WSR 13-04-027
EMERGENCY RULES
OFFICE OF INSURANCE COMMISSIONER

[Insurance Commissioner Matter No. R 2013-03—Filed January 29, 2013, 3:08 p.m., effective January 29, 2013, 3:08 p.m.]

Effective Date of Rule: Immediately.

Purpose: Provide health plan issuers with specific guidance regarding form and rate filing of nongrandfathered individual and small group health plans for the 2014 benefit year, in relation to ensuring that an issuer's product and plan filing is substantially equal to the essential health benefits (EHB)-benchmark plan, and that the actuarial values for each EHB category are substantially equal to the EHB-benchmark plan. The rules identify the specific services that are classified to the ten EHB categories, as found in the base-benchmark plan and the supplemental benchmark plans; habilitative services are defined and benefit limitation and scope for those services are set forth in the rule.

Statutory Authority for Adoption: RCW 48.02.060, 48.21.241, 48.21.320, 48.44.460, 48.44.341, 48.46.291, 48.46.530, and 48.43.715.

Other Authority: P.L. 111-148, section 1302 (2010).

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.

Reasons for this Finding: Health plan issuers must replace currently offered nongrandfathered individual and small group plans for the 2014 benefit year due to a number of required changes pursuant to federal health care reform. The deadline for state decisions to approve or disapprove proposed replacement products is July 31, 2013. To meet this deadline, products must be filed for review by the commissioner not later than April 1, 2013. This emergency rule provides issuers with the necessary information to ensure that products are timely filed, so that issuers are able to participate in the individual and small group health plan markets in Washington.

Number of Sections Adopted in Order to Comply with Federal Statute: New 9, Amended 0, Repealed 0; Federal Rules or Standards: New 9, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 9, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 9, Amended 0, Repealed 0.

Date Adopted: January 29, 2013.

Mike Kreidler
Insurance Commissioner

NEW SECTION

WAC 284-43-849 Purpose and scope. For plan years beginning on or after January 1, 2014, each nongrandfathered health benefit plan offered, issued, amended or renewed to small employers or individuals, both inside and outside the Washington health benefit exchange, must provide coverage for a package of essential health benefits, pursuant to RCW 48.43.715. This subchapter explains the regulatory standards related to this coverage, establishes supplementation of the base-benchmark plan, consistent with PPACA and RCW 48.43.715, and the final parameters for the state EHB-benchmark plan.

(1) This subchapter does not apply to a health benefit plan that provides excepted benefits as described in section 2722 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-21), or a health benefit plan that qualifies as a grandfathered health plan as defined in RCW 48.43.005.

(2) This subchapter does not require provider reimbursement at the same levels negotiated by the base-benchmark plan's issuer for their plan.

(3) This subchapter does not require a plan to exclude the services or treatments from coverage that are excluded in the base-benchmark plan.

NEW SECTION

WAC 284-43-852 Definitions. The following definitions apply to this subchapter unless the context indicates otherwise.

"Base-benchmark plan" means the small group plan with the largest enrollment, as designated in WAC 284-43-850(1), prior to any adjustments made pursuant to RCW 48.43.715.

"EHB-benchmark plan" means the set of benefits that an issuer must include in non-grandfathered plans offered in the individual or small group market in Washington state.

"Health benefit," unless defined differently pursuant to federal rules, regulations, or guidance issued pursuant to section 1302(b) of PPACA, means health care items or services for injury, disease, or a health condition, including a behavioral health condition.

"Individual plan" includes any nongrandfathered health benefit plan offered, issued, amended or renewed by an admitted issuer in the state of Washington for the individual health benefit plan market, unless the certificate of coverage is issued to an individual pursuant to or issued through an organization meeting the definition established in 45 C.F.R. 144.103, and sections 3(5) and 3(40) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.).

"Mandated benefit" or "required benefit" means a health plan benefit for a specific type of service, device or medical equipment, or treatment for a specified condition or conditions that a health plan is required to cover by either state or federal law. Required benefits do not include provider, definition, delivery method, or health status based requirements.

"Meaningful health benefit" means a benefit that must be included in an essential health benefit category in order for the category to reasonably provide medically necessary services for an individual patient's condition on a nondiscriminatory basis.

"Medical necessity determination process" means the process used by a health issuer to make a coverage determination about whether a medical item or service is medically necessary for an individual patient.

"PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

"Scope and limitation requirements" means any requirement applicable to a benefit that limits its duration, the number of times coverage is available for the benefit, or imposes a legally permitted eligibility or reference-based limitation on a specific benefit.

"Small group plan" includes any nongrandfathered health benefit plan offered, issued, amended or renewed by an admitted issuer in the state of Washington for the small group health benefit plan market to a small group, as defined in RCW 48.43.005, unless the certificate of coverage is issued to a small group pursuant to a master contract held by or issued through an organization meeting the definition established in 45 C.F.R. 144.103, and sections 3(5) and 3(40) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.).

"Stand-alone dental plan" means coverage for a set of benefits limited to oral care including, but not necessarily limited to, pediatric oral care, as referenced in RCW 43.71.-065.

NEW SECTION

WAC 284-43-860 Medical necessity determination. (1) An issuer's certificate of coverage and the summary of coverage for the health plan must specifically explain any uniformly applied limitation on the scope, visit number or duration of a benefit, and state whether the uniform limitation is subject to adjustment based on the specific treatment requirements of the patient.

(2) An issuer's medical necessity determination process must:

(a) Be clearly explained in the certificate of coverage, plan document, or contract for health benefit coverage;

(b) Be conducted fairly, and with transparency to enrollees and providers, at a minimum when an enrollee or their representative appeals or seeks review of an adverse benefit determination;

(c) Include consideration of services that are a logical next step in reasonable care if they are appropriate for the patient, even if the service has not been the subject of clinical studies. Medical necessity determination processes must explicitly address the information needed in the decision making process and incorporate appropriate outcomes within a developmental framework;

(d) Ensure that when the interpretation of the medical purpose of interventions is part of the medical necessity decision making, the interpretation standard can be explained in writing to an enrollee and providers, and is broad enough to address any of the services encompassed in the ten essential health benefits categories of care;

(e) Comply with inclusion of the ten essential health benefits categories and prohibitions against discrimination based on age, disability, and expected length of life;

(f) Include consideration of the treating provider's clinical judgment and recommendations regarding the medical purpose of the requested service, and the extent to which the service is likely to produce incremental health benefits for the enrollee;

(g) Identify by role who will participate in the decision making process; and

(h) Support flexibility in the sites of service delivery.

(3) An issuer's medical necessity determination process may include, but is not limited to, evaluation of the effectiveness and benefit of a service for the individual patient based on scientific evidence considerations, up-to-date and consistent professional standards of care, convincing expert opinion and a comparison to alternative interventions, including no interventions. Cost effectiveness may be criteria for determining medical necessity if it is not limited to lowest price.

(4) Medical necessity criteria for medical/surgical benefits and mental health/substance use disorder benefits or for other essential health benefit categories must be furnished to an enrollee or provider within thirty days of a request to do so.

NEW SECTION

WAC 284-43-877 Plan design. (1) A nongrandfathered individual or small group health benefit plan issued, renewed, amended, or offered on or after January 1, 2014, must provide coverage that is substantially equal to the EHB-benchmark plan, as described in WAC 284-43-878 and 284-43-879.

(a) For plans offered, issued, amended or renewed for a plan or policy year beginning on or after January 1, 2014, until December 31, 2015, an issuer must offer the EHB-benchmark plan without substituting benefits for those specifically identified in the EHB-benchmark plan.

(b) For plan or policy years beginning on or after January 1, 2015, an issuer may substitute benefits to the extent that the benefits are substantially equal to the EHB-benchmark plan.

(c) For the purposes of this section "substantially equal" means that:

(i) The scope and level of benefits offered within each essential health benefit category is meaningful;

(ii) The aggregate value of the benefits across all essential health benefit categories does not vary more than a de minimus aggregate value of the EHB-benchmark base plan; and

(iii) Within each essential health benefit category, the actuarial value of the category must not vary more than a de minimus amount from the actuarial value of the category for the EHB-benchmark plan.

(2) An issuer must classify covered services to an essential health benefits category consistent with WAC 284-43-878 and 284-43-879 for purposes of determining actuarial value. An issuer may not use classification of services to an essential health benefits category for purposes of determining

actuarial value as the basis for denying coverage under a health benefit plan.

(3) The base-benchmark plan does not specifically list all types of services, settings and supplies that can be classified to each essential health benefits category. The base-benchmark plan is designed so that coverage for benefits that are not specifically listed in the base-benchmark plan document is determined under that plan based on medical necessity. For this reason, the plan document does not list each and every service, supply or covered benefit. An issuer may design its plan in this way and comply with the EHB-benchmark plan requirements if each of the essential health benefit categories is specifically covered in a manner substantially equal to the EHB-benchmark plan.

(4) An issuer is not required to exclude services excluded by the base-benchmark plan, but must not include those services as part of its calculation of actuarial value for a category to which those services are classified. A plan may not exclude a benefit that is specifically included in the base-benchmark plan.

(5) An issuer must not apply visit limitations or limit the scope of the benefit category based on the type of provider delivering the service, other than requiring that the service must be within the provider's scope of license for purposes of coverage. This obligation does not require an issuer to contract with any willing provider, nor is an issuer restricted from establishing reasonable requirements for credentialing of and access to providers within its network.

(6) Telemedicine or telehealth services are considered provider services, and not a benefit for purposes of the essential health benefits package.

(7) Consistent with state and federal law, a health benefit plan must not contain an exclusion that unreasonably restricts access to medically necessary services for populations with special needs including, but not be limited to, a chronic condition caused by illness or injury, either acquired or congenital.

(8) Unless an age based reference limitation is specifically included in the base-benchmark plan or a supplemental base-benchmark plan for a category set forth in WAC 284-43-878, an issuer's scope of coverage for those categories of benefits must cover both pediatric and adult populations.

(9) A health benefit plan may not be offered if the commissioner determines that:

(a) It creates a risk of biased selection based on health status;

(b) The benefits within an essential health benefit category are limited so that the coverage for the category is not a meaningful benefit; or

(c) The benefit violates the antidiscrimination requirements of PPACA, section 511 of Public Law 110-343 (the federal Mental Health Parity and Addiction Equity Act of 2008).

(10) An issuer must not impose annual or lifetime dollar limits on an essential health benefit, other than those permitted as reference based limitations pursuant to WAC 284-43-878 and 284-43-879.

NEW SECTION

WAC 284-43-878 Essential health benefit categories. (1) A health benefit plan must cover "ambulatory patient services." For purposes of determining a plan's actuarial value, an issuer must classify medically necessary services delivered to enrollees in settings other than a hospital or skilled nursing facility, which are generally recognized and accepted for diagnostic or therapeutic purposes to treat illness or injury, in a substantially equivalent manner to the base-benchmark plan as ambulatory patient services.

(a) A health benefit plan must include the following services, which are specifically covered by the base-benchmark plan, and classify them as ambulatory patient services:

(i) Home and out-patient dialysis services;

(ii) Hospice and home health care, including skilled nursing care as an alternative to hospitalization consistent with WAC 284-44-500, 284-46-500, and 284-96-500;

(iii) Provider office visits and treatments, and associated supplies and services, including therapeutic injections and related supplies;

(iv) Urgent care center visits, including provider services, facility costs and supplies;

(v) Ambulatory surgical center professional services, including anesthesiologist, assistant surgeon and surgeon services, surgical supplies and facility costs;

(vi) Diagnostic procedures including colonoscopies, cardiovascular testing, pulmonary function studies and neurology/neuromuscular procedures; and

(vii) Provider contraceptive services and supplies including, but not limited to, vasectomy, tubal ligation and insertion of IUD or Norplant, or extraction of FDA-approved contraceptive devices.

(b) A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. These services are specifically excluded by the base-benchmark plan, and should not be included in establishing actuarial value for this category.

(i) Infertility treatment and reversal of voluntary sterilization;

(ii) Routine foot care for those that are not diabetic;

(iii) Coverage of dental services following injury to sound natural teeth, but not excluding services or appliances necessary for or resulting from medical treatment if the service is:

(A) Emergency in nature; or

(B) Requires extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease. Oral surgery related to trauma and injury must be covered.

(iv) Private duty nursing for hospice care and home health care, to the extent consistent with state and federal law;

(v) Adult dental care and orthodontia delivered by a dentist or in a dentist's office;

(vi) Nonskilled care and help with activities of daily living;

(vii) Hearing care, routine hearing examinations, programs or treatment for hearing loss including, but not limited to, externally worn or surgically implanted hearing aids, and the surgery and services necessary to implant them, other than for cochlear implants, which are covered, and for hear-

ing screening tests required under the preventive services category;

(viii) Obesity or weight reduction or control other than covered nutritional counseling.

(c) The base-benchmark plan establishes specific limitations on services classified to the ambulatory patient services category that conflict with state or federal law as of January 1, 2014. The base-benchmark plan limits nutritional counseling to three visits per lifetime, if the benefit is not associated with diabetes management. This lifetime limitation for nutritional counseling is not part of the state EHB-benchmark plan. An issuer may limit this service based on medical necessity, and may establish an additional reasonable visit limitation requirement for nutritional counseling for medical conditions when supported by evidence based medical criteria.

(d) The base-benchmark plan's visit limitations on services in this category include:

(i) Ten spinal manipulation services per calendar year without referral;

(ii) Twelve acupuncture services per calendar year without referral;

(iii) Fourteen days respite care on either an inpatient or outpatient basis for hospice patients, per lifetime;

(v) One hundred thirty visits per calendar year for home health care.

