

Chapter 284-96 WAC
GROUP AND BLANKET DISABILITY INSURANCE

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WAC 284-96-010 Purpose. The purpose of this chapter is to provide a consolidated location within Title 284 of the Washington Administrative Code for regulations applying to disability insurance companies marketing group and blanket disability insurance as it is defined in chapter 48.21 RCW.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.18.120. WSR 92-21-100 (Order R 92-16), § 284-96-010, filed 10/21/92, effective 11/21/92.]

WAC 284-96-012 Discretionary clauses prohibited. (1) No disability insurance policy may contain a discretionary clause. "Discretionary clause" means a provision that purports to reserve discretion to an insurer, its agents, officers, employees, or designees in interpreting the terms of a policy 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 insurer's interpretation of the terms of the policy is binding;

(b) That the insurer's decision regarding eligibility or continued receipt of benefits is binding;

(c) That the insurer'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 insurer's interpretation of the contract or claim decision; and

(f) That the standard of review of an insurer's interpretation of the policy or claim decision is other than a de novo review.

(2) Nothing in this section prohibits an insurer from including a provision in a policy that informs an insured that as part of its routine operations the insurer applies the terms of its policies 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), § 284-96-012, filed 8/5/09, effective 9/5/09.]

WAC 284-96-015 Experimental and investigational prescriptions, treatments, procedures, or services—Definition required—Standard for definition—Written notice of denial required—Appeal process required.

(1) Every group disability insurance policy 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 policy 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 group disability insurer 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 policy and any certificate of coverage issued thereunder. As an example, and not by way of limitation, the requirement to set forth criteria in the policy 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, we 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, we 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 group disability insurer 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 policy 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 group disability insurer 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 group disability insurer 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 group disability insurer 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 group disability insurer in each policy and any certificate of coverage issued thereunder which contains an experimental or investigational exclusion or limitation.

(5) Whenever a covered person appeals the insurer's decision and delay would jeopardize the covered person's life or health, the group disability insurer 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), § 284-96-015, 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), § 284-96-015, filed 11/29/99, effective 12/30/99. Statutory Authority: RCW 48.02.060 (3) (a) and 48.18.120. WSR 92-21-100 (Order R 92-16), § 284-96-015, filed 10/21/92, effective 11/21/92.]

WAC 284-96-020 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 48.21.320, each offer of new or renewal group disability coverage made on or after January 1, 1993, must include one or more offers of optional coverage for the treatment of temporomandibular joint disorders. Group disability insurers 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:

(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 in-

dividual, 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 policy 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 policy 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 policy 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

(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 group insurer's application

form(s) and retained by the insurer for five years or until the completion of the next examination of the insurer by the insurance commissioner, whichever occurs first. In those cases where there is no written application form, the group insurer 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, group disability insurers 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 insurer 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 group disability policies exempted by RCW 48.21.320(3) or 48.21.045, or other applicable law.

[Statutory Authority: RCW 48.21.320(2) and 48.02.060 (3)(a). WSR 92-24-045 (Order R 92-23), § 284-96-020, filed 11/25/92, effective 12/26/92.]

WAC 284-96-500 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 group or blanket disability insurance policy, contract or certificate issued, amended, or renewed on or after January 1, 1995, which provides coverage for hospitalization or other institutional expenses to a resident 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) An insurer 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 policy or contract, and may include all deductibles and co-insurances which would be payable by the insured under the hospital or other institutional expense coverage of the insured's policy or contract.

(6) This section shall not apply to long-term care, medicare supplement, or disability income protection insurance policies or contracts. This section shall not apply to guaranteed renewable disability insurance policies 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), § 284-96-500, filed 9/9/94, effective 10/10/94.]

WAC 284-96-550 Standard disclosure form for group coverage—Illness-triggered fixed payment insurance, hospital confinement fixed payment insurance, or other fixed payment insurance. (1) All disability insurers offering group policies that provide benefits in the form of illness-triggered fixed payments, hospital confinement fixed payments or other fixed payment insurance, must issue a disclosure form in substantially the format and content outlined below. The disclosure form must be provided to the master policyholder at the time of solicitation and completion of the application form and to all enrollees at the time of enrollment. Every insurer must have a mechanism in place

to verify delivery of the disclosure to the master policyholder and to every enrollee.

(2) The type size and font of the disclosure form must be easily read and be no smaller than 10 point.

(3) The insurer's disclosure form must be filed **for approval** with the commissioner prior to use.

(4) The standard disclosure form replaces any outline of coverage that would otherwise be required for fixed payment policies and must include, at a minimum, the following information:

(Insurer's name and address)
**IMPORTANT INFORMATION ABOUT THE
COVERAGE YOU ARE BEING OFFERED**

Save this statement! It may be important to you in the future. The Washington State Insurance Commissioner requires that we give you the following information about fixed payment benefits.

This coverage is not comprehensive health care insurance and will not cover the cost of most hospital and other medical services.

This disclosure provides a very brief description of the important features of the coverage being considered. It is not an insurance contract and only the actual policy provisions will control. The policy itself will include in detail the rights and obligations of both the master policyholder and (insurer's name).

This coverage is designed to pay you a fixed dollar amount regardless of the amount that the provider charges. Payments are not based on a percentage of the provider's charge and are paid in addition to any other health plan coverage you may have.

CAUTION: If you are also covered under a High Deductible Health Plan (HDHP) and are contributing to a Health Savings Account (HSA), you should check with your tax advisor or benefit advisor prior to purchasing this coverage to be sure that you will continue to be eligible to contribute to the HSA if this coverage is purchased.

The benefits under this policy are summarized below.

- Type of coverage:
- Benefit amount:
- Benefit trigger (identify any periods of no coverage such as eligibility or waiting periods):
- Duration of coverage:
- Renewability of coverage:

Policy provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described above include the following:

(List all exclusions including those that relate to limitations for preexisting conditions.)

[Statutory Authority: RCW 48.02.060, 48.20.550, and 48.21.370. WSR 07-21-073 (Matter No. R 2007-05), § 284-96-550, filed 10/15/07, effective 11/15/07.]