Chapter 284-43 WAC
HEALTH CARRIERS AND HEALTH PLANS

WAC

SUBCHAPTER A
GENERAL PROVISIONS

SUBCHAPTER B
HEALTH CARE NETWORKS

SUBCHAPTER C
PROVIDER CONTRACTS AND PAYMENT

SUBCHAPTER D
UTILIZATION REVIEW

SUBCHAPTER F
GRIEVANCE AND COMPLAINT PROCEDURES

SUBCHAPTER H
HEALTH PLAN BENEFITS

SUBCHAPTER I—HEALTH PLAN RATES

SUBCHAPTER J
HEALTH PLAN ENROLLMENT AND COVERAGE REQUIREMENTS

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

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 Repealed by 98-04-005 (Matter No. R 97-3), filed 1/22/98, effective 2/22/98.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

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 Repealed by 98-04-005 (Matter No. R 97-3), filed 1/22/98, effective 2/22/98.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

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 Repealed by 08-17-037 (Matter No. R 2008-17), filed 8/13/08, effective 9/13/08.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

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 Repealed by 01-03-033 (Matter No. R 2000-02), filed 1/9/01, effective 7/1/01.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

284-43-700 Purpose. [Statutory Authority: RCW 48.02.060, 48.20.-450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. 98-04-005 (Matter No. R 97-3), § 284-43-700, filed 1/22/98, effective 2/22/98.] Repealed by 08-09-022 (Matter No. R 2008-01), filed 4/7/08, effective 5/8/08. Statutory Authority: RCW 48.02.060, 48.20.-450, 48.20.460, 48.44.050, 48.46.030, 48.46.200.

284-43-710 Portability of health insurance benefits. [Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.030, 48.46.200. 00-04-034 (Matter No. R 99-2), § 284-43-710, filed 1/24/00, effective 2/24/00. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020,

48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. 98-04-005 (Matter No. R 97-3), § 284-43-710, filed 1/22/98, effective 2/22/98.] Repealed by 08-09-022 (Matter No. R 2008-01), filed 4/7/08, effective 5/8/08. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.44.050, 48.46.030, 48.46.200.

284-43-720 Guaranteed issue and restrictions on the denial, exclusion, or limitation of health benefits for preexisting conditions. [Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.030, 48.46.200. 00-04-034 (Matter No. R 99-2), § 284-43-720, filed 1/24/00, effective 2/24/00. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. 98-04-005 (Matter No. R 97-3), § 284-43-720, filed 1/22/98, effective 2/22/98.] Repealed by 08-09-022 (Matter No. R 2008-01), filed 4/7/08, effective 5/8/08. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.44.050, 48.46.030, 48.46.200.

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

284-43-810 Coverage for mental health services. [Statutory Authority: RCW 48.02.060, 48.30.010, 48.44.050, 48.46.200, 48.30.040, 48.44.110 and 48.46.400. 99-19-032 (Matter No. R 98-7), § 284-43-810, filed 9/8/99, effective 10/9/99.] Repealed by 08-09-021 (Matter No. R 2008-02), filed 4/7/08, effective 5/8/08. Statutory Authority: RCW 48.02.060, 48.18.120(2), 48.20.450, 48.20.460, 48.44.050, 48.46.200. Later promulgation, see RCW 48.20.580, 48.21.240, 48.44.341 and 48.46.291.

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

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

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

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

284-43-955 Effective date. [Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066. 98-04-011 (Matter No. R 97-2), § 284-43-955, filed 1/23/98, effective 3/1/98.] Repealed by 05-07-006 (Matter No. R 2004-05), filed 3/3/05, effective 4/3/05. Statutory Authority: RCW 48.02.060, 48.44.-050, and 48.46.200.

SUBCHAPTER A
GENERAL PROVISIONS

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

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

WAC 284-43-120 Applicability and scope. This chapter shall apply to all health plans and all health carriers subject to the jurisdiction of the state of Washington except as otherwise expressly provided in this chapter. Health carriers are responsible for compliance with the provisions of this chapter and are responsible for the compliance of any person or organization acting on behalf of or at the direction of the carrier, or acting pursuant to carrier standards or requirements concerning the coverage of, payment for, or provision of health care services. A carrier may not offer as a defense to a violation of any provision of this chapter that the violation arose from the act or omission of a participating provider or facility, network administrator, claims administrator, or other person acting on behalf of or at the direction of the carrier, or acting pursuant to carrier standards or requirements under a contract with the carrier rather than from the direct act or omission of the carrier. Nothing in this chapter shall be construed to permit the direct regulation of health care providers or facilities by the office of the insurance commissioner.

[Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.030, 48.46.200. 00-04-034 (Matter No. R 99-2), § 284-43-120, filed 1/24/00, effective 2/24/00. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.-080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. 98-04-005 (Matter No. R 97-3), § 284-43-120, filed 1/22/98, effective 2/22/98.]

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

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

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

(1) "Adverse determination and noncertification" means a decision by a health carrier 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 facility.

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

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

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

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

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

(7) "Emergency services" means otherwise covered health care services medically necessary to evaluate and treat an emergency medical condition, provided in a hospital emergency department.

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

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

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

(11) "Grievance" means a written or an oral complaint submitted by or on behalf of a covered person regarding:

(a) Denial of health care services or payment for health care services; or

(b) Issues other than health care services or payment for health care services including dissatisfaction with health care services, delays in obtaining health care services, conflicts with carrier staff or providers, and dissatisfaction with carrier practices or actions unrelated to health care services.

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

(a) A person regulated under Title 18 RCW or chapter 70.127 RCW, to practice health or health-related services or otherwise practicing health care services in this state consistent with state law; or

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

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

(14) "Health carrier" or "carrier" means a disability insurance company regulated under chapter 48.20 or 48.21 RCW, a health care service contractor as defined in RCW 48.44.010, and a health maintenance organization as defined in RCW 48.46.020.

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

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

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

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

(d) Disability income;

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

(f) Workers' compensation coverage;

(g) Accident only coverage;

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

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

(j) Dental only and vision only coverage; and

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

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

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

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

(19) "Mental health services" means in-patient or out-patient treatment, partial hospitalization or out-patient treatment to manage or ameliorate the effects of a mental disorder listed in the *Diagnostic and Statistical Manual (DSM) IV* published by the American Psychiatric Association, excluding diagnoses and treatments for substance abuse, 291.0 through 292.9 and 303.0 through 305.9.

(20) "Network" means the group of participating providers and facilities providing health care services to a particular health plan. A health plan network for carriers offering more than one health plan may be smaller in number than the total number of participating providers and facilities for all plans offered by the carrier.

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

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

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

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

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

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

(27) "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.

(28) "Small group" means a health plan issued to a small employer as defined under RCW 48.43.005(24) comprising from one to fifty eligible employees.

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

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

[Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.100, 48.46.200, 48.43.505, 48.43.510, 48.43.515, 48.43.520, 48.43.525, 48.43.530, 48.43.535. 01-03-033 (Matter No. R 2000-02), § 284-43-130, filed 1/9/01, effective 7/1/01. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.200, 2000 c 79 § 26, and RCW 48.30.040, 48.44.110, 48.46.400. 01-03-032 (Matter No. R 2000-04), § 284-43-130, filed 1/9/01, effective 2/9/01. Statutory Authority: RCW 48.02.060, 48.30.010, 48.44.050, 48.46.200, 48.30.040, 48.44.110 and 48.46.400. 99-19-032 (Matter No. R 98-7), § 284-43-130, filed 9/8/99, effective 10/9/99. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. 98-04-005 (Matter No. R 97-3), § 284-43-130, filed 1/22/98, effective 2/22/98.]

SUBCHAPTER B
HEALTH CARE NETWORKS

WAC 284-43-200 Network adequacy. (1) A health carrier shall maintain each plan network in a manner that is sufficient in numbers and types of providers and facilities to assure that all health plan services to covered persons will be accessible without unreasonable delay. Each covered person shall have adequate choice among each type of health care provider, including those types of providers who must be included in the network under WAC 284-43-205. In the case of emergency services, covered persons shall have access twenty-four hours per day, seven days per week. The carrier's service area shall not be created in a manner designed to discriminate against persons because of age, sex, family structure, ethnicity, race, health condition, employment status, or socioeconomic status. Each carrier shall ensure that its networks will meet these requirements by the end of the first year of initial operation of the network and at all times thereafter.