(e) State benefit requirements classified to this category are:

(i) Chiropractic care (RCW 48.20.412, 48.21.142, and 48.44.310);

(ii) TMJ disorder treatment (RCW 48.21.320, 48.44.460, and 48.46.530);

(iii) Diabetes-related care and supplies (RCW 48.20.391, 48.21.143, 48.44.315, and 48.46.272).

(2) A health benefit plan must cover "emergency medical services." For purposes of determining a plan's actuarial value, an issuer must classify care and services related to an emergency medical condition to the emergency medical services category.

(a) A health benefit plan must include the following services which are specifically covered by the base-benchmark plan and classify them as emergency services:

(i) Ambulance transportation to an emergency room and treatment provided as part of the ambulance service;

(ii) Emergency room based services, supplies and treatment, including professional charges, facility costs, and outpatient charges for patient observation and medical screening exams required to stabilize a patient experiencing an emergency medical condition;

(iii) Prescription medications associated with an emergency medical condition, including those purchased in a foreign country.

(b) The base-benchmark plan does not exclude services classified to the emergency medical care category.

(c) The base-benchmark base plan does not establish specific limitations on services classified to the emergency medical services category that conflict with state or federal law as of January 1, 2014.

(d) The base-benchmark plan does not establish visit limitations on services in this category.

(e) State benefit requirements covered under this category include services necessary to screen and stabilize a covered person (RCW 48.43.093).

(3) A health benefit plan must cover "hospitalization." For purposes of determining a plan's actuarial value, an issuer must classify medically necessary medical services delivered in a hospital or skilled nursing setting including, but not limited to, professional services, facility fees, supplies, laboratory, therapy or other types of services delivered on an inpatient basis, in a manner substantially equivalent to the base-benchmark plan as hospitalization services.

(a) A health benefit plan must include the following services which are specifically covered by the base-benchmark plan and classify them as hospitalization services:

(i) Hospital visits, facility costs, provider and staff services and treatments delivered during an inpatient hospital stay, including inpatient pharmacy services;

(ii) Skilled nursing facility costs, including professional services and pharmacy services and prescriptions filled in the skilled nursing facility pharmacy;

(iii) Transplant services for donors and recipients, including the transplant facility fees performed in either a hospital setting or outpatient setting;

(iv) Dialysis services delivered in a hospital;

(v) Artificial organ transplants based on an issuer's medical guidelines and manufacturer recommendation;

(vi) Respite care services delivered on an inpatient basis in a hospital or skilled nursing facility.

(b) A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. These services are specifically excluded by the base-benchmark plan, and should not be included in establishing actuarial value:

(i) Hospitalization where mental illness is the primary diagnosis to the extent that it is classified under the mental health and substance use disorder benefits category;

(ii) Cosmetic or reconstructive services and supplies except in the treatment of a congenital anomaly, to restore a physical bodily function lost as a result of injury or illness, or related to breast reconstruction following a medically necessary mastectomy;

(iii) Bariatric surgery and supplies, orthognathic surgery and supplies unless due to temporomandibular joint disorder or injury, sleep apnea or congenital anomaly, and sexual reassignment treatment and surgery;

(iv) Reversal of sterilizations;

(v) Surgical procedures to correct refractive errors/astigmatism or reversals or revisions of surgical procedures which alter the refractive character of the eye.

(c) The base-benchmark plan establishes specific limitations on services classified to the hospitalization category that conflict with state or federal law as of January 1, 2014. The state EHB-benchmark plan limitations for these services are:

(i) The transplant waiting period must not be longer than ninety days, inclusive of prior creditable coverage, if an issuer elects to apply a limitation to the benefit.

(ii) Where transplant benefit services are delivered in a nonhospital setting, the same waiting period limitation may be applied.

(d) The base-benchmark plan's visit limitations on services in this category include:

(i) Sixty inpatient days per calendar year for illness, injury or physical disability in a skilled nursing facility;

(ii) Thirty inpatient rehabilitation service days per calendar year. This benefit may be classified to this category for determining actuarial value or to the rehabilitation services category, but not to both.

(e) State benefit requirements covered under this category are:

(i) General anesthesia and facility charges for dental procedures for those who would be at risk if the service were performed elsewhere and without anesthesia (RCW 48.43.185);

(ii) Reconstructive breast surgery resulting from a mastectomy that resulted from disease, illness or injury (RCW 48.20.395, 48.21.230, 48.44.330, and 48.46.280);

(iii) Coverage for treatment of temporomandibular joint disorder (RCW 48.21.320, 48.44.460, and 48.46.530);

(iv) Coverage at a long-term care facility following hospitalization (RCW 48.43.125).

(4) A health benefit plan must cover "maternity and newborn" services. For purposes of determining a plan's actuarial value, an issuer must classify to the maternity and newborn services category medically necessary care and services delivered to women during pregnancy and in relation to delivery and recovery from delivery, and to newborn children, in a manner substantially equivalent to the base-benchmark plan.

(a) A health benefit plan must cover the following services which are specifically covered by the base-benchmark plan and classify them as maternity and newborn services:

(i) In utero treatment for the fetus;

(ii) Vaginal or cesarean childbirth delivery in a hospital or birthing center, including facility fees;

(iii) Nursery services and supplies for newborns, including newly adopted children;

(iv) Infertility diagnosis;

(v) Prenatal and postnatal care and services, including screening;

(vi) Complications of pregnancy such as, but not limited to, fetal distress, gestational diabetes, and toxemia; and

(vii) Termination of pregnancy.

(b) A health benefit plan may include, but is not required to include, the following service as part of the EHB-benchmark package. This service is specifically excluded by the base-benchmark plan, and should not be included in determining actuarial value: Genetic testing of the child's father.

(c) The base-benchmark plan establishes specific limitations on services classified to the maternity and newborn category that conflict with state or federal law as of January 1, 2014. The state EHB-benchmark plan requirements for these services are:

(i) Maternity coverage for dependent daughters must be included in the base-benchmark plan on the same basis that the coverage is included for other enrollees;

(ii) Newborns delivered of dependent daughters must be covered to the same extent, and on the same basis, as newborns delivered to the other enrollees under the plan.

(d) The base-benchmark plan's limitations on services in this category include covering home birth by a midwife or nurse midwife only for low risk pregnancy.

(e) State benefit requirements covered under this category include:

(i) Maternity services that include diagnosis of pregnancy, prenatal care, delivery, care for complications of pregnancy, physician services, and hospital services (RCW 48.43.041);

(ii) Newborn coverage that is not less than the coverage for the mother, for no less than three weeks (RCW 48.43.-115);

(iii) Prenatal diagnosis of congenital disorders by screening/diagnostic procedures if medically necessary (RCW 48.20.430, 48.21.244, 48.44.344, and 48.46.375).

(5) A health benefit plan must cover "mental health and substance use disorder services, including behavioral health treatment." For purposes of determining a plan's actuarial value, an issuer must classify as mental health and substance use disorder services, including behavioral health treatment medically necessary care, treatment and services for mental health conditions and substance use disorders categorized in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, including behavioral health treatment for those conditions, in a manner substantially equivalent to the base-benchmark plan.

(a) A health benefit plan must include the following services, when medically necessary, which are specifically covered by the base-benchmark plan, and classify them as mental health and substance use disorder services, including behavioral health treatment:

(i) Inpatient, residential and outpatient mental health and substance use disorder treatment, including partial hospital programs or inpatient services;

(ii) Chemical dependency detoxification;

(iii) Behavioral treatment for a DSM category diagnosis;

(iv) Services provided by a licensed behavioral health provider for a covered diagnosis in a skilled nursing facility;

(v) Prescription medication prescribed during an inpatient and residential course of treatment;

(vi) Acupuncture treatment visits without application of the visit limitation requirements for chemical dependency.

(b) A health benefit plan may include, but is not required to include, the following services as part of the EHB-benchmark package. These services are specifically excluded by the base-benchmark plan, and should not be included in establishing actuarial value.

(i) Counseling in the absence of illness, other than family counseling when the patient is a child or adolescent with a covered diagnosis and the family counseling is part of the treatment for mental health services;

(ii) Mental health treatment for diagnostic codes 302 through 302.9 in the DSM-IV, or for "V code" diagnoses except for medically necessary services for parent-child relational problems for children five years of age or younger, neglect or abuse of a child for children five years of age or younger, and bereavement for children five years of age or younger, unless this exclusion is preempted by federal law;

(iii) Not medically necessary court-ordered mental health treatment.

(c) The base-benchmark plan establishes specific limitations on services classified to the mental health and substance abuse disorder services category that conflict with state or federal law as of January 1, 2014. The state EHB-benchmark plan requirements for these services are:

(i) Coverage for eating disorder treatment must be covered for a diagnosis of a DSM-IV or DSM-V categorized mental health condition;

(ii) Chemical detoxification coverage must not be uniformly limited to thirty days. Medical necessity, utilization review and criteria consistent with federal law may be applied by an issuer in designing coverage for this benefit;

(iii) Mental health services and substance use disorder treatment must be delivered in a home health setting on parity with medical surgical benefits, consistent with state and federal law.

(d) The benchmark-base plan's visit limitations on services in this category include:

(i) Court ordered treatment only when medically necessary.

(e) State benefit requirements covered under this category include:

(i) Mental health parity (RCW 48.20.580, 48.21.241, 48.44.341, and 48.46.285);

(ii) Chemical dependency detoxification services (RCW 48.21.180, 48.44.240, 48.44.245, 48.46.350, and 48.46.355);

(iii) Services delivered pursuant to involuntary commitment proceedings (RCW 48.21.242, 48.44.342, and 48.46.-292).

(g) The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343) (MHPAEA) applies to a health benefit plan subject to this section. Coverage of mental health and substance use disorder services, along with any scope and duration limits imposed on the benefits, must comply with the MHPAEA, and all rules, regulations and guidance issued pursuant to Section 2726 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26) where state law is silent, or where federal law preempts state law.

(6) A health benefit plan must cover "prescription drug services." For purposes of determining actuarial value, an issuer must classify as prescription drug services medically necessary prescribed drugs, medication and drug therapies, in a manner substantially equivalent to the base-benchmark plan.

(a) A health benefit plan must include the following services, which are specifically covered by the base-benchmark plan,:

(i) Those classes of drugs, and the specific drugs in the drug formulary, both generic and brand name, including self-administrable prescription medications;

(ii) Prescribed medical supplies, including diabetic supplies that are not otherwise covered as durable medical equipment under the rehabilitative and habilitative services category, including test strips, glucagon emergency kits, insulin and insulin syringes;

(iii) All FDA approved contraceptive methods, and prescription based sterilization procedures for women with reproductive capacity;

(iv) Certain preventive medications including, but not limited to, aspirin, fluoride, and iron, and medications for tobacco use cessation, according to, and as recommended by, the United States Preventive Services Task Force, when obtained with a prescription order.

(b) A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. These services are specifically excluded by the base-benchmark plan as prescription drug or pharmacy benefit services, and should not be included in establishing actuarial value for this category:

(i) Insulin pumps and their supplies, which are classified to and covered under the rehabilitation and habilitation services category;

(ii) Weight loss drugs.

(c) The base-benchmark plan establishes specific limitations on services classified to the prescription drug services category that conflict with state or federal law as of January 1, 2014. The state EHB-benchmark plan requirements for these services are:

(i) Preauthorized tobacco cessation products must be covered consistent with state and federal law. Brand name tobacco cessation products must be available pursuant to an issuer's formulary exception or substitution process;

(ii) Medication prescribed as part of a clinical trial, which is not the subject of the trial, must be covered in a manner consistent with state and federal law.

(d) The base-benchmark plan's visit limitations on services in this category include:

(i) Prescriptions for self-administrable injectable medication are limited to thirty day supplies at a time, other than insulin, which may be offered with more than a thirty day supply;

(ii) Teaching doses of self-administrable injectable medications are limited to three doses per medication per lifetime.

(e) State benefit requirements classified to this category include:

(i) Medical foods to treat inborn errors of metabolism including, but not limited to, formula for phenylketonuria (RCW 48.44.440, 48.46.510, 48.20.520, and 48.21.300);

(ii) Diabetes supplies ordered by the physician (RCW 48.44.315, 48.46.272, 48.20.391, and 48.21.143). Inclusion of this mandate does not bar issuer variation in diabetic supply manufacturers under its drug formulary;

(iii) Mental health prescription drugs to the extent not covered under the hospitalization or skilled nursing facility services, or mental health and substance use disorders categories (RCW 48.44.341, 48.46.291, 48.20.580, and 48.21.241).

(f) An issuer's formulary is part of the prescription drug services category. The formulary filed with the commissioner must be substantially equal to the benchmark base plan formulary, both as to therapeutic classes covered and included drugs in each class.

(i) An issuer must file its formulary quarterly following the filing instructions defined by the Insurance Commissioner's office in WAC 284-44A-040, WAC 284-46A-040 and WAC 284-58-025, and note in its actuarial filings any substitutions in comparison to the EHB-benchmark plan formulary, with reference to both the therapeutic class and the drug being replaced.

(ii) An issuer's formulary does not have to be substantially equal to the base-benchmark plan formulary in terms of formulary placement.

(7) A health benefit plan must cover "rehabilitative and habilitative services." For purposes of determining a plan's actuarial value, an issuer must classify as rehabilitative services medically necessary services that help a person keep, restore or improve skills and function for daily living that have been lost or impaired because a person was sick, hurt or disabled, in a manner substantially equivalent to the base-benchmark plan.

(a) A health benefit plan must include the following services, which are specifically covered by the base-benchmark plan, and classify them as rehabilitative services:

(i) Cochlear implants;

(ii) In-patient rehabilitation facility and professional services delivered in those facilities;

(iii) Outpatient physical therapy, occupational therapy and speech therapy for rehabilitative purposes;

(iv) Braces, splints, prostheses, orthopedic appliances and orthotic devices, supplies or apparatuses used to support, align or correct deformities or to improve the function of moving parts;

(v) Durable medical equipment and mobility enhancing equipment used to serve a medical purpose, including sales tax.

