The original or a true copy of the actual insurance contract or policy shall be filed with the insurance commissioner, health care services division, prior to its effective date.

[Statutory Authority: RCW 48.44.050. WSR 82-23-010 (Order R 82-6), § 284-44-310, filed 11/5/82, effective 1/1/83.]

**WAC 284-44-320 Agreement guaranteed by a surety company.** (1) If, pursuant to RCW 48.44.030, the agreement is guaranteed by a surety company, such agreement shall:

(a) Be in an amount equal to the greater of (i) one hundred fifty thousand dollars, or (ii) one-twelfth of the total sum of money received during the preceding calendar year as prepayment for health care services, except as provided by WAC 284-44-340;

(b) Contain a provision that the bond will be for the benefit of the persons who have paid for or contracted for the health care services;

(c) Contain a provision that in the event of cancellation, the bond will continue to cover liabilities for services provided prior to the effective date of such cancellation;

(d) Contain a provision that it may not be cancelled or terminated without ninety days advance written notice to the assured or surety company by the cancelling party;

(e) Contain a provision requiring not less than sixty days advance notice to the insurance commissioner, health care services division, by the surety company of any cancellation of such surety agreement.

(2) The original or a true copy of the actual surety bond shall be filed with the insurance commissioner, health care services division, prior to its effective date.

[Statutory Authority: RCW 48.44.050. WSR 82-23-010 (Order R 82-6), § 284-44-320, filed 11/5/82, effective 1/1/83.]

**WAC 284-44-330 Agreement guaranteed by a deposit of cash or securities.** (1) If, pursuant to RCW 48.44.030, the agreement is guaranteed by a deposit of cash or securities, the deposit must be in an amount equal to the greater of (i) one hundred fifty thousand dollars, or (ii) one-twelfth of the total sum of money received during the preceding calendar year as prepayment for health care services, except as provided by WAC 284-44-340.

(2) Securities eligible for the deposit are those set forth in RCW 48.13.009 (12), (14), and 48.13.061 (2) and (4).

(3) In determining the value to be assigned to securities for compliance with the depository requirements, market value is the measurement.

[Statutory Authority: RCW 48.02.060, 48.13.171(1) and chapter 48.13 RCW. WSR 17-19-026 (Matter No. R 2017-02), § 284-44-330, filed 9/11/17, effective 10/12/17. Statutory Authority: RCW 48.44.050. WSR 82-23-010 (Order R 82-6), § 284-44-330, filed 11/5/82, effective 1/1/83.]

**WAC 284-44-340 Modification of amount of reimbursement or indemnity.** (1) Reduced deposit requirements may be permitted when data satisfactory to the commissioner are provided which indicate an amount less than that set forth in WAC 284-44-320 and 284-44-330 is adequate to cover incurred but unpaid reimbursement or indemnity benefits. In determining a lesser requirement, the commissioner will include in his consideration:

(a) The overall adequacy of the contractor's reserves for future benefits;

(b) The relationship between indemnity claims and claims covered by contractual agreements with providers;

(c) The overall financial stability of the contractor; and

(d) A reasonable projection of any increase or decrease of such benefits.

(9/11/17)

(2) The commissioner may from time to time require additional indemnification to be furnished when a review of the health care service contractor's affairs demonstrates that existing indemnification is inadequate.

[Statutory Authority: RCW 48.44.050. WSR 82-23-010 (Order R 82-6), § 284-44-340, filed 11/5/82, effective 1/1/83.]

**WAC 284-44-350 Records and reporting.** (1) Each health care service contractor shall maintain records which separately reflect the amount of service benefits and the amount of reimbursement or indemnity benefits. Reasonable approximation based on paid claims data may be used to project incurred indemnity benefits. Such amounts shall be reported to the commissioner on forms prescribed by the commissioner and shall be filed with the annual statement and at such other times as the commissioner may require. The report shall be accompanied by an inventory and valuation of any securities which are used to satisfy the depository requirement. If the amount of the guarantee is not sufficient to satisfy the requirements, an appropriate additional amount shall be obtained, and shall be deposited with, or evidenced to, the commissioner within thirty days of the filing of the report.

(2) A health care service contractor using either a policy of insurance or a surety bond to provide for indemnification shall notify the insurance commissioner, health care services division, sixty days in advance of termination or cancellation of the contract or policy of insurance or surety bond.

[Statutory Authority: RCW 48.44.050. WSR 82-23-010 (Order R 82-6), § 284-44-350, filed 11/5/82, effective 1/1/83.]

**WAC 284-44-450 PKU formula coverage requirements and exceptions.** (1) The purpose of this section is to effectuate the provisions of section 3, chapter 173, Laws of 1988, by establishing the requirements and exceptions with respect to coverage for the formulas necessary for the treatment of phenylketonuria (PKU), applicable to health care service contractors registered pursuant to RCW 48.44.015.