(2) Sufficiency and adequacy of choice may be established by the carrier with reference to any reasonable criteria used by the carrier, including but not limited to: Provider-covered person ratios by specialty, primary care provider-covered person ratios, geographic accessibility, waiting times for appointments with participating providers, hours of operation, and the volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care. Evidence of carrier compliance with network adequacy standards that are substantially similar to those standards established by state agency health care purchasers (e.g., the state health care authority and the department of social and health services) and by private managed care accreditation organizations may be used to demonstrate sufficiency. At a minimum, a carrier will be held accountable for meeting those standards described under WAC 284-43-220.

(3) In any case where the health carrier has an absence of or an insufficient number or type of participating providers or facilities to provide a particular covered health care service, the carrier shall ensure through referral by the primary care provider or otherwise that the covered person obtains the covered service from a provider or facility within reasonable proximity of the covered person at no greater cost to the covered person than if the service were obtained from network providers and facilities, or shall make other arrangements acceptable to the commissioner.

(4) The health carrier shall establish and maintain adequate arrangements to ensure reasonable proximity of network providers and facilities to the business or personal residence of covered persons. Health carriers shall make reasonable efforts to include providers and facilities in networks in a manner that limits the amount of travel required to obtain covered benefits. For example, a carrier should not require travel of thirty miles or more when a provider who meets carrier standards is available for inclusion in the network and practices within five miles of enrollees. In determining whether a health carrier has complied with this provision, the commissioner will give due consideration to the relative availability of health care providers or facilities in the service area under consideration and to the standards established by

state agency health care purchasers. Relative availability includes the willingness of providers or facilities in the service area to contract with the carrier under reasonable terms and conditions.

(5) A health carrier shall monitor, on an ongoing basis, the ability and clinical capacity of its network providers and facilities to furnish health plan services to covered persons.

(6) Beginning July 1, 2000, the health carrier shall disclose to covered persons that limitations or restrictions on access to participating providers and facilities may arise from the health service referral and authorization practices of participating providers and facilities. The carrier shall provide instructions to covered persons as to how they can receive details about such practices from their primary care provider or through other formally established processes. For example, a covered person relying on such instructions or processes could discover if the choice of a particular primary care provider would result in the covered person's inability to obtain a referral to certain other participating providers.

(7) To provide adequate choice to covered persons who are American Indians, each health carrier shall maintain arrangements that ensure that American Indians who are covered persons have access to Indian health care services and facilities that are part of the Indian health system. Carriers shall ensure that such covered persons may obtain covered services from the Indian health system at no greater cost to the covered person than if the service were obtained from network providers and facilities. Carriers are not responsible for credentialing providers and facilities that are part of the Indian health system. Nothing in this subsection prohibits a carrier from limiting coverage to those health services that meet carrier standards for medical necessity, care management, and claims administration or from limiting payment to that amount payable if the health service were obtained from a network provider or facility.

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

WAC 284-43-205 Every category of health care providers. (1) To effectuate the requirement of RCW 48.43.045 that health plans provide coverage for treatments and services by every category of provider, health carriers shall not exclude any category of providers licensed by the state of Washington who provide health care services or care within the scope of their practice for conditions covered by basic health plan (BHP) services as defined by RCW 48.43.005(4). If the BHP covers the condition, the carrier may not exclude a category of provider who is licensed to provide services for that condition, and is acting within the scope of practice, unless such services would not meet the carrier's standards pursuant to RCW 48.43.045 (1)(b). For example, if the BHP provides coverage for outpatient treatment of lower back pain, any category of provider that provides cost-effective and clinically efficacious outpatient treatment for lower back pain within its scope practice and otherwise abides by standards pursuant to RCW 48.43.045 (1)(b) may not be excluded from the network.

(2) RCW 48.43.045 (1)(b) permits health carriers to require providers to abide by certain standards. These standards may not be used in a manner designed to exclude categories of providers unreasonably. For example, health carriers may not decide that a particular category of provider can never render any cost-effective or clinically efficacious services and thereby exclude that category of provider completely from health plans on that basis. However, health carriers may determine that particular services for particular conditions by particular categories of providers are not cost-effective or clinically efficacious, and may exclude such services from coverage or reimbursement under a health plan. Any such determinations must be supported by relevant information or evidence of the type usually considered and relied upon in making determinations of cost-effectiveness or clinical efficacy.

(3) Health plans are not prohibited by this section from placing reasonable limits on individual services rendered by specific categories of providers. However, health plans may not contain unreasonable limits, and may not include limits on the type of provider permitted to render the covered service unless such limits comply with RCW 48.43.045 (1)(b).

(4) This section does not prohibit health plans from using restricted networks. Health carriers offering plans with restricted networks may select the individual providers in any category of provider with whom they will contract or whom they will reimburse. A health carrier is not required by RCW 48.43.045 or this section to accede to a request by any individual provider for inclusion in any network for any health plan. Health plans that use "gatekeepers" for access to specialist providers may use them for access to specified categories of providers.

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

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

(7) All health carriers and their plans, provider contracts, networks and operations shall conform to the provisions of this section WAC 284-43-205, by January 1, 2000.

[Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050 and 48.46.200. 99-16-036 (Matter No. R 98-20), § 284-43-205, filed 7/28/99, effective 8/28/99.]

WAC 284-43-220 Network reports—Format. Each health carrier must file with the commissioner a Provider Network Form A and a Network Enrollment Form B.

(1) **Provider Network Form A.** A carrier must file an electronic report of all participating providers by network. This report must contain all data items shown in Provider Network Form A prescribed by and available from the commissioner. Updated reports must be filed each month. Filing of this data satisfies the reporting requirements of RCW 48.44.080 and the requirements of RCW 48.46.030 relating to filing of notices that describes changes in the provider network.

(2) **Network Enrollment Form B.** By March 31, 2004, and every year thereafter, a carrier must prepare an electronic report showing the total number of covered persons who were entitled to health care services during each month of the year, excluding nonresidents. A separate report must be filed for each network by line of business. The report must contain all data items shown in and conform to the format of Network Enrollment Form B prescribed by and available from the commissioner.

(3) For purposes of this section:

(a) "Line of business" means either individual, small group or large group coverage;

(b) "Network" means the group of participating providers and facilities providing health care services to a particular line of business.

[Statutory Authority: RCW 48.02.060, 48.43.510 and 48.43.515. 11-07-015 (Matter No. R 2011-01), § 284-43-220, filed 3/8/11, effective 4/8/11. Statutory Authority: RCW 48.02.060. 08-17-037 (Matter No. R 2008-17), § 284-43-220, filed 8/13/08, effective 9/13/08. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.43.515, 48.44.050, 48.46.-030, 48.46.200, 48.42.100, 48.43.515, 48.46.030. 03-09-142 (Matter No. R 2003-01), § 284-43-220, filed 4/23/03, effective 5/24/03. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.030, 48.46.200. 00-04-034 (Matter No. R 99-2), § 284-43-220, filed 1/24/00, effective 1/1/01. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. 98-04-005 (Matter No. R 97-3), § 284-43-220, filed 1/22/98, effective 2/22/98.]

WAC 284-43-250 Health carrier standards for women's right to directly access certain health care practitioners for women's health care services. (1)(a) "Women's health care services" is defined to include, but need not be limited to, maternity care, reproductive health services, gynecological care, general examination, and preventive care as medically appropriate, and medically appropriate follow-up visits for these services. General examinations, preventive care, and medically appropriate follow-up care are limited to services related to maternity, reproductive health services, gynecological care, or other health services that are particular to women, such as breast examinations. Women's health care services also include any appropriate health care service for other health problems, discovered and treated during the course of a visit to a women's health care practitioner for a women's health care service, which is within the practitioner's scope of practice. For purposes of determining a woman's right to directly access health services covered by the plan, maternity care, reproductive health, and preventive services include, contraceptive services, testing and treatment for sexually transmitted diseases, pregnancy termination, breast-feeding, and complications of pregnancy.

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

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

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

(3)(a) All health carriers shall permit each female policyholder, subscriber, enrolled participant, or beneficiary of carrier policies, plans, and programs written, amended, or renewed after July 23, 1995, to directly access the types of women's health care practitioners identified in RCW 48.42.100(2), for appropriate covered women's health care services without prior referral from another health care practitioner.