(b) A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. These services are specifically excluded by the base-benchmark plan, and should not be included in establishing actuarial value.

(i) Off the shelf shoe inserts and orthopedic shoes;

(ii) Exercise equipment for medically necessary conditions;

(iii) Durable medical equipment that serves solely as a comfort or convenience item; and

(iv) Hearing aids other than cochlear implants.

(c) The base-benchmark plan does not cover certain federally required services under this category. The state EHB-benchmark plan requirements for habilitative services are:

(i) For purposes of determining actuarial value, the issuer must classify the range of medically necessary health care services and health care devices designed to assist an individual in partially or fully developing, keeping and learning age appropriate skills and functioning, within the individual's environment, or to compensate for a person's progressive physical, cognitive, and emotional illness as habilitative services.

(ii) A health benefit plan must cover habilitative services in a manner consistent with RCW 48.43.045. An issuer must not exclude otherwise covered habilitative services provided by an individual who is supervised by a provider qualified pursuant to RCW 48.43.045.

(iii) An issuer may establish limitations on habilitative services at parity with those for rehabilitative services. A health benefit plan may include reference based limitations only if the limitations take into account the unique needs of the individual and target measurable, and specific treatment goals appropriate for the person's age, and physical and mental condition. When habilitative services are delivered to treat a mental health diagnosis categorized in the most recent version of the DSM, the mental health parity requirements apply and supercede any rehabilitative services parity limitations permitted by this subsection.

(iv) Absent a federal or state requirement to do so, this section does not require an issuer to coordinate its benefits in conjunction with services provided by a public or government program. However, a health benefit plan must not limit an enrollee's access to covered services on the basis that some, but not all of the services in a plan of treatment are provided by a public or government program.

(v) An issuer may establish utilization review guidelines and practice guidelines for habilitative services that are recognized by the medical community as efficacious. The guidelines may not require a return to a prior level of function.

(vi) Habilitative health care devices may be limited to those that require FDA approval and a prescription to dispense the device.

(vii) Consistent with the standards in (c) of this subsection, speech therapy, occupational therapy, physical therapy, and aural therapy are habilitative services. Day habilitation services designed to provide training, structured activities and specialized assistance to adults, chore services to assist with basic needs, vocational or custodial services are not classified as habilitative services.

(viii) An issuer must not exclude coverage for habilitative services received at a school-based health care center unless the habilitative services and devices are delivered pursuant to federal Individuals with Disabilities Education Act of 2004 (IDEIA) requirements pursuant to an individual educational plan (IEP).

(d) The base-benchmark plan's visit limitations on services in this category include:

(i) In-patient rehabilitation facility and professional services delivered in those facilities are limited to thirty days per calendar year;

(ii) Outpatient physical therapy, occupational therapy and speech therapy are limited to twenty-five outpatient visits per calendar year, on a combined basis, for rehabilitative purposes.

(e) State benefit requirements covered under this category include:

(i) State sales tax for durable medical equipment;

(ii) Coverage of diabetic supplies and equipment (RCW 48.44.315, 48.46.272, 48.20.391, and 48.21.143).

(f) An issuer must not classify services to the rehabilitative services category if the classification results in a limitation of coverage for therapy that is medically necessary for an enrollee's treatment for cancer, chronic pulmonary or respiratory disease, cardiac disease or other similar chronic conditions or diseases. For purposes of this subsection, an issuer must establish limitations on the number of visits and coverage of the rehabilitation therapy consistent with its medical necessity and utilization review guidelines for medical/surgical benefits. Examples of these are, but are not limited to, breast cancer rehabilitation therapy, respiratory therapy, and cardiac rehabilitation therapy. Such services may be classified to the ambulatory patient or hospitalization services categories for purposes of determining actuarial value.

(8) A health plan must cover "laboratory services." For purposes of determining actuarial value, an issuer must classify as laboratory services medically necessary laboratory services and testing, including those performed by a licensed provider to determine differential diagnoses, conditions, outcomes and treatment, and including blood and blood services, storage and procurement, and ultrasound, X ray, MRI, CAT scan and PET scans, in a manner substantially equivalent to the base-benchmark plan.

(a) A health benefit plan must include the following services, which are specifically covered by the base-benchmark plan, and classify them as laboratory services:

(i) Laboratory services, supplies and tests, including genetic testing;

(ii) Radiology services, including X ray, MRI, CAT scan, PET scan, and ultrasound imaging;

(iii) Blood, blood products, and blood storage, including the services and supplies of a blood bank.

(b) A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. These services are specifically excluded by the base-benchmark plan, and should not be included in establishing actuarial value: An enrollee's not medically indicated procurement and storage of personal blood supplies provided by a member of the enrollee's family.

(9) A health plan must cover "preventive and wellness services, including chronic disease management." For purposes of determining a plan's actuarial value, an issuer must classify as preventive and wellness services, including chronic disease management, services that identify or prevent the onset or worsening of disease or disease conditions, illness or injury, often asymptomatic, services that assist in the multidisciplinary management and treatment of chronic diseases, services of particular preventive or early identification of disease or illness of value to specific populations, such as women, children and seniors, in a manner substantially equivalent to the base-benchmark plan,.

(a) A health benefit plan must include the following services as preventive and wellness services:

(i) Immunizations recommended by the Centers for Disease Control's Advisory Committee on Immunization Practices;

(ii) Screening and tests with A and B recommendations by the U.S. Preventive Services Task Force for prevention and chronic care, for recommendations issued on or before the applicable plan year;

(iii) Services, tests and screening contained in the U.S. Health Resources and Services Administration Bright Futures guidelines as set forth by the American Academy of Pediatricians;

(iv) Services, tests, screening and supplies recommended in the U.S. Health Resources and Services Administration women's preventive and wellness services guidelines;

(v) Chronic disease management services; and

(vi) Wellness services.

(b) The base-benchmark plan does not exclude any services that could reasonably be classified to this category.

(c) The base-benchmark plan does not apply any limitations or scope restrictions that conflict with state or federal law as of January 1, 2014.

(d) The base-benchmark plan does not establish visit limitations on services in this category.

(e) State benefit requirements classified in this category are:

(i) Colorectal cancer screening as set forth in RCW 48.43.043;

(ii) Mammogram services, both diagnostic and screening (RCW 48.21.225, 48.44.325, and 48.46.275);

(iii) Prostate cancer screening (RCW 48.20.392, 48.21.-227, 48.44.327, and 48.46.277).

Reviser's note: The typographical errors in the above section occurred in the copy filed by the agency and appear in the Register pursuant to the requirements of RCW 34.08.040.

NEW SECTION

WAC 284-43-879 Essential health benefit category—Pediatric oral services. A health plan must include "pediatric oral services" in its essential health benefits package. The base-benchmark plan covers pediatric services for the categories set forth in WAC 284-43-878 (1) through (9), but does not include pediatric oral services. Pediatric services are services delivered to those age 19 and under.

(1) A health plan must cover pediatric oral services either as an embedded set of services, offered through a rider or as a contracted service. If a health plan is subsequently certified by the health benefit exchange as a qualified health plan, this requirement is met for that benefit year for the certified plan if a stand-alone dental plan that covers pediatric oral services as set forth in the EHB-benchmark plan is offered in the health benefit exchange for that benefit year.

(2) If a health plan is a stand-alone dental plan offered through the health benefit exchange, then the requirements of this section are the sole essential health benefit requirements applicable to the stand-alone dental plan.

(3) A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. The supplemental base-benchmark plan specifically excludes oral implants, and an issuer should not include benefits for oral implants in establishing a plan's actuarial value.

(4) The state EHB-benchmark plan requirements for pediatric oral benefits must be offered and classified consistent with the designated supplemental base-benchmark plan for pediatric oral services, the Washington state CHIP plan. The oral benefits included in the "pediatric" category are:

(a) Diagnostic services;

(b) Preventive care;

(c) Restorative care;

(d) Oral surgery and reconstruction to the extent not covered under the hospitalization benefit;

(e) Endodontic treatment;

(f) Periodontics;

(g) Crown and fixed bridge;

(h) Removable prosthetics; and

(i) Medically necessary orthodontia.

(5) The supplemental base-benchmark plan's visit limitations on services in this category are:

(a) Diagnostic exams once every six months, beginning before one year of age;

(b) Bitewing X ray once a year;

(c) Panoramic X rays once every three years;

(d) Prophylaxis every six months beginning at age six months;

(e) Fluoride three times in a twelve-month period for ages six and under; two times in a twelve-month period for ages seven and older; three times in a twelve-month period during orthodontic treatment; sealant once every three years for occlusal surfaces only; oral hygiene instruction two times in twelve months for ages eight and under if not billed on the same day as a prophylaxis treatment;

(f) Every two years for the same restoration (fillings);

(g) Frenulectomy or frenuloplasty covered for ages six and under without prior authorization;

(h) Root canals on baby primary posterior teeth only;

(i) Root canals on permanent anterior, bicuspid and molar teeth, excluding teeth 1, 16, 17 and 32;

(j) Periodontal scaling and root planing once per quadrant in a two-year period for ages thirteen and older, with prior authorization;

(k) Periodontal maintenance once per quadrant in a twelve-month period for ages thirteen and older, with prior authorization;

(l) Stainless steel crowns for primary anterior teeth once every three years; if age thirteen and older with prior authorization;

(m) Stainless steel crowns for permanent posterior teeth once every three years;

(n) Metal/porcelain crowns and porcelain crowns on anterior teeth only, with prior authorization;

(o) Space maintainers for missing primary molars A, B, I, J, K, L, S, and T;

(p) One resin based partial denture, replaced once within a three-year period;

(q) One complete denture upper and lower, and one replacement denture per lifetime after at least five years from the seat date;

(r) Rebasing and relining of complete or partial dentures once in a three-year period, if performed at least six months from the seating date.

(6) State benefit requirements that are limited to those receiving pediatric services, but that are classified to other categories for purposes of determining actuarial value, are:

(a) Neurodevelopmental therapy to age six, consisting of physical, occupational and speech therapy and maintenance to restore or improve function based on developmental delay, which cannot be combined with rehabilitative services for the same condition (RCW 48.44.450, 48.46.520, and 48.21.310 (may be classified to ambulatory patient services or mental health and substance abuse disorder including behavioral health categories));

(b) Congenital anomalies in newborn and dependent children (RCW 48.20.430, 48.21.155, 48.44.212, and 48.46.-250 (may be classified to hospitalization, ambulatory patient services or maternity and newborn categories)).

NEW SECTION

WAC 284-43-880 Pediatric vision services A health plan must include "pediatric vision services" in its essential health benefits package. The base-benchmark plan covers pediatric services for the categories set forth in WAC 284-43-878 (1) through (9), but does not include pediatric vision services. Pediatric services are services delivered to enrollees age 19 and under.

(1) A health plan must cover pediatric vision services either as an embedded set of services or as a contracted service.

(2) The state EHB-benchmark plan requirements for pediatric vision benefits must be offered and classified consistent with the designated supplemental base-benchmark plan for pediatric vision services, the Federal Employees Vision Plan with the largest enrollment and published by the U.S. Department of Health and Human Services at www.cciioo.cms.gov on July 2, 2012,

(a) The vision services included in the "pediatric" category are:

(i) Routine vision screening for children, including dilation and with refraction every calendar year, including dilation;

(ii) One pair of prescription lenses or contacts every calendar year, including polycarbonate lenses and scratch resistant coating;

(iii) One pair of frames every calendar year;

(iv) Low vision optical devices including low vision services, and an aid allowance with follow-up care when preauthorized.

(b) The pediatric vision benefits specifically exclude:

(i) Visual therapy;

(ii) Two pairs of glasses may not be ordered in lieu of bifocals.

NEW SECTION

WAC 284-43-882 Plan cost-sharing and benefit substitution of limitations. (1) A health benefit plan must not apply cost-sharing requirements to Native Americans purchasing a health benefit plan through the exchange, whose incomes are at or below three hundred percent of federal poverty level.

(2) A small group health benefit plan that includes the essential health benefits package may not impose annual cost-sharing or deductibles that exceed the maximum annual amounts that apply to high deductible plans linked to health savings accounts, as set forth in the most recent version of IRS Publication 969, pursuant to Section 106 (c)(2) of the Internal Revenue Code of 1986, and Section 1302 (c)(2) of PPACA.

(3) An issuer may use reasonable medical management techniques to control costs, including promoting the use of appropriate, high value preventive services, providers and settings. An issuer's policies must accommodate enrollees for whom it would be medically inappropriate to have the service provided in one setting versus another, as determined by the attending provider, and permit waiver of an otherwise applicable copayment for the service that is tied to one setting but not the preferred high-value setting.

(4) An issuer may not require cost-sharing for preventive services delivered by network providers, specifically related to those with an A or B rating in the most recent recommendations of the United States Preventive Services Task Force,

women's preventive health care services recommended by the U.S. Health Resources and Services Administration (HRSA) and HRSA Bright Futures guideline designated pediatric services. An issuer must post on its web site a list of the specific preventive and wellness services mandated by PPACA that it covers.

(5) An issuer must establish cost-sharing levels, structures or tiers for specific essential health benefit categories that are not discriminatory based on health status. "Cost-sharing" has the same meaning as set forth in RCW 48.43.-005 and WAC 284-43-130(8).

(a) An issuer must not apply cost-sharing or coverage limitations differently to enrollees with chronic disease or complex underlying medical conditions than to other enrollees, unless the difference provides the enrollee with access to care and treatment commensurate with the enrollee's specific medical needs without imposing a surcharge or other additional cost to the enrollee beyond normal cost-sharing requirements under the plan.

