WSR 13-07-022
EMERGENCY RULES
OFFICE OF INSURANCE COMMISSIONER

[Insurance Commissioner Matter No. R 2013-04—Filed March 12, 2013, 4:49 p.m., effective March 12, 2013, 4:49 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. Changes from a prior emergency rule reflect grammatical changes, and changes required by the final federal rules issued on EHBs.

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); 45 C.F.R. 147.150; 45 C.F.R. 155.170; 45 C.F.R. 156.20; 45 C.F.R. 156.110; 45 C.F.R. 156.115; 45 C.F.R. 156.125; 45 C.F.R. 156.130.

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Number of Sections Adopted in Order to Comply with Federal Statute: New 9, Amended 0, Repealed 0; Federal Rules or Standards: New 9, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 9, Amended 0, Repealed 0.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: March 12, 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 parameters of 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 284-43-865(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 nongrandfathered 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 pursuant to 29 U.S.C. 1002(5).

"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 or limitation requirement" means a 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 U.S.C. 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 logical next step in reasonable care if they are appropriate for the patient. Medical necessity determination processes must identify 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, present or predicted disability, expected length of life, degree of medical dependency, quality of life or other health conditions, race, gender, national origin, sexual orientation and gender identity;

(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) Ensure that where medically appropriate, an enrollee is not restricted as to the site 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 minimis amount from the 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 minimis 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 design does not specifically list each covered service, supply or treatment; coverage for not specifically excluded benefits is determined based on medical necessity. 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 must 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 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 284-443-880, 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 has a discriminatory effect in practice, outcome or purpose in relation to age, present or predicted disability, and expected length of life, degree of medical dependency, quality of life or other health conditions, race, gender, national origin, sexual orientation and gender identity or in the application of 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 as ambulatory patient services 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 equal manner 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 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 anesthesiology services, professional surgical services, and 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 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, unless coverage for these services and devices are required as part of and classified to another essential health benefits 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;

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

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

(i) Chiropractic care (RCW 48.44.310);

(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 as hospitalization services 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 equal 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 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, supplies and treatment 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) The following types of surgery:

(A) Bariatric surgery and supplies;

(B) Orthognathic surgery and supplies unless due to temporomandibular joint disorder or injury, sleep apnea or congenital anomaly; and

(C) 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 equal 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. Termination of pregnancy

may be included in an issuer's essential health benefits package, but nothing in this section requires an issuer to offer the benefit, consistent with 42 U.S.C. 18023 (b)(a)(A)(i) and 45 C.F.R. 156.115.

(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 coverage of 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 equal 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, when provided 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 when associated with a diagnosis of a DSM 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: Court ordered treatment only when medically necessary.

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

(i) Mental health services (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).

(f) 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 equal 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) Drugs and medications both generic and brand name, including self-administrable prescription medications, consistent with the requirements of (b) through (f) of this subsection;

(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;

(v) Medical foods to treat inborn errors of metabolism.

(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;

(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. This limitation is a floor, and an issuer may permit supplies greater than thirty days as part of its EHB-benchmark plan;

(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 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 U.S. Pharmacopeia therapeutic category and classes covered and number of drugs in each class. If the benchmark formulary does not cover at least one drug in a category or class, an issuer must include at least one drug in the uncovered category or class.

(i) An issuer must file its formulary quarterly, following the filing instructions defined by the insurance commissioner in WAC 284-44A-040, 284-46A-050, and 284-58-025.

(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."

(a) 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 equal to the base-benchmark plan.

(b) 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.

(c) 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.

(d) The base-benchmark plan does not cover certain federally required services under this category. A health benefit plan must cover habilitative services, but these services are not specifically covered in the base-benchmark plan. Therefore, this category is supplemented. The state EHB-benchmark plan requirements for habilitative services are:

(i) For purposes of determining actuarial value, the issuer must classify as habilitative services 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.

(ii) An issuer must establish limitations on habilitative services at a minimum on 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.

(iii) 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.

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

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

(vi) Consistent with the standards in 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.

(vii) 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 (IDEA) requirements pursuant to an individual educational plan (IEP).

(e) 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.

(f) 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).

(g) 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 equal 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 preventative 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 equal 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).

(10) 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).

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 but does not include pediatric oral services. Pediatric services are services delivered to those under nineteen.