(b) Beginning July 1, 2000, direct access may be limited to those women's health care practitioners who have signed participating provider agreements with the carrier for a specific benefit plan network. Irrespective of the financial arrangements a carrier may have with participating providers, a carrier may not limit and shall not permit a network provider to limit access to a subset of participating women's health care practitioners within the network. Such an impermissible limitation might arise when a primary care provider's group practice receives a capitation payment for comprehensive care to a covered person and then represents to the covered person that only those gynecologists in the primary care provider's clinic are available for direct access. Nothing in this subsection shall be interpreted to prohibit a carrier from contracting with a provider to render limited health care services.

(c) Every carrier shall include in each provider network, a sufficient number of each type of practitioner included in the definition of women's health care practitioners in RCW 48.42.100(2) to ensure that enrollees can exercise their right of direct access.

(d) Beginning July 1, 2000, a woman's right to directly access practitioners for health care services as provided under RCW 48.42.100, includes the right to obtain appropriate women's health care services ordered by the practitioner from a participating facility used by the practitioner.

(4) To inform enrollees of their rights under RCW 48.42.100, all health carriers shall include in enrollee handbooks a written explanation of a woman's right to directly access women's health care practitioners for covered women's health care services. Enrollee handbooks shall

include information regarding any limitations to direct access, including, but not limited to:

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

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

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

[Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.030, 48.46.200. 00-04-034 (Matter No. R 99-2), § 284-43-250, filed 1/24/00, effective 2/24/00. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. 98-04-005 (Matter No. R 97-3), § 284-43-250, filed 1/22/98, effective 2/22/98.]

WAC 284-43-251 Covered person's access to providers. (1) Each carrier must allow a covered person to choose a primary care provider who is accepting new patients from a list of participating providers. Covered persons also must be permitted to change primary care providers at any time with the change becoming effective no later than the beginning of the month following the covered person's request for the change.

(2) Each carrier must have a process whereby a covered person with a complex or serious medical or psychiatric condition may receive a standing referral to a participating specialist for an extended period of time. The standing referral must be consistent with the covered person's medical needs and plan benefits. For example, a one-month standing referral would not satisfy this requirement when the expected course of treatment was indefinite. However, a referral does not preclude carrier performance of utilization review functions.

(3) Each carrier shall provide covered persons with direct access to the participating chiropractor of the covered person's choice for covered chiropractic health care without the necessity of prior referral. Nothing in this subsection shall prevent carriers from restricting covered persons to seeing only chiropractors who have signed participating provider agreements or from utilizing other managed care and cost containment techniques and processes. For purposes of this subsection, "covered chiropractic health care" means covered benefits and limitations related to chiropractic health services as stated in the plan's medical coverage agreement, with the exception of any provisions related to prior referral for services.

(4) Each carrier must provide, upon the request of a covered person, access by the covered person to a second opinion regarding any medical diagnosis or treatment plan from a qualified participating provider of the covered person's choice. The carrier may not impose any charge or cost upon the covered person for such second opinion other than a charge or cost imposed for the same service in otherwise similar circumstances.

(5) Each carrier must cover services of a primary care provider whose contract with the plan or whose contract with a subcontractor is being terminated by the plan or subcontractor without cause under the terms of that contract for at least sixty days following notice of termination to the covered persons or, in group coverage arrangements involving periods of open enrollment, only until the end of the next open enrollment period. Notice to covered persons shall include information of the covered person's right of access to the terminating provider for an additional sixty days. The provider's relationship with the carrier or subcontractor must be continued on the same terms and conditions as those of the contract the plan or subcontractor is terminating, except for any provision requiring that the carrier assign new covered persons to the terminated provider.

(6) Each carrier shall make a good faith effort to assure that written notice of a termination within fifteen working days of receipt or issuance of a notice of termination is provided to all covered persons who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause.

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

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

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

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

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

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

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

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

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

(d) Must have professional liability insurance coverage; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SUBCHAPTER C
PROVIDER CONTRACTS AND PAYMENT

WAC 284-43-300 Provider and facility contracts with health carriers—Generally. A health carrier contracting with providers or facilities for health care service delivery to covered persons shall satisfy all the requirements contained in this subchapter. The health carrier shall ensure that providers and facilities subcontracting with these providers and facilities under direct contract with the carrier also satisfy the requirements of this subchapter.

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

WAC 284-43-310 Selection of participating providers—Credentialing and unfair discrimination. (1) Health carrier selection standards for participating providers and facilities shall be developed by the carrier for primary care providers and each health care provider or facility license or professional specialty. The standards shall be used in determining the selection of health care providers and facilities by the health carrier. The standards shall be consistent with rules or standards established by the state department of health or other regulatory authority established in Title 18 RCW for health care providers specified in RCW 18.130.040. Selection criteria shall not be established in a manner:

(a) That would allow a health carrier to avoid risk by excluding providers or facilities because they are located in geographic areas that contain populations presenting a risk of higher than average claims, losses, or health services utilization; or

(b) That would exclude providers or facilities because they treat or specialize in treating persons presenting a risk of higher than average claims, losses, or health services utilization or because they treat or specialize in treating minority or special populations.

(2) The provisions of subsection (1)(a) and (b) of this section shall not be construed to prohibit a carrier from declining to select a provider or facility who fails to meet other legitimate selection criteria of the carrier. The purpose of these provisions is to prevent network creation and provider or facility selection to serve as a substitute for prohibited health risk avoidance or prohibited discrimination.

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

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

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

WAC 284-43-320 Provider contracts—Standards—Hold harmless provisions. The execution of a contract by a health carrier shall not relieve the health carrier of its obligations to any covered person for the provision of health care services, nor of its responsibility for compliance with statutes or regulations. In addition to the contract form filing requirements of this subchapter, all individual provider and facility contracts shall be in writing and available for review upon request by the commissioner.

(1) A health carrier shall establish a mechanism by which its participating providers and facilities can obtain timely information on patient eligibility for health care services and health plan benefits, including any limitations or conditions on services or benefits.

Nothing contained in a participating provider or a participating facility contract may have the effect of modifying benefits, terms, or conditions contained in the health plan. In the event of any conflict between the contract and a health plan, the benefits, terms, and conditions of the health plan shall govern with respect to coverage provided to covered persons.

(2) Each participating provider and participating facility contract shall contain the following provisions or variations approved by the commissioner:

(a) "{Name of provider or facility} hereby agrees that in no event, including, but not limited to nonpayment by {name of carrier}, {name of carrier's} insolvency, or breach of this contract shall {name of provider or facility} bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against a covered person or person acting on their behalf, other than {name of carrier}, for services provided pursuant to this contract. This provision shall not prohibit collection of {deductibles, copayments, coinsurance, and/or noncovered services}, which have not otherwise been paid by a primary or secondary carrier in accordance with regulatory standards for coordination of benefits, from covered persons in accordance with the terms of the covered person's health plan."

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

(c) "Notwithstanding any other provision of this contract, nothing in this contract shall be construed to modify the rights and benefits contained in the covered person's health plan."

(d) "{Name of provider or facility} may not bill the covered person for covered services (except for deductibles, copayments, or coinsurance) where {name of carrier} denies payments because the provider or facility has failed to comply with the terms or conditions of this contract."

(e) "{Name of provider or facility} further agrees (i) that the provisions of (a), (b), (c), and (d) of this subsection {or identifying citations appropriate to the contract form} shall survive termination of this contract regardless of the cause giving rise to termination and shall be construed to be for the benefit of {name of carrier's} covered persons, and (ii) that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between {name of provider or facility} and covered persons or persons acting on their behalf."

(f) "If {name of provider or facility} contracts with other providers or facilities who agree to provide covered services to covered persons of {name of carrier} with the expectation of receiving payment directly or indirectly from {name of carrier}, such providers or facilities must agree to abide by the provisions of (a), (b), (c), (d), and (e) of this subsection {or identifying citations appropriate to the contract form}."

(3) The contract shall inform participating providers and facilities that willfully collecting or attempting to collect an amount from a covered person knowing that collection to be in violation of the participating provider or facility contract constitutes a class C felony under RCW 48.80.030(5).

(4) A health carrier shall notify participating providers and facilities of their responsibilities with respect to the health carrier's applicable administrative policies and programs, including but not limited to payment terms, utilization review, quality assessment and improvement programs, credentialing, grievance procedures, data reporting requirements, confidentiality requirements and any applicable federal or state requirements.