(b) An issuer must not establish a different cost-sharing structure for a specific benefit or tier for a benefit than is applied to the plan in general if the sole type of enrollee who would access that benefit or benefit tier is one with a chronic illness or medical condition.

NEW SECTION

WAC 284-43-885 Representations regarding coverage. A health plan issuer must not indicate or imply that a health benefit plan covers essential health benefits unless the plan, policy, or contract covers the essential health benefits in compliance with this subchapter. This requirement applies to any health benefit plan offered on or off the Washington health benefit exchange.

WSR 13-04-033
EMERGENCY RULES
OFFICE OF INSURANCE COMMISSIONER

[Insurance Commissioner Matter No. R 2013-04—Filed January 30, 2013, 2:33 p.m., effective January 30, 2013, 2:33 p.m.]

Effective Date of Rule: Immediately.

Purpose: Provide health plan issuers with specific guidance regarding form and rate filing of nongrandfathered individual and small group health plans for the 2014 benefit year, in relation to ensuring that an issuer's product and plan filing is substantially equal to the essential health benefits (EHB)-benchmark plan, and that the actuarial values for each EHB category are substantially equal to the EHB-benchmark plan. The rules identify the specific services that are classified to the ten EHB categories, as found in the base-benchmark plan and the supplemental benchmark plans; habilitative services are defined and benefit limitation and scope for those services are set forth in the rule.

Statutory Authority for Adoption: RCW 48.02.060, 48.21.241, 48.21.320, 48.44.460, 48.44.341, 48.46.291, 48.46.530, and 48.43.715.

Other Authority: P.L. 111-148, section 1302 (2010).

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.

Reasons for this Finding: Health plan issuers must replace currently offered nongrandfathered individual and small group plans for the 2014 benefit year due to a number of required changes pursuant to federal health care reform. The deadline for state decisions to approve or disapprove proposed replacement products is July 31, 2013. To meet this deadline, products must be filed for review by the commissioner not later than April 1, 2013. This emergency rule provides issuers with the necessary information to ensure that products are timely filed, so that issuers are able to participate in the individual and small group health plan markets in Washington.

Number of Sections Adopted in Order to Comply with Federal Statute: New 9, Amended 0, Repealed 0; Federal Rules or Standards: New 9, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 9, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 9, Amended 0, Repealed 0.

Date Adopted: January 30, 2013.

Mike Kreidler
Insurance Commissioner

NEW SECTION

WAC 284-43-849 Purpose and scope. For plan years beginning on or after January 1, 2014, each nongrandfathered health benefit plan offered, issued, amended or renewed to small employers or individuals, both inside and outside the Washington health benefit exchange, must provide coverage for a package of essential health benefits, pursuant to RCW 48.43.715. This subchapter explains the regulatory standards related to this coverage, establishes supplementation of the base-benchmark plan consistent with PPACA and RCW 48.43.715, and the final parameters for the state EHB-benchmark plan.

(1) This subchapter does not apply to a health benefit plan that provides excepted benefits as described in section 2722 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-21), or a health benefit plan that qualifies as a grandfathered health plan as defined in RCW 48.43.005.

(2) This subchapter does not require provider reimbursement at the same levels negotiated by the base-benchmark plan's issuer for their plan.

(3) This subchapter does not require a plan to exclude the services or treatments from coverage that are excluded in the base-benchmark plan.

NEW SECTION

WAC 284-43-852 Definitions The following definitions apply to this subchapter unless the context indicates otherwise.

"Base-benchmark plan" means the small group plan with the largest enrollment, as designated in WAC 284-43-850(1), prior to any adjustments made pursuant to RCW 48.43.715.

"EHB-benchmark plan" means the set of benefits that an issuer must include in non-grandfathered plans offered in the individual or small group market in Washington state.

"Health benefit," unless defined differently pursuant to federal rules, regulations, or guidance issued pursuant to section 1302(b) of PPACA, means health care items or services for injury, disease, or a health condition, including a behavioral health condition.

"Individual plan" includes any nongrandfathered health benefit plan offered, issued, amended or renewed by an admitted issuer in the state of Washington for the individual health benefit plan market, unless the certificate of coverage is issued to an individual pursuant to or issued through an organization meeting the definition established in 45 C.F.R. 144.103, and sections 3(5) and 3(40) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.).

"Mandated benefit" or "required benefit" means a health plan benefit for a specific type of service, device or medical equipment, or treatment for a specified condition or conditions that a health plan is required to cover by either state or federal law. Required benefits do not include provider-type, definitions, delivery method, or health status based requirements.

"Meaningful health benefit" means a benefit that must be included in an essential health benefit category in order for the category to reasonably provide medically necessary services for an individual patient's condition on a nondiscriminatory basis.

"Medical necessity determination process" means the process used by a health issuer to make a coverage determination about whether a medical item or service is medically necessary for an individual patient.

"PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

"Scope and limitation requirements" means any requirement applicable to a benefit that limits its duration, the number of times coverage is available for the benefit, or imposes a legally permitted eligibility or reference-based limitation on a specific benefit.

"Small group plan" includes any nongrandfathered health benefit plan offered, issued, amended or renewed by an admitted issuer in the state of Washington for the small group health benefit plan market to a small group, as defined in RCW 48.43.005, unless the certificate of coverage is issued to a small group pursuant to a master contract held by or issued through an organization meeting the definition established pursuant to 29 USC 1002(5).

"Stand-alone dental plan" means coverage for a set of benefits limited to oral care including, but not necessarily limited to, pediatric oral care, as referenced in RCW 43.71.-065.

NEW SECTION

WAC 284-43-860 Medical necessity determination. (1) An issuer's certificate of coverage and the summary of coverage for the health plan must specifically explain any uniformly applied limitation on the scope, visit number or duration of a benefit, and state whether the uniform limitation is subject to adjustment based on the specific treatment requirements of the patient.

(2) An issuer's medical necessity determination process must:

(a) Be clearly explained in the certificate of coverage, plan document, or contract for health benefit coverage;

(b) Be conducted fairly, and with transparency to enrollees and providers, at a minimum when an enrollee or their representative appeals or seeks review of an adverse benefit determination;

(c) Include consideration of services that are a clinically appropriate next step in reasonable care if they are appropriate for the patient, even if the service has not been the subject of clinical studies. Medical necessity determination processes must address the information needed in the decision making process and incorporate appropriate outcomes within a developmental framework;

(d) Ensure that when the interpretation of the medical purpose of interventions is part of the medical necessity decision making, the interpretation standard can be explained in writing to an enrollee and providers, and is broad enough to address any of the services encompassed in the ten essential health benefits categories of care;

(e) Comply with inclusion of the ten essential health benefits categories and prohibitions against discrimination based on age, disability, and expected length of life;

(f) Include consideration of the treating provider's clinical judgment and recommendations regarding the medical purpose of the requested service, and the extent to which the service is likely to produce incremental health benefits for the enrollee;

(g) Identify by role who will participate in the decision making process; and

(h) Permit clinically appropriate flexibility in the sites of service delivery.

(3) An issuer's medical necessity determination process may include, but is not limited to, evaluation of the effectiveness and benefit of a service for the individual patient based on scientific evidence considerations, up-to-date and consistent professional standards of care, convincing expert opinion and a comparison to alternative interventions, including no interventions. Cost effectiveness may be criteria for determining medical necessity if it is not limited to lowest price.

(4) Medical necessity criteria for medical/surgical benefits and mental health/substance use disorder benefits or for other essential health benefit categories must be furnished to

an enrollee or provider within thirty days of a request to do so.

NEW SECTION

WAC 284-43-877 Plan design. (1) A nongrandfathered individual or small group health benefit plan issued, renewed, amended, or offered on or after January 1, 2014, must provide coverage that is substantially equal to the EHB-benchmark plan, as described in WAC 284-43-878, 284-43-879 and 284-43-880.

(a) For plans offered, issued, amended or renewed for a plan or policy year beginning on or after January 1, 2014, until December 31, 2015, an issuer must offer the EHB-benchmark plan without substituting benefits for those specifically identified in the EHB-benchmark plan.

(b) For plan or policy years beginning on or after January 1, 2015, an issuer may substitute benefits to the extent that the benefits are substantially equal to the EHB-benchmark plan.

(c) For the purposes of this section "substantially equal" means that:

(i) The scope and level of benefits offered within each essential health benefit category is meaningful;

(ii) The aggregate value of the benefits across all essential health benefit categories does not vary more than a de minimus aggregate value of the EHB-benchmark base plan; and

(iii) Within each essential health benefit category, the actuarial value of the category must not vary more than a de minimus amount from the actuarial value of the category for the EHB-benchmark plan.

(2) An issuer must classify covered services to an essential health benefits category consistent with WAC 284-43-878, 284-43-879 and 284-43-880 for purposes of determining actuarial value. An issuer may not use classification of services to an essential health benefits category for purposes of determining actuarial value as the basis for denying coverage under a health benefit plan.

(3) The base-benchmark plan does not specifically list all types of services, settings and supplies that can be classified to each essential health benefits category. The base-benchmark plan is designed so that coverage for benefits that are not specifically listed in the base-benchmark plan document is determined under that plan based on medical necessity. For this reason, the plan document does not list each and every service, supply or covered benefit. An issuer may design its plan in this way and comply with the EHB-benchmark plan requirements if each of the essential health benefit categories is specifically covered in a manner substantially equal to the EHB-benchmark plan.

(4) An issuer is not required to exclude services excluded by the base-benchmark plan, but must not include those services as part of its calculation of actuarial value for a category to which those services are classified. A plan may not exclude a benefit that is specifically included in the base-benchmark plan.

(5) An issuer must not apply visit limitations or limit the scope of the benefit category based on the type of provider delivering the service, other than requiring that the service must be within the provider's scope of license for purposes of coverage. This obligation does not require an issuer to contract with any willing provider, nor is an issuer restricted from establishing reasonable requirements for credentialing of and access to providers within its network.

(6) Telemedicine or telehealth services are considered provider services, and not a benefit for purposes of the essential health benefits package.

(7) Consistent with state and federal law, a health benefit plan must not contain an exclusion that unreasonably restricts access to medically necessary services for populations with special needs including, but not be limited to, a chronic condition caused by illness or injury, either acquired or congenital.

(8) Unless an age based reference limitation is specifically included in the base-benchmark plan or a supplemental base-benchmark plan for a category set forth in WAC 284-43-878, 284-43-879 or 284-43-880 an issuer's scope of coverage for those categories of benefits must cover both pediatric and adult populations.

(9) A health benefit plan may not be offered if the commissioner determines that:

(a) It creates a risk of biased selection based on health status;

(b) The benefits within an essential health benefit category are limited so that the coverage for the category is not a meaningful benefit; or

(c) The benefit violates the antidiscrimination requirements of PPACA, section 511 of Public Law 110-343 (the federal Mental Health Parity and Addiction Equity Act of 2008).

(10) An issuer must not impose annual or lifetime dollar limits on an essential health benefit, other than those permitted as reference based limitations pursuant to WAC 284-43-878, 284-43-879 and 284-43-880.

NEW SECTION

WAC 284-43-878 Essential health benefit categories. (1) A health benefit plan must cover "ambulatory patient services." For purposes of determining a plan's actuarial value, an issuer must classify medically necessary services delivered to enrollees in settings other than a hospital or skilled nursing facility, which are generally recognized and accepted for diagnostic or therapeutic purposes to treat illness or injury, in a substantially equivalent manner to the base-benchmark plan as ambulatory patient services.

(a) A health benefit plan must include the following services, which are specifically covered by the base-benchmark plan, and classify them as ambulatory patient services:

(i) Home and out-patient dialysis services;

(ii) Hospice and home health care, including skilled nursing care as an alternative to hospitalization consistent with WAC 284-44-500, 284-46-500, and 284-96-500;

(iii) Provider office visits and treatments, and associated supplies and services, including therapeutic injections and related supplies;

(iv) Urgent care center visits, including provider services, facility costs and supplies;

(v) Ambulatory surgical center professional services, including anesthesiologist, assistant surgeon and surgeon services, surgical supplies and facility costs;

(vi) Diagnostic procedures including colonoscopies, cardiovascular testing, pulmonary function studies and neurology/neuromuscular procedures; and

(vii) Provider contraceptive services and supplies including, but not limited to, vasectomy, tubal ligation and insertion of IUD or Norplant, or extraction of FDA-approved contraceptive devices.

(b) A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. These services are specifically excluded by the base-benchmark plan, and should not be included in establishing actuarial value for this category.

(i) Infertility treatment and reversal of voluntary sterilization;

(ii) Routine foot care for those that are not diabetic;

(iii) Coverage of dental services following injury to sound natural teeth, but not excluding services or appliances necessary for or resulting from medical treatment if the service is:

(A) Emergency in nature; or

(B) Requires extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease. Oral surgery related to trauma and injury must be covered.

(iv) Private duty nursing for hospice care and home health care, to the extent consistent with state and federal law;

(v) Adult dental care and orthodontia delivered by a dentist or in a dentist's office;

(vi) Nonskilled care and help with activities of daily living;

(vii) Hearing care, routine hearing examinations, programs or treatment for hearing loss including, but not limited to, externally worn or surgically implanted hearing aids, and the surgery and services necessary to implant them, other than for cochlear implants, which are covered, and for hearing screening tests required under the preventive services category;

(viii) Obesity or weight reduction or control other than covered nutritional counseling.

(c) The base-benchmark plan establishes specific limitations on services classified to the ambulatory patient services category that conflict with state or federal law as of January 1, 2014. The base-benchmark plan limits nutritional counseling to three visits per lifetime, if the benefit is not associated with diabetes management. This lifetime limitation for nutritional counseling is not part of the state EHB-benchmark plan. An issuer may limit this service based on medical necessity, and may establish an additional reasonable visit limitation requirement for nutritional counseling for medical conditions when supported by evidence based medical criteria.