(2) Each contract for health care services which is delivered or issued for delivery or renewed in this state on or after September 1, 1988, shall provide coverage for the formulas necessary for the treatment of phenylketonuria, subject to the following exceptions:

(a) A contract that is subject to chapter 48.66 RCW and provides medicare supplemental insurance need not provide the PKU formula coverage;

(b) A contract that is subject to chapter 48.84 RCW and provides long-term care insurance need not provide the PKU formula coverage;

(c) A contract that provides benefits for hospital services only or for custodial services only may limit the coverage for PKU formulas to a benefit that supplies the formula needed, or pays for the formula used, during time such services are provided.

(d) A contract which provides services or reimbursement exclusively for optometric or vision care services, dental or orthodontic services, podiatric services, ambulance services, mental health services, or chiropractic services need not provide coverage for PKU formula.

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(e) A contract that is governed by 5 U.S.C. chapter 89 or 42 U.S.C. section 1395mm need not provide the PKU formula coverage.

(f) In response to the written request of a contractor, other contracts may exclude coverage for the PKU formula with the written consent of the commissioner upon a finding that such coverage would be inappropriate.

(3) Coverage for the formulas necessary for the treatment of phenylketonuria may be limited to the usual and customary charge for such formulas, and may be made subject to deductibles, copayments, coinsurance or other reductions only to the extent that deductibles, copayments, coinsurance or other reductions are applied to general expenses incurred for common sicknesses or disorders under the provisions of the particular contract. (Relating the PKU formula to a special expense benefit, such as a prescription drug benefit, is not acceptable unless it results in the PKU formula benefit being paid at an amount no less than the amount that would be produced by application of the reimbursement formula for medically necessary treatment for common sicknesses or disorders.)

(4) The amount charged by a health care service contractor shall be no greater to a family or individual receiving benefits under the PKU formula coverage, by reason thereof, than to a family or individual under the same contract form or group contract who is not receiving such benefits.

(5) Preexisting condition provisions shall not be used with respect to PKU formula coverage, and no contractor shall cancel or decline to renew any contract, or restrict, modify, exclude, or reduce the amount of benefits payable or type of coverage provided in any contract, because an applicant or covered person has phenylketonuria.

(6) For purposes of section 3, chapter 173, Laws of 1988, and this section, a contract is "renewed" when it is continued beyond the earliest date after September 1, 1988, upon which, at the contractor's sole option:

(a) The contract's termination could have been effectuated, for other than nonpayment of premium; or

(b) The contract could have been amended to add the PKU formula coverage, with, if justified, an appropriate rate increase for any increased cost in providing the PKU formula coverage under the contract.

The failure of the contractor to take any such steps does not prevent the contract from being "renewed." The intent of this subsection is to bring the PKU formula coverage under the maximum number of contracts possible at the earliest possible time, by permitting the contractor to exclude such coverage from only those contracts as to which there exists a right of renewal on the part of a contract holder without any change in any provision of the contract.

[Statutory Authority: RCW 48.02.060 (3)(a), 48.44.050 and 48.46.200. WSR 88-16-065 (Order R 88-7), § 284-44-450, filed 8/1/88.]

**WAC 284-44-500 Alternative care—General rules as to minimum standards.** (1) As an alternative to hospitalization or institutionalization of an insured and with the intent to cover placement of the insured patient in the most appropriate and cost-effective setting, every individual or group contract of a health care service contractor issued, amended, or renewed on or after January 1, 1995, which provides coverage for hospitalization or other institutional expenses to a res-

ident of this state shall include substitution of home health care, provided in lieu of hospitalization or other institutional care, furnished by home health, hospice and home care agencies licensed under chapter 70.127 RCW, at equal or lesser cost.

(2) In addition, such expenses may include coverage for durable medical equipment which permits the insured to stay at home, care provided in Alzheimer's centers, adult family homes, assisted living facilities, congregate care facilities, adult day health care, home health, hospice and home care, or similar alternative care arrangements which provide necessary care in less restrictive or less expensive environments.

(3) Substitution of less expensive or less intensive services shall be made only with the consent of the insured and upon the recommendation of the insured's attending physician or licensed health care provider that such services will adequately meet the insured patient's needs. The decision to substitute less expensive or less intensive services shall be determined based on the medical needs of the individual insured patient.

(4) A health care service contractor may require that home health agencies or similar alternative care providers have written treatment plans which are approved by the insured patient's attending physician or other licensed health care provider.

(5) Coverage may be limited to no less than the maximum benefits which would be payable for hospital or other institutional expenses under the contract, and may include all deductibles and coinsurances which would be payable by the insured under the hospital or other institutional expense coverage of the insured's contract.

(6) This section shall not apply to long-term care or medicare supplement insurance contracts. This section shall not apply to guaranteed renewable contracts issued prior to January 1, 1995.

[Statutory Authority: RCW 48.01.030, 48.02.060, 48.44.050, 48.44.020, 48.46.200 and 48.46.060. WSR 94-19-015 (Order R 94-16), § 284-44-500, filed 9/9/94, effective 10/10/94.]