Documents, procedures, and other administrative policies and programs referenced in the contract must be available for review by the provider or facility prior to contracting. Participating providers and facilities must be given reasonable notice of not less than sixty days of changes that affect provider or facility compensation and that affect health care service delivery unless changes to federal or state law or regulations make such advance notice impossible, in which case notice shall be provided as soon as possible. Subject to any termination and continuity of care provisions of the contract, a provider or facility may terminate the contract without penalty if the provider or facility does not agree with the changes. No change to the contract may be made retroactive without the express consent of the provider or facility.

(5) The following provision is a restatement of a statutory requirement found in RCW 48.43.075 included here for ease of reference:

(a) "No health carrier subject to the jurisdiction of the state of Washington may in any way preclude or discourage their providers from informing patients of the care they require, including various treatment options, and whether in their view such care is consistent with medical necessity, medical appropriateness, or otherwise covered by the patient's service agreement with the health carrier. No health carrier may prohibit, discourage, or penalize a provider otherwise practicing in compliance with the law from advocating on behalf of a patient with a health carrier. Nothing in this section shall be construed to authorize providers to bind health carriers to pay for any service."

(b) "No health carrier may preclude or discourage patients or those paying for their coverage from discussing the comparative merits of different health carriers with their providers. This prohibition specifically includes prohibiting or limiting providers participating in those discussions even if critical of a carrier."

(6) A health carrier shall require participating providers and facilities to make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of covered persons subject to applicable state and federal laws related to the confidentiality of medical or health records.

(7) A health carrier and participating provider and facility shall provide at least sixty days' written notice to each other before terminating the contract without cause. The health carrier shall make a good faith effort to assure that written notice of a termination within fifteen working days of

receipt or issuance of a notice of termination is provided to all covered persons who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause. Where a contract termination involves a primary care provider, that carrier shall make a good faith effort to assure that notice is provided to all covered persons who are patients of that primary care provider.

(8) A health carrier is responsible for ensuring that participating providers and facilities furnish covered services to covered persons without regard to the covered person's enrollment in the plan as a private purchaser of the plan or as a participant in publicly financed programs of health care services. This requirement does not apply to circumstances when the provider should not render services due to limitations arising from lack of training, experience, skill, or licensing restrictions.

(9) A health carrier shall not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the health carrier that jeopardizes patient health or welfare or that may violate state or federal law.

(10) The following provision is a restatement of a statutory requirement found in RCW 48.43.085: "Notwithstanding any other provision of law, no health carrier subject to the jurisdiction of the state of Washington may prohibit directly or indirectly its enrollees from freely contracting at any time to obtain any health care services outside the health care plan on any terms or conditions the enrollees choose. Nothing in this section shall be construed to bind a carrier for any services delivered outside the health plan."

(11) Every participating provider contract shall contain procedures for the fair resolution of disputes arising out of the contract.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.43.055, 48.44.050, 48.44.070, 48.46.030, 48.46.200 and 48.46.243. 99-21-016 (Matter No. R 98-21), § 284-43-320, filed 10/11/99, effective 11/11/99. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.-050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. 98-04-005 (Matter No. R 97-3), § 284-43-320, filed 1/22/98, effective 2/22/98.]

WAC 284-43-321 Provider contracts—Terms and conditions of payment. (1) Every participating provider and facility contract shall set forth a schedule for the prompt payment of amounts owed by the carrier to the provider or facility and shall include penalties for carrier failure to abide by that schedule. At a minimum, these contract provisions shall conform to the standards of this section.

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

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

(ii) Ninety-five percent of the monthly volume of all claims shall be paid or denied within sixty days of receipt by the responsible carrier or agent of the carrier, except as agreed to in writing by the parties on a claim-by-claim basis.

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

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

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

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

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

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

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

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

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

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

WAC 284-43-322 Provider contracts—Dispute resolution process. Except as otherwise required by a specific federal or state statute or regulation governing dispute resolution, no process for the resolution of disputes arising out of a participating provider or facility contract shall be considered fair under RCW 48.43.055 unless the process meets all the provisions of this section.

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

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

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

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

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

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

WAC 284-43-323 Pharmacy identification cards. (1) This rule outlines the minimum standards for prescription claims processing as directed by RCW 48.43.023.

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

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

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

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

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

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

(3) Provider and facility contracts may not contain billing audit standards that are not mutual. For example, if the carrier grants itself the right to audit hospital billing records, then the hospital has the right to audit carrier denials of the hospital's claims.

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

WAC 284-43-330 Participating provider—Filing and approval. (1) Beginning May 1, 1998, a health carrier shall file with the commissioner fifteen working days prior to use sample contract forms proposed for use with its participating providers and facilities. A health carrier need not submit contract provisions governing payment rates, amounts, or similar proprietary information that would indicate provider or facility compensation.

(2) A health carrier shall submit material changes to a sample contract form to the commissioner fifteen working days prior to use. Carriers shall indicate in the filing whether any change affects a provision required by this chapter. All changes to contracts must be indicated through strike outs for deletions and underlines for new material. Alternatively, carriers may refile a sample contract that incorporates changes along with a copy of the contract addendum or amendment and any correspondence that will be sent to providers and facilities sufficient for a clear determination of contract changes. Changes not affecting a provision required by this chapter are deemed approved upon filing.

(3) If the commissioner takes no action within fifteen working days after submission of a sample contract or a material change to a sample contract form by a health carrier, the change or form is deemed approved except that the commissioner may extend the approval period an additional fifteen working days upon giving notice before the expiration of the initial fifteen-day period. Approval may be subsequently withdrawn for cause.

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

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.43.055, 48.44.050, 48.44.070, 48.46.030, 48.46.200 and 48.46.243. 99-21-016 (Matter No. R 98-21), § 284-43-330, filed 10/11/99, effective 11/11/99. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.-050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. 98-04-005 (Matter No. R 97-3), § 284-43-330, filed 1/22/98, effective 2/22/98.]

WAC 284-43-331 Effective date. (1) All participating provider and facility contracts entered into after the effective date of these rules shall comply with these rules no later than July 1, 2000.

(2) Participating provider and facility contracts entered into prior to the effective date of these rules shall be amended upon renewal to comply with these rules, and all such contracts shall conform to these provisions no later than January 1, 2001. The commissioner may extend the January 1, 2001, deadline for a health carrier for an additional six months, if the health carrier makes a written request. That request must explain how a good faith effort at compliance has been made, provide the specific reasons the deadline cannot be met, and state the date the health carrier expects to be in compliance (no more than six months beyond January 1, 2001).

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.43.055, 48.44.050, 48.44.070, 48.46.030, 48.46.200 and 48.46.243. 99-21-016 (Matter No. R 98-21), § 284-43-331, filed 10/11/99, effective 11/11/99.]

WAC 284-43-340 Effective date. (1) All participating provider and facility contracts entered into after the effective date of this subchapter shall comply with this subchapter no later than July 1, 1998.

(2) Participating provider and facility contracts entered into prior to the effective date of this subchapter shall be amended upon renewal to comply with the provisions of this subchapter, and all such contracts shall conform to the provisions of this subchapter no later than July 1, 1999. The commissioner may extend the July 1, 1999 deadline, for an additional period not to exceed six months if the health carrier demonstrates good cause for an extension.

[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. 98-04-005 (Matter No. R 97-3), § 284-43-340, filed 1/22/98, effective 2/22/98.]

SUBCHAPTER D
UTILIZATION REVIEW

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

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

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

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

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

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

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

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

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

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

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

(3) The utilization review program must meet accepted national certification standards such as those used by the National Committee for Quality Assurance except as otherwise required by this chapter and must have staff who are properly qualified, trained, supervised, and supported by explicit written clinical review criteria and review procedures.

(4) Each carrier when conducting utilization review must:

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) If the review request from the provider is not accompanied by all necessary information, the carrier must tell the provider what additional information is needed and the dead-

line for its submission. Upon the sooner of the receipt of all necessary information or the expiration of the deadline for providing information, the time frames for carrier review determination and notification must be no less favorable than federal Department of Labor standards, as follows:

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

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

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

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

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

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

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

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

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

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

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

[Statutory Authority: RCW 48.02.060, 48.43.530, P.L. 111-148 (2010, as amended) and regulations issued on June 24, 2011, amending 45 C.F.R. Part 147. 11-24-004 (Matter No. R 2011-18), § 284-43-410, filed 11/28/11, effective 12/29/11. Statutory Authority: RCW 48.02.060 and 48.43.520. 10-23-051 (Matter No. R 2009-19), § 284-43-410, filed 11/10/10, effective 12/11/10. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.100, 48.46.200, 48.43.505, 48.43.510, 48.43.515, 48.43.520, 48.43.525, 48.43.530, 48.43.535. 01-03-033 (Matter No. R 2000-02), § 284-43-410, filed 1/9/01, effective 7/1/01.]