(d) The base-benchmark plan's visit limitations on services in this category include:

(i) Ten spinal manipulation services per calendar year without referral;

(ii) Twelve acupuncture services per calendar year without referral;

(iii) Fourteen days respite care on either an inpatient or outpatient basis for hospice patients, per lifetime;

(v) One hundred thirty visits per calendar year for home health care.

(e) State benefit requirements classified to this category are:

(i) Chiropractic care (RCW 48.20.412, 48.21.142, and 48.44.310);

(ii) TMJ disorder treatment (RCW 48.21.320, 48.44.460, and 48.46.530);

(iii) Diabetes-related care and supplies (RCW 48.20.391, 48.21.143, 48.44.315, and 48.46.272).

(2) A health benefit plan must cover "emergency medical services." For purposes of determining a plan's actuarial value, an issuer must classify care and services related to an emergency medical condition to the emergency medical services category.

(a) A health benefit plan must include the following services which are specifically covered by the base-benchmark plan and classify them as emergency services:

(i) Ambulance transportation to an emergency room and treatment provided as part of the ambulance service;

(ii) Emergency room based services, supplies and treatment, including professional charges, facility costs, and outpatient charges for patient observation and medical screening exams required to stabilize a patient experiencing an emergency medical condition;

(iii) Prescription medications associated with an emergency medical condition, including those purchased in a foreign country.

(b) The base-benchmark plan does not exclude services classified to the emergency medical care category.

(c) The base-benchmark base plan does not establish specific limitations on services classified to the emergency medical services category that conflict with state or federal law as of January 1, 2014.

(d) The base-benchmark plan does not establish visit limitations on services in this category.

(e) State benefit requirements covered under this category include services necessary to screen and stabilize a covered person (RCW 48.43.093).

(3) A health benefit plan must cover "hospitalization." For purposes of determining a plan's actuarial value, an issuer must classify medically necessary medical services delivered in a hospital or skilled nursing setting including, but not limited to, professional services, facility fees, supplies, laboratory, therapy or other types of services delivered on an inpatient basis, in a manner substantially equivalent to the base-benchmark plan as hospitalization services.

(a) A health benefit plan must include the following services which are specifically covered by the base-benchmark plan and classify them as hospitalization services:

(i) Hospital visits, facility costs, provider and staff services and treatments delivered during an inpatient hospital stay, including inpatient pharmacy services;

(ii) Skilled nursing facility costs, including professional services and pharmacy services and prescriptions filled in the skilled nursing facility pharmacy;

(iii) Transplant services for donors and recipients, including the transplant facility fees performed in either a hospital setting or outpatient setting;

(iv) Dialysis services delivered in a hospital;

(v) Artificial organ transplants based on an issuer's medical guidelines and manufacturer recommendation;

(vi) Respite care services delivered on an inpatient basis in a hospital or skilled nursing facility.

(b) A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. These services are specifically excluded by the base-benchmark plan, and should not be included in establishing actuarial value:

(i) Hospitalization where mental illness is the primary diagnosis to the extent that it is classified under the mental health and substance use disorder benefits category;

(ii) Cosmetic or reconstructive services and supplies except in the treatment of a congenital anomaly, to restore a physical bodily function lost as a result of injury or illness, or related to breast reconstruction following a medically necessary mastectomy;

(iii) Bariatric surgery and supplies, orthognathic surgery and supplies unless due to temporomandibular joint disorder or injury, sleep apnea or congenital anomaly, and sexual reassignment treatment and surgery;

(iv) Reversal of sterilizations;

(v) Surgical procedures to correct refractive errors/astigmatism or reversals or revisions of surgical procedures which alter the refractive character of the eye.

(c) The base-benchmark plan establishes specific limitations on services classified to the hospitalization category that conflict with state or federal law as of January 1, 2014. The state EHB-benchmark plan limitations for these services are:

(i) The transplant waiting period must not be longer than ninety days, inclusive of prior creditable coverage, if an issuer elects to apply a limitation to the benefit.

(ii) Where transplant benefit services are delivered in a nonhospital setting, the same waiting period limitation may be applied.

(d) The base-benchmark plan's visit limitations on services in this category include:

(i) Sixty inpatient days per calendar year for illness, injury or physical disability in a skilled nursing facility;

(ii) Thirty inpatient rehabilitation service days per calendar year. This benefit may be classified to this category for determining actuarial value or to the rehabilitation services category, but not to both.

(e) State benefit requirements covered under this category are:

(i) General anesthesia and facility charges for dental procedures for those who would be at risk if the service were performed elsewhere and without anesthesia (RCW 48.43.185);

(ii) Reconstructive breast surgery resulting from a mastectomy that resulted from disease, illness or injury (RCW 48.20.395, 48.21.230, 48.44.330, and 48.46.280);

(iii) Coverage for treatment of temporomandibular joint disorder (RCW 48.21.320, 48.44.460, and 48.46.530);

(iv) Coverage at a long-term care facility following hospitalization (RCW 48.43.125).

(4) A health benefit plan must cover "maternity and newborn" services. For purposes of determining a plan's actuarial value, an issuer must classify to the maternity and newborn services category medically necessary care and services delivered to women during pregnancy and in relation to delivery and recovery from delivery, and to newborn children, in a manner substantially equivalent to the base-benchmark plan.

(a) A health benefit plan must cover the following services which are specifically covered by the base-benchmark plan and classify them as maternity and newborn services:

(i) In utero treatment for the fetus;

(ii) Vaginal or cesarean childbirth delivery in a hospital or birthing center, including facility fees;

(iii) Nursery services and supplies for newborns, including newly adopted children;

(iv) Infertility diagnosis;

(v) Prenatal and postnatal care and services, including screening;

(vi) Complications of pregnancy such as, but not limited to, fetal distress, gestational diabetes, and toxemia; and

(vii) Termination of pregnancy.

(b) A health benefit plan may include, but is not required to include, the following service as part of the EHB-benchmark package. This service is specifically excluded by the base-benchmark plan, and should not be included in determining actuarial value: Genetic testing of the child's father.

(c) The base-benchmark plan establishes specific limitations on services classified to the maternity and newborn category that conflict with state or federal law as of January 1, 2014. The state EHB-benchmark plan requirements for these services are:

(i) Maternity coverage for dependent daughters must be included in the base-benchmark plan on the same basis that the coverage is included for other enrollees;

(ii) Newborns delivered of dependent daughters must be covered to the same extent, and on the same basis, as newborns delivered to the other enrollees under the plan.

(d) The base-benchmark plan's limitations on services in this category include covering home birth by a midwife or nurse midwife only for low risk pregnancy.

(e) State benefit requirements covered under this category include:

(i) Maternity services that include diagnosis of pregnancy, prenatal care, delivery, care for complications of pregnancy, physician services, and hospital services (RCW 48.43.041);

(ii) Newborn coverage that is not less than the coverage for the mother, for no less than three weeks (RCW 48.43.-115);

(iii) Prenatal diagnosis of congenital disorders by screening/diagnostic procedures if medically necessary (RCW 48.20.430, 48.21.244, 48.44.344, and 48.46.375).

(5) A health benefit plan must cover "mental health and substance use disorder services, including behavioral health treatment." For purposes of determining a plan's actuarial value, an issuer must classify as mental health and substance use disorder services, including behavioral health treatment medically necessary care, treatment and services for mental health conditions and substance use disorders categorized in

the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, including behavioral health treatment for those conditions, in a manner substantially equivalent to the base-benchmark plan.

(a) A health benefit plan must include the following services, when medically necessary, which are specifically covered by the base-benchmark plan, and classify them as mental health and substance use disorder services, including behavioral health treatment:

(i) Inpatient, residential and outpatient mental health and substance use disorder treatment, including partial hospital programs or inpatient services;

(ii) Chemical dependency detoxification;

(iii) Behavioral treatment for a DSM category diagnosis;

(iv) Services provided by a licensed behavioral health provider for a covered diagnosis in a skilled nursing facility;

(v) Prescription medication prescribed during an inpatient and residential course of treatment;

(vi) Acupuncture treatment visits without application of the visit limitation requirements for chemical dependency.

(b) A health benefit plan may include, but is not required to include, the following services as part of the EHB-benchmark package. These services are specifically excluded by the base-benchmark plan, and should not be included in establishing actuarial value.

(i) Counseling in the absence of illness, other than family counseling when the patient is a child or adolescent with a covered diagnosis and the family counseling is part of the treatment for mental health services;

(ii) Mental health treatment for diagnostic codes 302 through 302.9 in the DSM-IV, or for "V code" diagnoses except for medically necessary services for parent-child relational problems for children five years of age or younger, neglect or abuse of a child for children five years of age or younger, and bereavement for children five years of age or younger, unless this exclusion is preempted by federal law;

(iii) Not medically necessary court-ordered mental health treatment.

(c) The base-benchmark plan establishes specific limitations on services classified to the mental health and substance abuse disorder services category that conflict with state or federal law as of January 1, 2014. The state EHB-benchmark plan requirements for these services are:

(i) Coverage for eating disorder treatment must be covered for a diagnosis of a DSM-IV or DSM-V categorized mental health condition;

(ii) Chemical detoxification coverage must not be uniformly limited to thirty days. Medical necessity, utilization review and criteria consistent with federal law may be applied by an issuer in designing coverage for this benefit;

(iii) Mental health services and substance use disorder treatment must be delivered in a home health setting on parity with medical surgical benefits, consistent with state and federal law.

(d) The benchmark-base plan's visit limitations on services in this category include:

(i) Court ordered treatment only when medically necessary.

(e) State benefit requirements covered under this category include:

(i) Mental health parity (RCW 48.20.580, 48.21.241, 48.44.341, and 48.46.285);

(ii) Chemical dependency detoxification services (RCW 48.21.180, 48.44.240, 48.44.245, 48.46.350, and 48.46.355);

(iii) Services delivered pursuant to involuntary commitment proceedings (RCW 48.21.242, 48.44.342, and 48.46.-292).

(g) The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343) (MHPAEA) applies to a health benefit plan subject to this section. Coverage of mental health and substance use disorder services, along with any scope and duration limits imposed on the benefits, must comply with the MHPAEA, and all rules, regulations and guidance issued pursuant to Section 2726 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26) where state law is silent, or where federal law preempts state law.

(6) A health benefit plan must cover "prescription drug services." For purposes of determining actuarial value, an issuer must classify as prescription drug services medically necessary prescribed drugs, medication and drug therapies, in a manner substantially equivalent to the base-benchmark plan.

(a) A health benefit plan must include the following services, which are specifically covered by the base-benchmark plan,:

(i) Those classes of drugs, in the drug formulary, both generic and brand name, including self-administrable prescription medications;

(ii) Prescribed medical supplies, including diabetic supplies that are not otherwise covered as durable medical equipment under the rehabilitative and habilitative services category, including test strips, glucagon emergency kits, insulin and insulin syringes;

(iii) All FDA approved contraceptive methods, and prescription based sterilization procedures for women with reproductive capacity;

(iv) Certain preventive medications including, but not limited to, aspirin, fluoride, and iron, and medications for tobacco use cessation, according to, and as recommended by, the United States Preventive Services Task Force, when obtained with a prescription order.

(b) A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. These services are specifically excluded by the base-benchmark plan as prescription drug or pharmacy benefit services, and should not be included in establishing actuarial value for this category:

(i) Insulin pumps and their supplies, which are classified to and covered under the rehabilitation and habilitation services category;

(ii) Weight loss drugs.

(c) The base-benchmark plan establishes specific limitations on services classified to the prescription drug services category that conflict with state or federal law as of January 1, 2014. The state EHB-benchmark plan requirements for these services are:

(i) Preauthorized tobacco cessation products must be covered consistent with state and federal law. Brand name

tobacco cessation products must be available pursuant to an issuer's formulary exception or substitution process;

(ii) Medication prescribed as part of a clinical trial, which is not the subject of the trial, must be covered in a manner consistent with state and federal law.

(d) The base-benchmark plan's visit limitations on services in this category include:

(i) Prescriptions for self-administrable injectable medication are limited to thirty day supplies at a time, other than insulin, which may be offered with more than a thirty day supply;

(ii) Teaching doses of self-administrable injectable medications are limited to three doses per medication per lifetime.

(e) State benefit requirements classified to this category include:

(i) Medical foods to treat inborn errors of metabolism including, but not limited to, formula for phenylketonuria (RCW 48.44.440, 48.46.510, 48.20.520, and 48.21.300);

(ii) Diabetes supplies ordered by the physician (RCW 48.44.315, 48.46.272, 48.20.391, and 48.21.143). Inclusion of this mandate does not bar issuer variation in diabetic supply manufacturers under its drug formulary;

(iii) Mental health prescription drugs to the extent not covered under the hospitalization or skilled nursing facility services, or mental health and substance use disorders categories (RCW 48.44.341, 48.46.291, 48.20.580, and 48.21.241).

(f) An issuer's formulary is part of the prescription drug services category. The formulary filed with the commissioner must be substantially equal to the benchmark base plan formulary, both as to therapeutic classes covered and included drugs in each class.

(i) An issuer must file its formulary quarterly following the filing instructions defined by the Insurance Commissioner's office in WAC 284-44A-040, WAC 284-46A-040 and WAC 284-58-025, and note in its actuarial filings any substitutions in comparison to the EHB-benchmark plan formulary, with reference to both the therapeutic class and the drug being replaced.

(ii) An issuer's formulary does not have to be substantially equal to the base-benchmark plan formulary in terms of formulary placement.