(1) A health plan must cover pediatric oral services as an embedded set of services. If a health plan is 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) The requirements of WAC 284-43-878 and 284-43-880 are not 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 base-benchmark plan covers pediatric services for the categories set forth in WAC 284-43-878, but does not

include pediatric oral services. Because the base-benchmark plan does not include pediatric oral benefits, 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.

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 under age nineteen.

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

(2) The state EHB-benchmark plan requirements for pediatric vision benefits must be offered at a substantially equal level 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 and eye exam for children, including dilation if professionally indicated, and with refraction every calendar year;

(ii) One pair of prescription lenses or contacts every calendar year, including polycarbonate lenses and scratch resistant coating. Lenses may include single vision, conventional lined bifocal or conventional lined trifocal, or lenticular;

(iii) One pair of frames every calendar year. An issuer may establish networks or tiers of frames within their plan design as long as there is a base set of frames to choose from available without cost sharing;

(iv) Contact lenses covered once every calendar year in lieu of the lenses and frame benefits. The benefit includes the evaluation, fitting and follow-up care relating to contact lenses. If determined to be medically necessary, contact lenses must be covered in lieu of eyeglasses at a minimum for the treatment of the following conditions: Keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, irregular astigmatism.

(v) Low vision optical devices including low vision services, training and instruction to maximize remaining usable vision as follows:

(A) One comprehensive low vision evaluation every five years;

(B) High power spectacles, magnifiers and telescopes as medically necessary, with reasonable limitations permitted; and

(C) Follow-up care of four visits in any five year period, if preauthorized.

(b) The pediatric vision benefits specifically exclude:

(i) Visual therapy;

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

(iii) Medical treatment of eye disease or injury, which is otherwise covered under the medical/surgical benefits of the plan;

(iv) Nonprescription (plano) lenses;

(v) Prosthetic devices and services, which are otherwise covered under the rehabilitative and habilitative benefit category.

NEW SECTION

WAC 284-43-882 Plan cost-sharing and benefit substitutions and 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 permit waiver of an otherwise applicable copayment for the service that is tied to one setting but not the preferred high-value setting, if the enrollee's provider determines that it would be medically inappropriate to have the service provided in the lower-value setting. A carrier may still apply applicable in-network requirements.

(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. "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 13-08-003
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 13-47—Filed March 20, 2013, 4:17 p.m., effective March 28, 2013, 12:01 a.m.]

Effective Date of Rule: March 28, 2013, 12:01 a.m.

Purpose: Amend recreational fishing rules.

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

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: Survey results show that adequate clams are available for harvest in Razor Clam Areas 1, 3, 4 and 5. 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: March 20, 2013.

Philip Anderson
Director

NEW SECTION

WAC 220-56-36000T 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 personal use from any beach in Razor Clam Areas 1, 3, 4, or 5, except as provided for in this section:

1. Effective 12:01 a.m. March 29 through 11:59 a.m. March 30, 2013, razor clam digging is allowed in Razor Clam Area 1. Digging is allowed from 12:01 a.m. to 11:59 a.m. each day only.

2. Effective 12:01 a.m. March 28 through 11:59 a.m. March 31, 2013, razor clam digging is allowed in Razor Clam Area 3. Digging is allowed from 12:01 a.m. to 11:59 a.m. each day only.

3. Effective 12:01 a.m. March 29 through 11:59 a.m. March 30, 2013, razor clam digging is allowed in Razor Clam Area 4. Digging is allowed from 12:01 a.m. to 11:59 a.m. each day only.

4. Effective 12:01 a.m. March 29 through 11:59 a.m. March 30, 2013, razor clam digging is allowed in Razor Clam Area 5. Digging is allowed from 12:01 a.m. to 11:59 a.m. each day only.

5. 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 p.m. March 31, 2013:

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

WSR 13-08-007
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 13-51—Filed March 21, 2013, 4:37 p.m., effective March 21, 2013, 7:00 p.m.]

Effective Date of Rule: March 21, 2013, 7:00 p.m.

Purpose: The purpose of this rule making is to allow nontreaty commercial fishing opportunities in the Columbia River while protecting fish listed as threatened or endangered under the Endangered Species Act (ESA). This rule making implements federal court orders governing Washington's relationship with treaty Indian tribes, federal law governing Washington's relationship with Oregon, and Washington fish and wildlife commission policy guidance for Columbia River fisheries.