SUBCHAPTER F
GRIEVANCE AND COMPLAINT PROCEDURES

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

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

(a) Provide a clear explanation of the grievance process upon request, upon enrollment to new covered persons, and annually to covered person and subcontractors of the carrier.

(b) Ensure that the grievance 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.

(c) Process as a grievance a covered person's expression of dissatisfaction about customer service or the quality or availability of a health service.

(d) Implement procedures for registering and responding to oral and written grievances in a timely and thorough manner including the notification of a covered person that a grievance or appeal has been received.

(e) Assist the covered person with all grievance and appeal processes.

(f) Cooperate with any representative authorized in writing by the covered person.

(g) Consider all information submitted by the covered person or representative.

(h) Investigate and resolve all grievances and appeals.

(i) Provide information on the covered person's right to obtain second opinions.

(j) 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.

[Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.100, 48.46.200, 48.43.505, 48.43.510, 48.43.515, 48.43.520, 48.43.525, 48.43.530, 48.43.535. 01-03-033 (Matter No. R 2000-02), § 284-43-615, filed 1/9/01, effective 7/1/01.]

WAC 284-43-620 Procedures for review and appeal of adverse determinations. (1) A covered person or the covered person's representative, including the treating provider (regardless of whether the provider is affiliated with the carrier) acting on behalf of the covered person may appeal an adverse determination in writing. The carrier must reconsider the adverse determination and notify the covered person of its decision within fourteen days of receipt of the appeal unless the carrier notifies the covered person that an extension is necessary to complete the appeal; however, the extension cannot delay the decision beyond thirty days of the request for appeal, without the informed, written consent of the coverage person.

(2) Whenever a health carrier makes an adverse determination and delay would jeopardize the covered person's life or materially jeopardize the covered person's health, the carrier shall expedite and process either a written or an oral

appeal and issue a decision no later than seventy-two hours after receipt of the appeal. If the treating health care provider determines that delay could jeopardize the covered person's health or ability to regain maximum function, the carrier shall presume the need for expeditious review, including the need for an expeditious determination in any independent review under WAC 284-43-630.

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

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

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

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

[Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.100, 48.46.200, 48.43.505, 48.43.510, 48.43.515, 48.43.520, 48.43.525, 48.43.530, 48.43.535. 01-03-033 (Matter No. R 2000-02), § 284-43-620, filed 1/9/01, effective 7/1/01. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.43.055, 48.44.050, 48.46.100 and 48.46.200. 99-24-075 (Matter No. R 98-17), § 284-43-620, filed 11/29/99, effective 12/30/99.]

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

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

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

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

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

(b) Provide IROs with:

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

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

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

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

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

[Statutory Authority: RCW 48.02.060 and 48.53.535(10). 08-07-101 (Matter R 2006-11), § 284-43-630, filed 3/19/08, effective 4/19/08. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.100, 48.46.200, 48.43.505, 48.43.510, 48.43.515, 48.43.520, 48.43.525, 48.43.530, 48.43.535. 01-03-033 (Matter No. R 2000-02), § 284-43-630, filed 1/9/01, effective 7/1/01.]

SUBCHAPTER H
HEALTH PLAN BENEFITS

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

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

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

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

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

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

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

WAC 284-43-815 Coverage for pharmacy services. (1) The commissioner may disapprove any contract issued or renewed after July 1, 2001, that includes coverage for pharmacy services if the following statement is not provided to covered persons at the time of enrollment:

YOUR RIGHT TO SAFE AND EFFECTIVE PHARMACY SERVICES

State and federal laws establish standards to assure safe and effective pharmacy services, and to guarantee your right to know what drugs are covered under this plan and what coverage limitations are in your contract. If you would like more information about the drug coverage policies under this plan, or if you have a question or a concern about your pharmacy

benefit, please contact us (the health carrier) at 1-800-???-????.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) Health plan disclosures must be current and:

(a) Provided by paper copy upon request;

(b) Provided by electronic communication upon request;

(c) Clearly identified as health plan disclosures; and

(d) Prominently displayed and accessible on the carrier's web site.

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

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

[Statutory Authority: RCW 48.02.060 and 48.43.510. 10-02-068 (Matter No. R 2008-16), § 284-43-820, filed 1/4/10, effective 2/4/10. Statutory

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

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

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

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

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

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

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

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

(f) For purposes of subsections (1) and (2) of this section, "prescription contraceptives" include United States Food and Drug Administration (FDA) approved contraceptive drugs, devices, and prescription barrier methods, including contraceptive products declared safe and effective for use as emergency contraception by the FDA.

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

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

WAC 284-43-899 Effective date. The effective date of WAC 284-43-130, 284-43-200, 284-43-251, 284-43-400, 284-43-410, 284-43-610, 284-43-615, 284-43-620, 284-43-630, and 284-43-820 is July 1, 2001.

[Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.100, 48.46.200, 48.43.505, 48.43.510, 48.43.515, 48.43.520, 48.43.525, 48.43.530, 48.43.535. 01-03-033 (Matter No. R 2000-02), § 284-43-899, filed 1/9/01, effective 2/9/01.]

SUBCHAPTER I—HEALTH PLAN RATES

WAC 284-43-901 Authority and purpose. This subchapter is adopted under the general authority of RCW 48.02.060, 48.44.017, 48.44.020, 48.44.050, 48.46.060, 48.46.062, and 48.46.200. Its purpose is to provide guidelines for the implementation of RCW 48.44.017(2), 48.44.020(3), 48.44.022, 48.44.023, 48.44.040, 48.46.060 (4) and (6), 48.46.062(2), 48.46.064, and 48.46.066 as to the filing of contract forms by health care service contractors and health maintenance organizations and the calculations and evaluations of premium rates for these contracts.

[Statutory Authority: RCW 48.02.060, 48.18.110, 48.44.020, 48.44.050, 48.46.060, 48.46.200. 08-20-071 (Matter No. R 2008-08), § 284-43-901, filed 9/25/08, effective 10/26/08.]

WAC 284-43-905 Applicability and scope. This subchapter applies to health benefit plans as defined in RCW 48.43.005, and contracts for limited health care services as defined in RCW 48.44.035, offered by health care service contractors and health maintenance organizations transacting business in this state under chapter 48.44 or 48.46 RCW. It applies to such plans purchased directly by individuals, small employers, large employers and other organizations.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 05-07-006 (Matter No. R 2004-05), § 284-43-905, filed 3/3/05, effective 4/3/05. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066. 98-04-011 (Matter No. R 97-2), § 284-43-905, filed 1/23/98, effective 3/1/98.]

WAC 284-43-910 Definitions. For the purpose of this subchapter:

(1) "Adjusted earned premium" means the amount of "earned premium" the "carrier" would have earned had the "carrier" charged current "premium rates" for all applicable "plans."

(2) "Annualized earned premium" means the "earned premium" that would be earned in a twelve-month period if earned at the same rate as during the applicable period.

(3) "Anticipated loss ratio" means the "projected incurred claims" divided by the "projected earned premium."

(4) "Base rate" means the "premium" for a specific "plan," expressed as a monthly amount per "covered person or subscriber," prior to any adjustments for geographic area, age, family size, wellness activities, tenure, or any other factors as may be allowed.

(5) "Capitation expenses" means the amount paid to a provider or facility on a per "covered person" basis, or as part

of risk-sharing provisions, for the coverage of specified health care services.

(6) "Carrier" means a health care service contractor or health maintenance organization.

(7) "Certificate" means the statement of coverage document furnished "subscribers" covered under a "group contract."

(8) "Claim reserves" means the "claims" that have been reported but not paid plus the "claims" that have not been reported but may be reasonably expected.

(9) "Claims" means the cost to the "carrier" of health care services provided to a "covered person" or paid to or on behalf of the "covered person" in accordance with the terms of a "plan." This includes "capitation payments" or other similar payments made to providers or facilities for the purpose of paying for health care services for a "covered person."