(7) A health benefit plan must cover "rehabilitative and habilitative services." For purposes of determining a plan's actuarial value, an issuer must classify as rehabilitative services medically necessary services that help a person keep, restore or improve skills and function for daily living that have been lost or impaired because a person was sick, hurt or disabled, in a manner substantially equivalent to the base-benchmark plan.

(a) A health benefit plan must include the following services, which are specifically covered by the base-benchmark plan, and classify them as rehabilitative services:

(i) Cochlear implants;

(ii) In-patient rehabilitation facility and professional services delivered in those facilities;

(iii) Outpatient physical therapy, occupational therapy and speech therapy for rehabilitative purposes;

(iv) Braces, splints, prostheses, orthopedic appliances and orthotic devices, supplies or apparatuses used to support, align or correct deformities or to improve the function of moving parts;

(v) Durable medical equipment and mobility enhancing equipment used to serve a medical purpose, including sales tax.

(b) A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. These services are specifically excluded by the base-benchmark plan, and should not be included in establishing actuarial value.

(i) Off the shelf shoe inserts and orthopedic shoes;

(ii) Exercise equipment for medically necessary conditions;

(iii) Durable medical equipment that serves solely as a comfort or convenience item; and

(iv) Hearing aids other than cochlear implants.

(c) The base-benchmark plan does not cover certain federally required services under this category. The state EHB-benchmark plan requirements for habilitative services are:

(i) For purposes of determining actuarial value, the issuer must classify the range of medically necessary health care services and health care devices designed to assist an individual in partially or fully developing, keeping and learning age appropriate skills and functioning, within the individual's environment, or to compensate for a person's progressive physical, cognitive, and emotional illness as habilitative services.

(ii) A health benefit plan must cover habilitative services in a manner consistent with RCW 48.43.045. An issuer must not exclude otherwise covered habilitative services provided by an individual who is supervised by a provider qualified pursuant to RCW 48.43.045.

(iii) An issuer may establish visit limitations on habilitative services at parity with those for rehabilitative services. A health benefit plan may include reference based limitations only if the limitations take into account the unique needs of the individual and target measurable, and specific treatment goals appropriate for the person's age, and physical and mental condition. When habilitative services are delivered to treat a mental health diagnosis categorized in the most recent version of the DSM, the mental health parity requirements apply and supercede any rehabilitative services parity limitations permitted by this subsection.

(iv) Absent a federal or state requirement to do so, this section does not require an issuer to coordinate its benefits in conjunction with services provided by a public or government program. However, a health benefit plan must not limit an enrollee's access to covered services on the basis that some, but not all of the services in a plan of treatment are provided by a public or government program.

(v) An issuer may establish utilization review guidelines and practice guidelines for habilitative services that are recognized by the medical community as efficacious. The guidelines may not require a return to a prior level of function.

(vi) Habilitative health care devices may be limited to those that require FDA approval and a prescription to dispense the device.

(vii) Consistent with the standards in (c) of this subsection, speech therapy, occupational therapy, physical therapy,

and aural therapy are habilitative services. Day habilitation services designed to provide training, structured activities and specialized assistance to adults, chore services to assist with basic needs, vocational or custodial services are not classified as habilitative services.

(viii) An issuer must not exclude coverage for habilitative services received at a school-based health care center unless the habilitative services and devices are delivered pursuant to federal Individuals with Disabilities Education Act of 2004 (IDEIA) requirements pursuant to an individual educational plan (IEP).

(d) The base-benchmark plan's visit limitations on services in this category include:

(i) In-patient rehabilitation facility and professional services delivered in those facilities are limited to thirty days per calendar year;

(ii) Outpatient physical therapy, occupational therapy and speech therapy are limited to twenty-five outpatient visits per calendar year, on a combined basis, for rehabilitative purposes.

(e) State benefit requirements covered under this category include:

(i) State sales tax for durable medical equipment;

(ii) Coverage of diabetic supplies and equipment (RCW 48.44.315, 48.46.272, 48.20.391, and 48.21.143).

(f) An issuer must not classify services to the rehabilitative services category if the classification results in a limitation of coverage for therapy that is medically necessary for an enrollee's treatment for cancer, chronic pulmonary or respiratory disease, cardiac disease or other similar chronic conditions or diseases. For purposes of this subsection, an issuer must establish limitations on the number of visits and coverage of the rehabilitation therapy consistent with its medical necessity and utilization review guidelines for medical/surgical benefits. Examples of these are, but are not limited to, breast cancer rehabilitation therapy, respiratory therapy, and cardiac rehabilitation therapy. Such services may be classified to the ambulatory patient or hospitalization services categories for purposes of determining actuarial value.

(8) A health plan must cover "laboratory services." For purposes of determining actuarial value, an issuer must classify as laboratory services medically necessary laboratory services and testing, including those performed by a licensed provider to determine differential diagnoses, conditions, outcomes and treatment, and including blood and blood services, storage and procurement, and ultrasound, X ray, MRI, CAT scan and PET scans, in a manner substantially equivalent to the base-benchmark plan.

(a) A health benefit plan must include the following services, which are specifically covered by the base-benchmark plan, and classify them as laboratory services:

(i) Laboratory services, supplies and tests, including genetic testing;

(ii) Radiology services, including X ray, MRI, CAT scan, PET scan, and ultrasound imaging;

(iii) Blood, blood products, and blood storage, including the services and supplies of a blood bank.

(b) A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. These services are specifically excluded by the base-benchmark plan, and should not be included in establishing actuarial value: An enrollee's not medically indicated procurement and storage of personal blood supplies provided by a member of the enrollee's family.

(9) A health plan must cover "preventive and wellness services, including chronic disease management." For purposes of determining a plan's actuarial value, an issuer must classify as preventive and wellness services, including chronic disease management, services that identify or prevent the onset or worsening of disease or disease conditions, illness or injury, often asymptomatic, services that assist in the multidisciplinary management and treatment of chronic diseases, services of particular preventive or early identification of disease or illness of value to specific populations, such as women, children and seniors, in a manner substantially equivalent to the base-benchmark plan,.

(a) A health benefit plan must include the following services as preventive and wellness services:

(i) Immunizations recommended by the Centers for Disease Control's Advisory Committee on Immunization Practices;

(ii) Screening and tests with A and B recommendations by the U.S. Preventive Services Task Force for prevention and chronic care, for recommendations issued on or before the applicable plan year;

(iii) Services, tests and screening contained in the U.S. Health Resources and Services Administration Bright Futures guidelines as set forth by the American Academy of Pediatricians;

(iv) Services, tests, screening and supplies recommended in the U.S. Health Resources and Services Administration women's preventive and wellness services guidelines;

(v) Chronic disease management services; and

(vi) Wellness services.

(b) The base-benchmark plan does not exclude any services that could reasonably be classified to this category.

(c) The base-benchmark plan does not apply any limitations or scope restrictions that conflict with state or federal law as of January 1, 2014.

(d) The base-benchmark plan does not establish visit limitations on services in this category.

(e) State benefit requirements classified in this category are:

(i) Colorectal cancer screening as set forth in RCW 48.43.043;

(ii) Mammogram services, both diagnostic and screening (RCW 48.21.225, 48.44.325, and 48.46.275);

(iii) Prostate cancer screening (RCW 48.20.392, 48.21.-227, 48.44.327, and 48.46.277).

Reviser's note: The typographical errors in the above section occurred in the copy filed by the agency and appear in the Register pursuant to the requirements of RCW 34.08.040.

NEW SECTION

WAC 284-43-879 Essential health benefit category—Pediatric oral services. A health plan must include "pediatric oral services" in its essential health benefits package. The base-benchmark plan covers pediatric services for the categories set forth in WAC 284-43-878 (1) through (9), but does

not include pediatric oral services. Pediatric services are services delivered to those age 19 and under.

(1) A health plan must cover pediatric oral services either as an embedded set of services, offered through a rider or as a contracted service. If a health plan is subsequently certified by the health benefit exchange as a qualified health plan, this requirement is met for that benefit year for the certified plan if a stand-alone dental plan that covers pediatric oral services as set forth in the EHB-benchmark plan is offered in the health benefit exchange for that benefit year.

(2) If a health plan is a stand-alone dental plan offered through the health benefit exchange, then the requirements of this section are the sole essential health benefit requirements applicable to the stand-alone dental plan.

(3) A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. The supplemental base-benchmark plan specifically excludes oral implants, and an issuer should not include benefits for oral implants in establishing a plan's actuarial value.

(4) The state EHB-benchmark plan requirements for pediatric oral benefits must be offered and classified consistent with the designated supplemental base-benchmark plan for pediatric oral services, the Washington state CHIP plan. The oral benefits included in the "pediatric" category are:

(a) Diagnostic services;

(b) Preventive care;

(c) Restorative care;

(d) Oral surgery and reconstruction to the extent not covered under the hospitalization benefit;

(e) Endodontic treatment;

(f) Periodontics;

(g) Crown and fixed bridge;

(h) Removable prosthetics; and

(i) Medically necessary orthodontia.

(5) The supplemental base-benchmark plan's visit limitations on services in this category are:

(a) Diagnostic exams once every six months, beginning before one year of age;

(b) Bitewing X ray once a year;

(c) Panoramic X rays once every three years;

(d) Prophylaxis every six months beginning at age six months;

(e) Fluoride three times in a twelve-month period for ages six and under; two times in a twelve-month period for ages seven and older; three times in a twelve-month period during orthodontic treatment; sealant once every three years for occlusal surfaces only; oral hygiene instruction two times in twelve months for ages eight and under if not billed on the same day as a prophylaxis treatment;

(f) Every two years for the same restoration (fillings);

(g) Frenulectomy or frenuloplasty covered for ages six and under without prior authorization;

(h) Root canals on baby primary posterior teeth only;

(i) Root canals on permanent anterior, bicuspid and molar teeth, excluding teeth 1, 16, 17 and 32;

(j) Periodontal scaling and root planing once per quadrant in a two-year period for ages thirteen and older, with prior authorization;

(k) Periodontal maintenance once per quadrant in a twelve-month period for ages thirteen and older, with prior authorization;

(l) Stainless steel crowns for primary anterior teeth once every three years; if age thirteen and older with prior authorization;

(m) Stainless steel crowns for permanent posterior teeth once every three years;

(n) Metal/porcelain crowns and porcelain crowns on anterior teeth only, with prior authorization;

(o) Space maintainers for missing primary molars A, B, I, J, K, L, S, and T;

(p) One resin based partial denture, replaced once within a three-year period;

(q) One complete denture upper and lower, and one replacement denture per lifetime after at least five years from the seat date;

(r) Rebasing and relining of complete or partial dentures once in a three-year period, if performed at least six months from the seating date.

(6) State benefit requirements that are limited to those receiving pediatric services, but that are classified to other categories for purposes of determining actuarial value, are:

(a) Neurodevelopmental therapy to age six, consisting of physical, occupational and speech therapy and maintenance to restore or improve function based on developmental delay, which cannot be combined with rehabilitative services for the same condition (RCW 48.44.450, 48.46.520, and 48.21.310 (may be classified to ambulatory patient services or mental health and substance abuse disorder including behavioral health categories));

(b) Congenital anomalies in newborn and dependent children (RCW 48.20.430, 48.21.155, 48.44.212, and 48.46.-250 (may be classified to hospitalization, ambulatory patient services or maternity and newborn categories)).

NEW SECTION

WAC 284-43-880 Pediatric vision services A health plan must include "pediatric vision services" in its essential health benefits package. The base-benchmark plan covers pediatric services for the categories set forth in WAC 284-43-878 (1) through (9), but does not include pediatric vision services. Pediatric services are services delivered to enrollees age 19 and under.

(1) A health plan must cover pediatric vision services as an embedded set of services.

(2) The state EHB-benchmark plan requirements for pediatric vision benefits must be offered and classified consistent with the designated supplemental base-benchmark plan for pediatric vision services, the Federal Employees Vision Plan with the largest enrollment and published by the U.S. Department of Health and Human Services at www.cciioo.cms.gov on July 2, 2012,

(a) The vision services included in the "pediatric" category are:

(i) Routine vision screening for children, including dilation and with refraction every calendar year, including dilation;

(ii) One pair of prescription lenses or contacts every calendar year, including polycarbonate lenses and scratch resistant coating;

(iii) One pair of frames every calendar year;

(iv) Low vision optical devices including low vision services, and an aid allowance with follow-up care when preauthorized.

(b) The pediatric vision benefits specifically exclude:

(i) Visual therapy;

(ii) Two pairs of glasses may not be ordered in lieu of bifocals.

NEW SECTION

WAC 284-43-882 Plan cost-sharing and benefit substitution of limitations. (1) A health benefit plan must not apply cost-sharing requirements to Native Americans purchasing a health benefit plan through the exchange, whose incomes are at or below three hundred percent of federal poverty level.

(2) A small group health benefit plan that includes the essential health benefits package may not impose annual cost-sharing or deductibles that exceed the maximum annual amounts that apply to high deductible plans linked to health savings accounts, as set forth in the most recent version of IRS Publication 969, pursuant to Section 106 (c)(2) of the Internal Revenue Code of 1986, and Section 1302 (c)(2) of PPACA.

(3) An issuer may use reasonable medical management techniques to control costs, including promoting the use of appropriate, high value preventive services, providers and settings. An issuer's policies must accommodate enrollees for whom it would be medically inappropriate to have the service provided in one setting versus another, as recommended by the attending provider, and permit waiver of an otherwise applicable copayment for the service that is tied to one setting but not the preferred high-value setting.

(4) An issuer may not require cost-sharing for preventive services delivered by network providers, specifically related to those with an A or B rating in the most recent recommendations of the United States Preventive Services Task Force, women's preventive health care services recommended by the U.S. Health Resources and Services Administration (HRSA) and HRSA Bright Futures guideline designated pediatric services. An issuer must post on its web site a list of the specific preventive and wellness services mandated by PPACA that it covers.