(10) "Community rate" means the weighted average of all "premium rates" within a filing with the weights determined according to current enrollment.

(11) "Contract" means an agreement to provide health care services or pay health care costs for or on behalf of a "subscriber" or group of "subscribers" and such eligible dependents as may be included therein.

(12) "Contract form" means the prototype of a "contract" and any associated riders and endorsements filed with the commissioner by a health care service contractor or health maintenance organization.

(13) "Contribution to surplus, contingency charges, or risk charges" means the portion of the "projected earned premium" not associated directly with "claims" or "expenses."

(14) "Covered person" or "enrollee" has the same meaning as that contained in RCW 48.43.005.

(15) "Current community rate" means the weighted average of the "community rates" at the renewal or initial effective dates of each plan for the year immediately preceding the renewal period, with weights determined according to current enrollment.

(16) "Current enrollment" means the monthly average number and demographic makeup of the "covered persons" for the applicable contracts during the most recent twelve months for which information is available to the carrier.

(17) "Earned premium" means the "premium" plus any rate credits or recoupments, applicable to an accounting period whether received before, during, or after such period.

(18) "Expenses" means costs that include but are not limited to the following:

(a) Claim adjudication costs;

(b) Utilization management costs if distinguishable from "claims";

(c) Home office and field overhead;

(d) Acquisition and selling costs;

(e) Taxes; and

(f) All other costs except "claims."

(19) "Experience period" means the most recent twelve-month period from which the carrier accumulates the data to support a filing.

(20) "Extraordinary expenses" means "expenses" resulting from occurrences atypical of the normal business activities of the "carrier" that are not expected to recur regularly in the near future.

(21) "Group contract" or "group plan" means an agreement issued to an employer, corporation, labor union, association, trust, or other organization to provide health care services to employees or members of such entities and the dependents of such employees or members.

(22) "Incurred claims" means "claims" paid during the applicable period plus the "claim reserves" as of the end of the applicable period minus the "claim reserves" as of the beginning of the applicable period. Alternatively, for the purpose of providing monthly data or trend analysis, "incurred claims" may be defined as the current best estimate of the "claims" for services provided during the applicable period.

(23) "Individual contract" means a "contract" issued to and covering an individual. An "individual contract" may include dependents.

(24) "Investment earnings" means the income, dividends, and realized capital gains earned on an asset.

(25) "Loss ratio" means "incurred claims" as a percentage of "earned premiums" before any deductions.

(26) "Medical care component of the consumer price index for all urban consumers" means the similarly named figure published monthly by the United States Bureau of Labor Statistics.

(27) "Net worth or reserves and unassigned funds" means the excess of assets over liabilities on a statutory basis.

(28) "Plan" means a "contract" that is a health benefit plan as defined in RCW 48.43.005 or a "contract" for limited health care services as defined in RCW 48.44.035.

(29) "Premium" has the same meaning as that contained in RCW 48.43.005.

(30) "Premium rate" means the "premium" per "subscriber" or "covered person" obtained by adjusting the "base rate" for geographic area, family size, age, wellness activities, or any other factors as may be allowed.

(31) "Projected earned premium" means the "earned premium" that would be derived from applying the proposed "premium rates" to the current enrollment.

(32) "Projected incurred claims" means the estimate of "incurred claims" for the rate renewal period based on the current enrollment.

(33) "Proposed community rate" means the weighted average of the "community rates" at the renewal dates of each plan for the renewal period, with weights determined according to current enrollment.

(34) "Provider" has the same meaning as that contained in RCW 48.43.005.

(35) "Rate renewal period" means the period for which the proposed "premium rates" are intended to remain in effect.

(36) "Rate schedule" means the schedule of all "base rates" for "plans" included in the filing.

(37) "Requested increase in the community rate" means the amount, expressed as a percentage, by which the "proposed community rate" exceeds the "current community rate."

(38) "Service type" means the category of service for which "claims" are paid, such as hospital, professional, dental, prescription drug, or other.

(39) "Small group contracts" or "small group plans" means the class of "group contracts" issued to "small employers," as that term is defined in RCW 48.43.005.

(40) "Staffing data" means statistics on the number of providers and associated compensation required to provide a fixed number of services or provide services to a fixed number of "covered persons."

(41) "Subscriber" means a person on whose behalf a "contract" or "certificate" is issued.

(42) "Unit cost data" means statistics on the cost per health care service provided to a "covered person."

(43) "Utilization data" means statistics on the number of services used by a fixed number of "covered persons" over a fixed length of time.

[Statutory Authority: RCW 48.02.060, 48.18.110, 48.44.020, 48.44.050, 48.46.060, 48.46.200. 08-20-071 (Matter No. R 2008-08), § 284-43-910, filed 9/25/08, effective 10/26/08. Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 05-07-006 (Matter No. R 2004-05), § 284-43-910, filed 3/3/05, effective 4/3/05. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066. 98-04-011 (Matter No. R 97-2), § 284-43-910, filed 1/23/98, effective 3/1/98.]

WAC 284-43-915 Demonstration that benefits provided are not reasonable in relation to the amount charged for a contract per RCW 48.44.020 and 48.46.060. (1) The provisions of this section are in addition to the requirements set forth in RCW 48.44.022, 48.44.023, 48.46.064, and 48.46.066.

(2) Benefits will be found not to be unreasonable if the projected earned premium for the rate renewal period is equal to the following:

(a) An actuarially sound estimate of incurred claims associated with the filing for the rate renewal period, where the actuarial estimate of claims recognizes, as applicable, the savings and costs associated with managed care provisions of the plans included in the filing; plus

(b) An actuarially sound estimate of prudently incurred expenses associated with the plans included in the filing for the rate renewal period, where the estimate is based on an equitable and consistent expense allocation or assignment methodology; plus

(c) An actuarially sound provision for contribution to surplus, contingency charges, or risk charges, where the justification recognizes the carrier's investment earnings on assets other than those related to claim reserves or other similar liabilities; minus

(d) An actuarially sound estimate of the forecasted investment earnings on assets related to claim reserves or other similar liabilities for the plans included in the filing for the rate renewal period.

(3) The contribution to surplus, contingency charges, or risk charges in subsection (2)(c) of this section, will not be required to be less than zero.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 05-07-006 (Matter No. R 2004-05), § 284-43-915, filed 3/3/05, effective 4/3/05. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066. 98-04-011 (Matter No. R 97-2), § 284-43-915, filed 1/23/98, effective 3/1/98.]

WAC 284-43-920 When a carrier is required to file. (1) Carriers must file with the commissioner every contract form and rate schedule and modification of a contract form and rate schedule:

(a) Before the contract form is offered for sale to the public and before the rate schedule is used; and

(b) Within thirty days after the end of an eighteen-month period during which a previous filing has remained unchanged for such period, including contract forms filed prior to the effective date of this regulation.

(2) Filings of negotiated contract forms, and applicable rate schedules, that are placed into effect at time of negotiation or that have a retroactive effective date are not required to be filed in accordance with subsection (1)(a) and (b) of this section, but must be filed within thirty working days after the earlier of:

(a) The date group contract negotiations are completed; or

(b) The date renewal premiums are implemented.

(3) An explanation for any filing delayed beyond the thirty-day period as described in subsection (2) of this section must be given on the filing document as set forth in WAC 284-43-950.

(4) If written confirmation of the commissioner's final action is desired, the carrier must submit with the filing duplicate copies of the filing transmittal and cover letter, along with a return self-addressed, stamped envelope. The duplicate transmittal will note the commissioner's final action and will be returned to the sender in the return envelope enclosed with the filing.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 05-07-006 (Matter No. R 2004-05), § 284-43-920, filed 3/3/05, effective 4/3/05. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066. 98-04-011 (Matter No. R 97-2), § 284-43-920, filed 1/23/98, effective 3/1/98.]

WAC 284-43-925 General contents of all filings. Each filing required by WAC 284-43-920 must be submitted with the filing transmittal form prescribed by and available from the commissioner. The form must include the name of the filing entity, its address, identification number, the type of filing being submitted, the form name or group name and number, and other relevant information. Filings also must include the information required on the filing summary set forth in WAC 284-43-945 for individual and small group plans and rate schedules or as set forth in WAC 284-43-950 for group plans and rate schedules other than those for small groups.

[Statutory Authority: RCW 48.02.060, 48.18.110, 48.44.020, 48.44.050, 48.46.060, 48.46.200. 08-20-071 (Matter No. R 2008-08), § 284-43-925, filed 9/25/08, effective 10/26/08. Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 05-07-006 (Matter No. R 2004-05), § 284-43-925, filed 3/3/05, effective 4/3/05. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066. 98-04-011 (Matter No. R 97-2), § 284-43-925, filed 1/23/98, effective 3/1/98.]

WAC 284-43-930 Contents of individual and small group filings. Under RCW 48.44.022 and 48.46.064 the experience of all individual plans must be pooled. Under RCW 48.44.023 and 48.46.066 the experience of all small group plans must be pooled. Filings for individual plans must include each individual plan rate schedule. Filings for small group plans must include base rates and annual base rate changes in dollar and percentage amounts for each small group plan. Each individual and small group filing must include the following information and documents:

(1) An actuarially sound estimate of incurred claims. Experience data, assumptions, and justifications of the carrier's projected incurred claims must be provided in a manner consistent with the carrier's rate-making methodology and incorporate the following elements:

(a) A brief description of the carrier's rate-making methodology, including identification of the data used and the kinds of assumptions and projections made.

(b) The number of subscribers by family size, or covered persons for the plans included in the filing. These figures must be shown for each month or quarter of the experience period and the prior two periods if not included in previous filings. This data must be presented in aggregate for the plans included in the filing and in aggregate for all of the carrier's plans.

(c) Earned premium for each month or quarter of the experience period and the prior two periods if not included in previous filings, for the plans included in the filing.

(d) An estimate of the adjusted earned premium for each month or quarter of the experience period and prior two periods for the plans included in the filing.

(e) Claims data for each month or quarter of the experience period and the prior two periods. Examples of claims data are incurred claims, capitation payments, utilization data, unit cost data, and staffing data. The specific data elements included in the filing must be consistent with the carrier's rate-making methodology.

(f) Documentation and justification of any adjustments made to the experience data.

(g) Documentation and justification of the factors and methods used to forecast incurred claims.

(2) An actuarially sound estimate of prudently incurred expenses. Experience data, assumptions, and justifications must be provided by the carrier as follows:

(a) A breakdown of the carrier's expenses allocated or assigned to the plans included in the filing for the experience period or for the period corresponding to the most recent "annual statement";

(i) An expense breakdown at least as detailed as the annual statement schedule "Underwriting and Investment Exhibit, Part 3, Analysis of Expenses" as revised from time to time;

(ii) The allocation and assignment methodology used in (a)(i) of this subsection may be based on readily available data and easily applied calculations;

(b) Identification of any extraordinary experience period expenses; and

(c) Documentation and justification of the assignment or allocation of expenses to the plans included in the filing; and

(d) Documentation and justification of forecasted changes in expenses.

(3) An actuarially sound provision for contribution to surplus, contingency charges, or risk charges. Assumptions and justifications must be provided by the carrier as follows:

(a) The methodology, justification, and calculations used to determine the contribution to surplus, contingency charges, or risk charges included in the proposed base rates; and

(b) The carrier's net worth or reserves and unassigned surplus at the beginning and end of the experience period.

(4) An actuarially sound estimate of forecasted investment earnings on assets related to claim reserves or other similar liabilities. The carrier must include documentation and justification of forecasted investment earnings identified in dollars, and as a percentage of total premiums and the amount credited to the plans included in the filing.

(5) Adjustment of the base rate. Experience data, assumptions, justifications, and methodology descriptions must be provided and must include:

(a) Justifications for adjustments to the base rate, supported by data if appropriate, attributable to geographic region, age, family size, tenure discounts, and wellness activities;

(b) Justifications, supported by data if appropriate, of any other factors or circumstances used to adjust the base rates; and

(c) Description of the methodology used to adjust the base rate to obtain the premium rate for a specific individual or group, which is detailed enough to allow the commissioner to replicate the calculation of premium rates if given the necessary data.

(6) Actuarial certification. Certification by an actuary, as required by RCW 48.44.017(2), 48.44.023(3), 48.46.062(2) and 48.46.066(3).

(7) The requirements of subsections (1) through (6) of this section may be waived or modified upon the finding by the commissioner that a plan contains or involves unique provisions or circumstances and that the requirements represent an extraordinary administrative burden on the carrier.

[Statutory Authority: RCW 48.02.060, 48.18.110, 48.44.020, 48.44.050, 48.46.060, 48.46.200. 08-20-071 (Matter No. R 2008-08), § 284-43-930, filed 9/25/08, effective 10/26/08. Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 05-07-006 (Matter No. R 2004-05), § 284-43-930, filed 3/3/05, effective 4/3/05. Statutory Authority: RCW 48.02.060 and 48.92.140. 98-11-089 (Matter No. R 98-8), § 284-43-930, filed 5/20/98, effective 6/20/98. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066. 98-04-011 (Matter No. R 97-2), § 284-43-930, filed 1/23/98, effective 3/1/98.]

WAC 284-43-935 Experience records. (1) For each plan, carriers must maintain the following records for five years:

(a) Incurred claims;

(b) Earned premiums; and

(c) Expenses.

(2) Such records must include data for rider and endorsement forms that are used with the contract forms. Separate data may be maintained for each rider or endorsement form as appropriate. For recordkeeping purposes, carriers may combine experience under contract forms that provide substantially similar coverage.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 05-07-006 (Matter No. R 2004-05), § 284-43-935, filed 3/3/05, effective 4/3/05. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066. 98-04-011 (Matter No. R 97-2), § 284-43-935, filed 1/23/98, effective 3/1/98.]

WAC 284-43-940 Evaluating experience data. In determining the credibility and appropriateness of experience data, consideration will be given to all relevant factors, including:

(1) Statistical credibility of the amount charged and services and benefits paid, such as low exposure, low loss frequency, and recoupment;

(2) Actual and projected trends relative to changes in medical costs and changes in utilization;

(3) The mix of business by risk classification; and

(4) Adverse selection or lapse factors reasonably expected in connection with revisions to plan provisions, services, benefits, and amount charged.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 05-07-006 (Matter No. R 2004-05), § 284-43-940, filed 3/3/05, effective 4/3/05. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066. 98-04-011 (Matter No. R 97-2), § 284-43-940, filed 1/23/98, effective 3/1/98.]

WAC 284-43-945 Summary for individual and small group contract filings.

INDIVIDUAL AND SMALL GROUP FILING SUMMARY

Carrier Name _____
Address _____
_____
_____
Carrier Identification Number _____

Rate Renewal Period: From _____ To _____
Date Submitted: _____

Proposed Rate Summary

Current community rate	_____ per month
Proposed community rate	_____ per month
Percentage change	_____ %
Portion of carrier's total enrollment affected	_____ %
Portion of carrier's total premium revenue affected	_____ %

Components of Proposed Community Rate

	Dollars Per Month	% of Total
a) Claims		
b) Expenses		
c) Contribution to surplus, contingency charges, or risk charges		
d) Investment earnings		
e) Total (a + b + c - d)		

Summary of Pooled Experience

	Experience Period From To	First Prior Period From To	Second Prior Period From To
Member Months			
Earned Premium			
Paid Claims			
Beginning Claim Reserve			
Ending Claim Reserve			
Incurred Claims			
Expenses			
Gain/Loss			
Loss Ratio Percentage			

General Information

1. Trend Factor Summary

Type of Service	Annual Trend Assumed	Portion of Claim Dollars
Hospital	%	%
Professional	%	%
Prescription Drugs	%	%
Dental	%	%
Other	%	%

2. List the effective date and the rate of increase for all rate changes in the past three rate periods.

1) _____ Date _____ % 2) _____ Date _____ % 3) _____ Date _____ %

3. Since the previous filing, have any changes been made to the factors or methodology for adjusting base rates?

Geographic Area	☐Yes	☐No
Family Size	☐Yes	☐No
Age	☐Yes	☐No
Wellness Activities	☐Yes	☐No
Other (specify)	☐Yes	☐No

4. Attach a table showing the base rate for each plan affected by this filing.
5. Attach comments or additional information.
6. Preparer's Information

Name: _____
Title: _____
Telephone Number: _____

[Statutory Authority: RCW 48.02.060, 48.18.110, 48.44.020, 48.44.050, 48.46.060, 48.46.200. 08-20-071 (Matter No. R 2008-08), § 284-43-945, filed 9/25/08, effective 10/26/08. Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 05-07-006 (Matter No. R 2004-05), § 284-43-945, filed 3/3/05, effective 4/3/05. Statutory Authority: RCW 48.02.060, 48.44.-050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066. 98-04-011 (Matter No. R 97-2), § 284-43-945, filed 1/23/98, effective 3/1/98.]