(5) An issuer must establish cost-sharing levels, structures or tiers for specific essential health benefit categories that are not discriminatory based on health status. "Cost-sharing" has the same meaning as set forth in RCW 48.43.-005 and WAC 284-43-130(8).

(a) An issuer must not apply cost-sharing or coverage limitations differently to enrollees with chronic disease or complex underlying medical conditions than to other enrollees, unless the difference provides the enrollee with access to care and treatment commensurate with the enrollee's specific medical needs without imposing a surcharge or other additional cost to the enrollee beyond normal cost-sharing requirements under the plan.

(b) An issuer must not establish a different cost-sharing structure for a specific benefit or tier for a benefit than is applied to the plan in general if the sole type of enrollee who would access that benefit or benefit tier is one with a chronic illness or medical condition.

NEW SECTION

WAC 284-43-885 Representations regarding coverage. A health plan issuer must not indicate or imply that a health benefit plan covers essential health benefits unless the plan, policy, or contract covers the essential health benefits in compliance with this subchapter. This requirement applies to any health benefit plan offered on or off the Washington health benefit exchange.

WSR 13-05-002
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 13-28—Filed February 6, 2013, 2:11 p.m., effective February 8, 2013]

Effective Date of Rule: February 8, 2013.

Purpose: Amend recreational fishing rules.

Citation of Existing Rules Affected by this Order: Repealing WAC 232-28-61900D; and amending WAC 232-28-619.

Statutory Authority for Adoption: RCW 77.12.047 and 77.04.020.

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.

Reasons for this Finding: Recent analyses of the ongoing steelhead fisheries in portions of the upper Columbia River has revealed sufficient natural origin steelhead impacts still remain under the NOAA issued ESA section 10 permit. Reopening steelhead fisheries in both the Wenatchee and Icicle rivers will help to reduce the proportion of hatchery fish on the spawning grounds and further reduce competition between natural origin and hatchery juvenile production. Opening these areas to steelhead angling also allows whitefish opportunity. There is insufficient time to adopt permanent rules.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 1, Amended 0, Repealed 1.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: February 6, 2013.

Philip Anderson
Director

NEW SECTION

WAC 232-28-61900V Exceptions to statewide rules—Columbia, Okanogan, Similkameen, Wenatchee and Icicle rivers Notwithstanding the provisions of WAC 232-28-619, effective one hour before official sunrise on February 8, 2013, in waters of the Columbia, Okanogan, Similkameen, Wenatchee and Icicle Rivers it is unlawful to violate the following provisions, provided that unless otherwise amended, all permanent rules remain in effect:

(1) Mandatory retention of adipose fin clipped steelhead, daily limit two (2) hatchery steelhead, 20 inch minimum size. Hatchery steelhead are identified by a missing adipose fin with a healed scar in its location.

(2) Adipose present steelhead must be released unharmed and cannot be removed from the water prior to release.

(3) Night closure and selective gear rules remain in effect, except bait allowed on mainstem Columbia River.

(a) A person may fish for steelhead in the Columbia River from Rock Island Dam to the boundary markers below Wells Dam and from the Highway 173 Bridge in Brewster to 400 feet below Chief Joseph Dam.

(b) A person may fish for steelhead in the Wenatchee River from the mouth to 400 feet below Tumwater Dam, including the Icicle River from the mouth to 500 feet downstream of the Leavenworth National Fish Hatchery Barrier Dam.

(c) A person may fish for steelhead in the Okanogan River from the mouth upstream to the Highway 97 Bridge in Oroville.

(d) A person may fish for steelhead in the Similkameen River from the mouth upstream to 400 feet below Enloe Dam.

(d) A person may fish for whitefish in the Wenatchee River from the mouth to the Hwy 2 bridge at Leavenworth.

(4) Effective one hour before official sunrise on Feb 8 2013, until further notice, it is unlawful to fish for whitefish in the following waters:

(a) Entiat River: Upstream from the Alternate Highway 97 Bridge, near the mouth of the Entiat River to Entiat Falls.

(b) Methow River: From Gold Creek to the confluence with the Chewuch River in Winthrop.

Reviser's note: The typographical error in the above section occurred in the copy filed by the agency and appears in the Register pursuant to the requirements of RCW 34.08.040.

REPEALER

The following section of the Washington Administrative Code is repealed effective one hour before official sunrise February 8, 2013:

WAC 232-28-61900D	Exceptions to statewide rules—Columbia, Entiat, Icicle, Methow, Okanogan, Similkameen, and Wenatchee rivers. (12-276)

WSR 13-05-008
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 13-30—Filed February 7, 2013, 9:11 a.m., effective February 8, 2013]

Effective Date of Rule: February 8, 2013.

Purpose: Amend commercial fishing rules.

Citation of Existing Rules Affected by this Order: Repealing WAC 220-52-07100W; and amending WAC 220-52-071.

Statutory Authority for Adoption: RCW 77.12.047 and 77.04.020.

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.

Reasons for this Finding: Harvestable amounts of sea cucumbers are available in sea cucumber districts listed. There is insufficient time to adopt permanent rules.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 1, Amended 0, Repealed 1.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: February 7, 2013.

Philip Anderson
Director

NEW SECTION

WAC 220-52-07100X Sea cucumbers. Notwithstanding the provisions of WAC 220-52-071, effective immedi-

ately until further notice, it is unlawful to take or possess sea cucumbers taken for commercial purposes except as provided for in this section:

(1) Sea cucumber harvest using shellfish diver gear is allowed in Sea Cucumber District 5 seven days-per-week.

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 220-52-07100W Sea cucumbers. (12-270)

WSR 13-05-010
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 13-29—Filed February 7, 2013, 10:14 a.m., effective February 15, 2013]

Effective Date of Rule: February 15, 2013.

Purpose: Amend recreational fishing rules.

Citation of Existing Rules Affected by this Order: Amending WAC 232-28-619.

Statutory Authority for Adoption: RCW 77.12.047 and 77.04.020.

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.

Reasons for this Finding: The spring chinook returns to the Kalama and Lewis rivers are predicted to be below average in 2013. The expected returns are needed to provide for the hatchery escapement goals and do not provide sufficient numbers of fish for harvest. The hatchery returns will be monitored weekly to assess the strength of the returns. There is insufficient time to adopt permanent rules.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 1, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: February 7, 2013.

Philip Anderson
Director

NEW SECTION

WAC 232-28-61900W Exceptions to statewide rules—Kalama and Lewis rivers. Notwithstanding the provisions of WAC 232-28-619:

(1) Effective February 15, 2013, until further notice, it is unlawful to fish for or possess Chinook salmon in the following waters:

a. Kalama River - from boundary markers at the mouth upstream to the upper salmon hatchery (Kalama Falls Hatchery).

b. Lewis River - from the mouth upstream to the mouth of the East Fork.

c. North Fork Lewis River - from the mouth of East Fork upstream to the overhead powerlines below Merwin Dam.

(2) Effective February 15, 2013 through May 31, 2013, it is unlawful to fish in the following waters:

a. North Fork Lewis River - from Johnson Creek upstream to the overhead powerlines below Merwin Dam.

WSR 13-05-018
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 13-31—Filed February 8, 2013, 4:04 p.m., effective February 13, 2013]

Effective Date of Rule: February 13, 2013.

Purpose: To amend cougar hunting rules described in WAC 232-28-297.

Citation of Existing Rules Affected by this Order: Repealing WAC 232-28-29700D; and amending WAC 232-28-297.

Statutory Authority for Adoption: RCW 77.12.047, 77.12.150.

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.

Reasons for this Finding: To correct an error that establishes contradictory rules governing areas open for hunting cougar. The seasons for cougar hunting have started, so there is no time for standard rule-making timeframes; and this correction will help hunters avoid hunting illegally.

This change also closes specific cougar hunting areas that have met or exceeded the area harvest guideline. Immediate action is necessary to protect cougars from overharvest in hunt areas that have met or exceeded the area harvest guideline.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 1, Amended 0, Repealed 1.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: February 13 [8], 2013.

Philip Anderson
Director

NEW SECTION

WAC 232-28-29700E 2012-2013, 2013-2014, and 2014-2015 Cougar hunting seasons and regulations. Notwithstanding the provisions of WAC 232-28-297, effective immediately until further notice:

General cougar seasons are closed in Game Management Units (GMUs) 105, 108, 111, 117, 121, 145, 149, 154, 157, 162, 163, 166, 175, 178, 242, 243, 328, 329, 335, 382, 388, 522, 642, 648, and 651.

REPEALER

The following section of the Washington Administrative Code is repealed effective February 13, 2013:

WAC 232-28-29700D	2012-2013, 2013-2014, and 2014-2015 Cougar hunting seasons and regulations.

WSR 13-05-027
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 13-32—Filed February 11, 2013, 4:44 p.m., effective February 11, 2013, 4:44 p.m.]

Effective Date of Rule: Immediately.

Purpose: Amend commercial fishing rules.

Citation of Existing Rules Affected by this Order: Repealing WAC 220-52-04000X and 220-52-04600I; and amending WAC 220-52-046.

Statutory Authority for Adoption: RCW 77.12.047 and 77.04.020.

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.

Reasons for this Finding: This emergency regulation closes Region 2 West where the Puget Sound state commercial fishery has now reached its final allocation. This emergency regulation also closes Region 2 East where the Puget Sound state commercial fishery has nearly reached its full allocation and will reach the absolute close date defined in a previous state/treaty agreement. Finally the regulation continues the closure of the Everett Flats portion of Region 2 East in order to protect soft shell crabs that occur at this time of year in this area. The Puget Sound commercial season is structured to meet harvest allocation objectives negotiated with applicable treaty tribes. There is insufficient time to adopt permanent regulations.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 1, Amended 0, Repealed 2.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: February 11, 2013.

Lisa M. Veneroso
for Philip Anderson
Director

NEW SECTION

WAC 220-52-04600J Puget Sound crab fishery—Seasons and areas. Notwithstanding the provisions of WAC 220-52-046:

(1) Effective immediately, until further notice, it is permissible to fish for Dungeness crab for commercial purposes in the following areas:

(a) Those waters of Marine Fish-Shellfish Management and Catch Reporting Area 20A between a line from the boat ramp at the western boundary of Birch Bay State Park to the western point of the entrance of the Birch Bay Marina, and a line from the same boat ramp to Birch Point.

(b) Those waters of Marine Fish-Shellfish Management and Catch Reporting Area 22B in Fidalgo Bay south of a line projected from the red number 4 entrance buoy at Cape Sante Marina to the northern end of the eastern-most oil dock.

(c) Those waters of Marine Fish-Shellfish Management and Catch Reporting Area 22A in Deer Harbor north of a line projected from Steep Point to Pole Pass.

(2) Effective immediately, until 6:00 PM Friday, February 15, 2013, it is permissible to fish for Dungeness crab for commercial purposes in the following areas:

(a) Port Gardner: That portion of Marine Fish-Shellfish Management and Catch Reporting Area 26A east of a line projected from the outermost tip of the ferry dock at Mukilteo, projected to the green #3 buoy at the mouth of the Snohomish River, and west of a line projected from that #3 buoy southward to the oil boom pier on the shoreline.

(b) Possession Point to Glendale: That portion of Marine Fish-Shellfish Management and Catch Reporting Area 26A east of a line that extends true north from the green #1 buoy

at Possession Point to Possession Point, and west of a line from the green #1 buoy at Possession Point extending northward along the 200-foot depth contour to the Glendale dock.

(c) Langley: That portion of Marine Fish-Shellfish Management and Catch Reporting Area 24C shoreward of the 400-foot depth contour within an area described by two lines projected northeasterly from Sandy Point and the entrance to the marina at Langley.

(3) The following areas are closed to commercial crab fishing:

(a) Effective 6:00 PM Tuesday, February 12, 2013, until further notice, Crab Management Region 2 West. This region includes Marine Fish-Shellfish Management and Catch Reporting Areas 25B, 25D and 26A West.

(b) Effective at 6:00 PM Friday, February 15, 2013, until further notice, Crab Management Region 2 East. This region includes Marine Fish-Shellfish Management and Catch Reporting Areas 24A, 24B, 24C, 24D and 26A East.

(c) Effective immediately, until further notice, that portion of Marine Fish-Shellfish Management and Catch Reporting Area 25A west of the 123° 7.0' longitude line projected from the new Dungeness light due south to the shore of Dungeness Bay.

(d) Effective immediately, until further notice, that portion of Marine Fish-Shellfish Management and Catch Reporting Area 23D west of a line from the eastern tip of Ediz Hook to the ITT Rayonier Dock.

(e) Effective immediately, until further notice, those waters of Marine Fish-Shellfish Management and Catch Reporting Area 24A east of a line projected true north from the most westerly tip of Skagit Island and extending south to the most westerly tip of Hope Island, thence southeast to Seal Rocks, thence southeast to the green can buoy at the mouth of Swinomish Channel, thence easterly to the west side of Goat Island.

(4) Effective immediately, until further notice, the Everett Flats portion of Region 2 East will be closed. This area is defined as follows:

(a) That portion of catch area 26A east of a line from Howarth Park due north to the south end of Gedney Island, and that portion of 24B east of a line from the north end of Gedney Island to Camano Head and south of a line drawn from Camano Head to Hermosa Point.

REPEALER

The following sections of the Washington Administrative Code are repealed effective immediately:

WAC 220-52-04600I	Puget Sound crab fishery—Seasons and areas. (13-18)
WAC 220-52-04000X	Commercial crab fishery—Lawful and unlawful gear, methods, and other unlawful acts. (13-18)

WSR 13-05-041
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 13-33—Filed February 12, 2013, 3:34 p.m., effective February 12, 2013, 3:34 p.m.]

Effective Date of Rule: Immediately.

Purpose: Amend recreational fishing rules.

Citation of Existing Rules Affected by this Order: Amending WAC 220-56-350.

Statutory Authority for Adoption: RCW 77.12.047 and 77.04.020.

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.

Reasons for this Finding: Recreational effort at Dosewallips State Park increased significantly in 2012 and the state share was overharvested, requiring a shorter season in 2013. Surveys indicate that the clam population at Point Whitney Tidelands has decreased, requiring a shorter season in 2013. There is insufficient time to adopt permanent rules.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 1, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: February 12, 2013.

Joe Stohr
for Philip Anderson
Director

NEW SECTION

WAC 220-56-35000V Clams other than razor clams—Areas and seasons. Notwithstanding the provisions of WAC 220-56-350, effective immediately until further notice, it is unlawful to take, dig for and possess clams, cockles, and mussels taken for personal use from the following public tidelands except during the open periods specified herein:

(1) Dosewallips State Park: Open April 1, 2013, until further notice, only in area defined by boundary markers and signs posted on the beach.

(2) Point Whitney Tidelands (excluding Point Whitney Lagoon): Open March 15 through March 31, 2013.

WSR 13-05-043
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 13-34—Filed February 12, 2013, 4:33 p.m., effective February 12, 2013, 4:33 p.m.]

Effective Date of Rule: Immediately.

Purpose: Amend commercial fishing rules.

Citation of Existing Rules Affected by this Order: Repealing WAC 220-52-0400W [220-52-04000W] and 220-52-04600H; and amending WAC 220-52-040 and 220-52-046.

Statutory Authority for Adoption: RCW 77.12.047 and 77.04.020.

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.

Reasons for this Finding: The special management areas are listed in accordance with state/tribal management agreements. The stepped opening periods/areas will also provide for fair start provisions. There is insufficient time to adopt permanent rules.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 2, Amended 0, Repealed 2.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: February 12, 2013.

Joe Stohr
for Philip Anderson
Director

NEW SECTION

WAC 220-52-04000Y Commercial crab fishery. Lawful and unlawful gear, methods and other unlawful acts. (1) Notwithstanding the provisions of WAC 220-52-040, effective immediately until further notice, it is unlawful for any fisher or wholesale dealer or buyer to land or purchase Dungeness crab taken from Grays Harbor, Willapa Bay, the Columbia River, or Washington coastal or adjacent waters of the Pacific Ocean through February 28, 2013, from any vessel unless:

(a) A valid Washington crab vessel inspection certificate has been issued to the delivering vessel.

(b) Vessel hold inspection certificates dated from December 30, 2012 to January 22, 2013 are only valid for the area south of 46°28.00.

(c) The vessel inspection certificate numbers are recorded on all shellfish tickets completed for coastal Dungeness crab landings through February 28, 2013.

NEW SECTION

WAC 220-52-04600K Coastal crab seasons. Notwithstanding the provisions of WAC 220-52-046, effective immediately until further notice, it is unlawful to fish for Dungeness crab in Washington coastal waters, the Pacific Ocean, Grays Harbor, Willapa Bay, or the Columbia River, except as provided for in this section.

(1) The area from US Canada Border to the WA/OR border (46°15.00) and Willapa Bay: Open.

(2) For the purposes of this order, the waters of Willapa Bay are defined to include the marine waters east of a line connecting 46°44.76 N, 124°05.76 W and 46°38.93 N, 124°04.33 W.

(3) Dungeness crab license holders, or any vessel or vessel operator designated on the license that participated in the coastal commercial Dungeness crab fishery in the waters from Point Arena, California, to Klipsan Beach, Washington (46°28.00), including Willapa Bay, before 12:01 a.m. January 24, 2013, are prohibited from:

a. Fishing in the area between Oysterville (46°33.00) and the U.S./Canada border until 8:00 A.M., February 28, 2013.

(4) The Quinault primary special management area (PSMA) is closed to fishing for Dungeness crab until further notice. The PSMA includes the area shoreward of a line approximating the 27-fathom depth curve between Raft River (47°28.00) and Copalis River (47°08.00) according to the following coordinates:

Northeast Corner (Raft River):	47°28.00 N. Lat.	124°20.70 W. Lon.
Northwest Corner:	47°28.00 N. Lat.	124°34.00 W. Lon.
Southwest Corner:	47°08.00 N. Lat.	124°25.50 W. Lon.
Southeast Corner (Copalis River):	47°08.00 N. Lat.	124°11.20 W. Lon.

(5) The Quileute special management area (SMA) is closed to fishing for Dungeness crab until further notice. The SMA includes the area shoreward of a line approximating the 30-fathom depth curve between Destruction Island and Cape Johnson according to the following points:

• Northeast Corner (Cape Johnson):	47°58.00' N. Lat.	124°40.40' W. Lon.
• Northwest Corner:	47°58.00' N. Lat.	124°49.00' W. Lon.
• Southwest Corner:	47°40.50' N. Lat.	124°40.00' W. Lon.
• Southeast Corner (Destruction Island):	47°40.50' N. Lat.	124°24.43' W. Lon.

(6) The Makah special management area (SMA) is closed to fishing until 8:00 A.M. February 23, 2013. The SMA includes the waters between 48°02.15 N. Lat. and 48°19.50 N. Lat. east of a line connecting those points and

approximating the 25-fathom line according to the following coordinates:

- Northeast Corner: Tatoosh Island
- Northwest Corner: 48°19.50 N. Lat. 124°50.45 W. Lon.
- Southwest Corner: 48°02.15 N. Lat. 124°50.45 W. Lon.
- Southeast Corner: 48°02.15 N. Lat. 124°41.00 W. Lon.

(7) It is unlawful for a vessel to use more than 200 pots in the Makah SMA beginning 8:00 A.M. February 23, 2013, until 8:00 A.M. March 25, 2013. Fishers must pre-register with the Department of Fish and Wildlife 24 hours prior to deploying gear in this area by one of the three following methods:

- Fax transmission to Carol Henry at 360-249-1229;
- E-mail to Carol Henry at Carol.Henry@dfw.wa.gov; or
- Telephone call to Carol Henry at 360-249-1296.

(8) All other provisions of the permanent rule remain in effect.

Reviser's note: The unnecessary underscoring in the above section occurred in the copy filed by the agency and appears in the Register pursuant to the requirements of RCW 34.08.040.

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 220-52-04000W	Commercial crab fishery. Lawful and unlawful gear, methods and other unlawful acts. (13-14
WAC 220-52-04600H	Coastal crab seasons (13-14)

Reviser's note: The typographical error in the above section occurred in the copy filed by the agency and appears in the Register pursuant to the requirements of RCW 34.08.040.

WSR 13-05-055
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 13-37—Filed February 14, 2013, 12:22 p.m., effective February 14, 2013, 12:22 p.m.]

Effective Date of Rule: Immediately.

Purpose: Amend commercial fishing rules.

Citation of Existing Rules Affected by this Order: Repealing WAC 220-52-07300D; and amending WAC 220-52-073.

Statutory Authority for Adoption: RCW 77.12.047 and 77.04.020.

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.

Reasons for this Finding: Harvestable amounts of red and green sea urchins exist in the areas described. By harvest management agreement, the legal size limits for red sea urchins have changed for the 2012-2013 harvest management period from those listed in the permanent sea urchin regulation. Prohibiting all diving from licensed sea urchin harvest vessels within Sea Urchin District 3 when those vessels have red sea urchin on-board discourages the taking of red urchins from the district (currently closed to red urchin harvest) and reporting the catch to the adjacent harvest district. There is insufficient time to adopt permanent rules.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 1, Amended 0, Repealed 1.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: February 14, 2013.

Joe Stohr
for Philip Anderson
Director

NEW SECTION

WAC 220-52-07300E Sea urchins. Notwithstanding the provisions of WAC 220-52-073, effective immediately until further notice, it is unlawful to take or possess sea urchins taken for commercial purposes except as provided for in this section:

(1) Green sea urchins: Sea Urchin Districts 1, 2, 3, 4, 6 and 7 are open seven days per week.

(2) Red sea urchins: Sea Urchin District 4 is open seven days per week. In Sea Urchin District 4, it is unlawful to harvest red sea urchins smaller than 3.25 inches or larger than 5.0 inches (size in largest test diameter exclusive of spines).

(3) It is unlawful to dive for any purpose from a commercially licensed sea urchin fishing vessel in Sea Urchin District 3 when the vessel has red sea urchins on-board.

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 220-52-07300D	Sea urchins. (12-283)

WSR 13-05-058
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 13-38—Filed February 14, 2013, 5:35 p.m., effective February 14, 2013, 5:35 p.m.]

Effective Date of Rule: Immediately.

Purpose: The purpose of this emergency rule is to change the season-end date for the North Skagit and Monroe spring black-bear hunts from May 31 to June 15, 2013, and to change the number of permits for the North Skagit hunt from 20 to 30.

Citation of Existing Rules Affected by this Order: Repealing WAC 232-28-28600E; and amending WAC 232-28-286.

Statutory Authority for Adoption: RCW 77.12.047, 77.12.150, and 77.12.240.

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.

Reasons for this Finding: Without a longer season in both spring black-bear hunt areas, and additional permits in the North Skagit hunt area, bear damage to trees will exceed the landowner's tolerance thresholds.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 1, Amended 0, Repealed 1.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: February 14, 2013.

Philip Anderson
Director

NEW SECTION

WAC 232-28-28600F 2013, 2014, and 2015 Spring black bear seasons and regulations. (1) Notwithstanding the provisions of WAC 232-28-286, effective immediately until further notice:

(a) The season timeframe for the Monroe spring black-bear hunt is April 15 - June 15, 2013.

(b) The season timeframe for the North Skagit spring black-bear hunt is April 15 - June 15, 2013, and the number of permits is 30.

(2) Unless otherwise amended, all other provisions of WAC 232-28-286 remain in effect.

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 232-28-28600E	2013, 2014, and 2015 Spring black bear seasons and regulations (13-25).

WSR 13-05-066
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 13-35—Filed February 15, 2013, 2:22 p.m., effective February 23, 2013, 12:01 a.m.]

Effective Date of Rule: February 23, 2013, 12:01 a.m.

Purpose: Amend recreational razor clam rules.

Citation of Existing Rules Affected by this Order: Repealing WAC 220-56-36000R; and amending WAC 220-56-360.

Statutory Authority for Adoption: RCW 77.12.047 and 77.04.120.

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.

Reasons for this Finding: Survey results show that adequate clams are available for harvest in Razor Clam Areas 1 and 3. The Washington department of health has certified clams from these beaches to be safe for human consumption. There is insufficient time to adopt permanent rules.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 1, Amended 0, Repealed 1.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: February 15, 2013.

Philip Anderson
Director

NEW SECTION

WAC 220-56-36000R Razor clams—Areas and seasons. Notwithstanding the provisions of WAC 220-56-360, it is unlawful to dig for or possess razor clams taken for per-

sonal use from any beach in Razor Clam Areas 1, 3, 4, or 5, except as provided for in this section:

1. Effective 12:01 p.m. February 23 through 11:59 p.m. February 24, 2013, razor clam digging is allowed in Razor Clam Area 1. Digging is allowed from 12:01 p.m. to 11:59 p.m. each day only.

2. Effective 12:01 p.m. February 23 through 11:59 p.m. February 24, 2013, razor clam digging is allowed in Razor Clam Area 3. Digging is allowed from 12:01 p.m. to 11:59 p.m. each day only.

3. It is unlawful to dig for razor clams at any time in Long Beach, Twin Harbors Beach or Copalis Beach Clam sanctuaries defined in WAC 220-56-372.

REPEALER

The following section of the Washington Administrative Code is repealed effective 12:01 a.m. February 25, 2013:

WAC 220-56-36000R	Razor clams—Areas and seasons.

WSR 13-05-074
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 13-36—Filed February 19, 2013, 2:09 p.m., effective March 16, 2013]

Effective Date of Rule: March 16, 2013.

Purpose: Amend recreational fishing rules.

Citation of Existing Rules Affected by this Order: Amending WAC 232-28-619.

Statutory Authority for Adoption: RCW 77.12.047 and 77.04.020.

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.

Reasons for this Finding: Spring chinook returns to the Wind River are predicted to be below average in 2013. The expected returns are needed to provide for the hatchery escapement goals and do not provide sufficient numbers of fish for a full season fishery. There is insufficient time to adopt permanent rules.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 1, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: February 19, 2013.

Lori Preuss
for Philip Anderson
Director

NEW SECTION

WAC 232-28-61900X Exceptions to statewide rule—Wind River (1) Notwithstanding the provisions of WAC 232-28-619, effective March 16, 2013, until further notice:

a. It is unlawful to fish in waters of the Wind River from 400 feet below Shipherd Falls upstream, including all tributaries.

b. Through March 31, 2013, it is unlawful to fish in waters of the Wind River from the mouth (boundary line/markers) upstream to 400 feet below Shipherd Falls.

(2) Effective April 1, 2013, until further notice, in waters of the Wind River from the mouth (boundary line/markers) upstream to 400 feet below Shipherd Falls:

a. The salmon and steelhead daily limit is 1 hatchery Chinook or 1 hatchery steelhead. Wild Chinook and wild steelhead must be released.

b. The regulation that allows for the most liberal daily limit between the adjacent mainstem Columbia River or Wind River, when both areas are open concurrently for salmon, has been rescinded.

c. Night closure is in effect.

(3) Effective May 1, 2013, until further notice:

d. Anti-snagging rule will be in effect from the Burlington Northern Railroad Bridge upstream. Only fish hooked inside the mouth may be retained.

e. The two-pole rule has been rescinded.

Reviser's note: The typographical error in the above section occurred in the copy filed by the agency and appears in the Register pursuant to the requirements of RCW 34.08.040.