WAC 284-43-950 Summary for group contract filings other than small group contract filings.

GROUPS OTHER THAN SMALL GROUPS FILING SUMMARY

Carrier Name _____
Address _____
_____
_____
Contract Holder/Pool Category and Name (Check One Box) ☐ Single Employer Group:
Employer Name:
☐ Multiemployer other than Association/Trust Groups
Group Pool Name:
☐ Association/Trust Groups
Association/Trust Group Name:
Contract Form Number _____
Rate Form Number (if different from Contract Form Number) _____
Product Name _____

If additional space is required to list the contract/rate form number and product name, attach a separate sheet.

Rate Renewal Period: From: _____ To: _____
Date Submitted: _____
Type of Filing (Check One Box) ☐New Group Contract ☐ Revision of Existing Group Contract

Proposed Rate Schedules: Attach a separate sheet to list all proposed tier rates.

Rate Summary

Current Rate (Composite per employee or per member)	$_____ per member per month
Percentage Rate Change	_____%
New Rate	$_____ per member per month
Average Number of Enrollees Each Month During the Experience Period (If the average number of enrollees is equal to or less than fifty, explain why this is not a small group, as defined in RCW 48.43.005.)	_____
Anticipated Loss Ratio	_____%
Portion of carrier's total enrollment affected	_____%
Portion of carrier's total premium revenue affected	_____%

Summary of Contract Experience

	Experience Period From To	First Prior Period From To	Second Prior Period From To
Member Months			
Billed Premium			
Incurred Claims			
Expenses			
Gain/Loss			
Experience Refund/Credit or Recoupment			
Earned Premium (Billed Premium - /+ Refund/Credit or Recoupment)			
Loss Ratio Percentage			

Attach comments or additional information.
Preparer's Information
Name: _____
Title: _____
Telephone Number: _____

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 05-07-006 (Matter No. R 2004-05), § 284-43-950, filed 3/3/05, effective 4/3/05. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066. 98-04-011 (Matter No. R 97-2), § 284-43-950, filed 1/23/98, effective 3/1/98.]

SUBCHAPTER J
HEALTH PLAN ENROLLMENT AND COVERAGE REQUIREMENTS

WAC 284-43-970 Purpose and scope. These rules explain the requirements in effect in Washington governing the issue of individual health insurance or health benefit plans to persons under age nineteen, based on section 2704 of the Public Health Service Act, as amended by section 1201 of the Patient Protection and Affordable Care Act, P.L. 111-148 and the interim final regulations interpreting it, 45 CFR 145.103 and 147.108 (2010), which provide that a carrier may not apply preexisting condition exclusions or coverage limitations for persons under age nineteen.

[Statutory Authority: RCW 48.02.060, 48.18.120(2), 48.20.450, 48.44.050, 48.46.200, and P.L. 111-148 and the interim final regulations issued June 28, 2010, found at Vol. 75 F.R. 37187-37241, and codified in 45 C.F.R. Parts 144, 146 and 147. 11-13-068 (Matter No. R 2010-16), § 284-43-970, filed 6/15/11, effective 7/16/11.]

WAC 284-43-975 Definitions. As used in this section, unless the context requires otherwise:

(1) "Applicant" means a person who applies for enrollment in an individual health plan as a subscriber or an enrollee, or the dependent or spouse of a subscriber or enrollee. For purposes of this subchapter J, a legal guardian is an applicant if they apply for an individual coverage on behalf of a person under age nineteen.

(2) "Carrier" has the same meaning as its definition in RCW 48.43.005(18) and includes "issuers" as that term is used in the Patient Protection and Affordable Care Act, P.L. 111-148.

(3) "Open enrollment" means a period of time as defined in these rules, held at the same time each year, 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.

(4) "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.

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

[Statutory Authority: RCW 48.02.060, 48.18.120(2), 48.20.450, 48.44.050, 48.46.200, and P.L. 111-148 and the interim final regulations issued June 28, 2010, found at Vol. 75 F.R. 37187-37241, and codified in 45 C.F.R. Parts 144, 146 and 147. 11-13-068 (Matter No. R 2010-16), § 284-43-975, filed 6/15/11, effective 7/16/11.]

WAC 284-43-980 Preexisting conditions. For individual health plan applicants and nongrandfathered individual plan enrollees under age nineteen, a carrier must not apply a preexisting condition to limit eligibility, exclude benefits, deny coverage or otherwise limit coverage. This requirement includes those persons under age nineteen with a preexisting condition who seek coverage as the primary insured or as a dependent or as a spouse under individual health benefit plans that permit the enrollment of dependents, and enrolled persons under age nineteen who seek benefits for which they are otherwise eligible.

[Statutory Authority: RCW 48.02.060, 48.18.120(2), 48.20.450, 48.44.050, 48.46.200, and P.L. 111-148 and the interim final regulations issued June 28, 2010, found at Vol. 75 F.R. 37187-37241, and codified in 45 C.F.R. Parts 144, 146 and 147. 11-13-068 (Matter No. R 2010-16), § 284-43-980, filed 6/15/11, effective 7/16/11.]

WAC 284-43-985 Enrollment of persons under age nineteen. (1) For any individual health benefit plan offered after January 1, 2011, a carrier must conduct an open enrollment period for persons under age nineteen during two time periods each year. The first open enrollment period must occur from March 15th through April 30th of each year, and the second open enrollment period must occur from September 15th through October 31st.

(2) A carrier must use the same method to establish the effective date of coverage for persons under age nineteen enrolling during either one of the open enrollment periods or

a special enrollment period set forth in this rule that they use for any other individual health plan enrollee.

(3) A carrier must make a special enrollment period of not less than thirty-one days available to any person under age nineteen who experiences a qualifying event. A qualifying event means the occurrence of one of the following:

(a) The discontinuation for any reason of employer sponsored insurance coverage of a person under age nineteen or the person under whose policy they were enrolled;

(b) The loss of eligibility of person under age nineteen for medicaid or a public program providing health benefits;

(c) The loss of coverage for a person under age nineteen as the result of dissolution of marriage;

(d) The person under age nineteen or the person under whose policy they were enrolled changes residence, and the health plan under which they were covered does not provide coverage in that person's new service area;

(e) The person for whom coverage is sought was born, placed for adoption or adopted within sixty days of the application for enrollment. For newborns enrolled under an individual policy, coverage must be effective as of the moment of birth;

(f) Nothing in this rule is intended to alter or affect the application of RCW 48.43.517.

(4) During the enrollment periods described in subsections (1) through (3) of this section, or any other enrollment period, a carrier must not require a person under age nineteen applying for an individual health benefit plan to complete the standard health questionnaire designated under chapter 48.41 RCW or otherwise provide evidence of insurability.

(5) A carrier may offer enrollment in an individual health benefit plan outside the open or special enrollment period, but must not require any evidence of insurability or completion of the standard health questionnaire if the applicant is a person under age nineteen.

(6) A carrier must not limit the choice of individual plan for which a person under age nineteen may apply based on the applicant's age.

(7) A carrier must prominently display on its web site information about open enrollment periods and special enrollment periods for persons under age nineteen.

(a) If a carrier elects to limit enrollment for persons under nineteen to the open enrollment periods or a special enrollment period triggered by a qualifying event, the carrier must:

(i) Explain that fact on its web site;

(ii) Promptly make application packets available to interested persons upon request, even if the request is made outside the open enrollment periods; and

(iii) Provide contact information for the Washington state high risk pool and the federally sponsored preexisting condition insurance pool - Washington.

(b) The web site information about special enrollment periods must provide a consumer with the ability to access or request and receive an application packet for enrollment at any time. The displayed information must also include details written in plain language explaining what constitutes a qualifying event for special enrollment.

[Statutory Authority: RCW 48.02.060, 48.18.120(2), 48.20.450, 48.44.050, 48.46.200, and P.L. 111-148 and the interim final regulations issued June 28, 2010, found at Vol. 75 F.R. 37187-37241, and codified in 45 C.F.R. Parts 144, 146 and 147. 11-13-068 (Matter No. R 2010-16), § 284-43-985, filed 6/15/11, effective 7/16/11.]