Citation of Existing Rules Affected by this Order: Repealing WAC 220-33-01000W; and amending WAC 220-33-010.

Statutory Authority for Adoption: RCW 77.04.130, 77.12.045, and 77.12.047.

Other Authority: *United States v. Oregon,* Civil No. 68-513-KI (D. Or.), Order Adopting 2008-2017 *United States v. Oregon* Management Agreement (Aug. 12, 2008) (Doc. No. 2546); *Northwest Gillnetters Ass'n v. Sandison,* 95 Wn.2d 638, 628 P.2d 800 (1981); Washington fish and wildlife commission policies concerning Columbia River fisheries; 40 Stat. 515 (Columbia River compact).

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: Provides two additional fishing periods during the winter season in the Deep River and Blind Slough area. The spring season remains in place without change. Impacts to nonlocal stocks have been less than expected, which allows for additional opportunity to harvest hatchery stocks. The fishery is consistent with the *U.S. v Oregon* Management Agreement and the associated biological opinion. Conforms Washington state rules with Oregon state rules. Regulation is consistent with compact action of January 30 and March 21, 2013. There is insufficient time to promulgate permanent rules.

Washington and Oregon jointly regulate Columbia River fisheries under the congressionally ratified Columbia River compact. Four Indian tribes have treaty fishing rights in the Columbia River. The treaties preempt state regulations that fail to allow the tribes an opportunity to take a fair share of the available fish, and the states must manage other fisheries accordingly. *Sohappy v. Smith,* 302 F. Supp. 899 (D. Or. 1969). A federal court order sets the current parameters for sharing between treaty Indians and others. *United States v. Oregon,* Civil No. 68-513-KI (D. Or.), Order Adopting 2008-2017 *United States v. Oregon* Management Agreement (Aug. 12, 2008) (Doc. No. 2546).

Some Columbia River Basin salmon and steelhead stocks are listed as threatened or endangered under the federal ESA. On May 5, 2008, the National Marine Fisheries Service issued a biological opinion under 16 U.S.C. § 1536 that allows for some incidental take of these species in treaty and nontreaty Columbia River fisheries governed by the 2008-2017 *U.S. v. Oregon* Management Agreement. The Washington and Oregon fish and wildlife commissions have developed policies to guide the implementation of such biological opinions in the states' regulation of nontreaty fisheries.

Columbia River nontreaty fisheries are monitored very closely to ensure compliance with federal court orders, the ESA, and commission guidelines. Because conditions change rapidly, the fisheries are managed almost exclusively by emergency rule. Representatives from the Washington (WDFW) and Oregon (ODFW) departments of fish and wildlife convene public hearings and take public testimony when considering proposals for new emergency rules. WDFW and ODFW then adopt regulations reflecting agreements reached.

Number of Sections Adopted in Order to Comply with Federal Statute: New 1, Amended 0, Repealed 1; Federal Rules or Standards: New 1, Amended 0, Repealed 1; 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: March 21, 2013.

Philip Anderson
Director

NEW SECTION

WAC 220-33-01000X Columbia River seasons below Bonneville. Notwithstanding the provisions of WAC 220-33-010, WAC 220-33-020, and WAC 220-33-030, it is unlawful for a person to take or possess salmon, sturgeon, and shad for commercial purposes from Columbia River Salmon Management and Catch Reporting Areas 1A, 1B, 1C, 1D, 1E and Select Areas, except during the times and conditions listed below:

1. Deep River Select Area

a) **Dates:** Winter Season: Open hours are 7 PM to 7 AM Monday and Thursday nights immediately through April 2, 2013. Spring Season: Open hours are 7 PM to 7 AM Thursday night, April 18; Tuesday night, April 23; and each Monday and Thursday night from April 25 through June 14, 2013.

b) **Area:** From the markers at USCG navigation marker #16, upstream to the Highway 4 Bridge.

c) **Gear:** Gillnets. Winter season: 7-inch minimum mesh. Spring season: 9 3/4-inch maximum mesh. Nets are restricted to 100 fathoms in length with no weight restriction on leadline. Use of additional weights or anchors attached directly to the leadline is allowed. Nets cannot be tied off to stationary structures. Nets may not fully cross navigation channel. It is unlawful to operate in any river, stream or channel any gillnet longer than three-fourths the width of the stream (WAC 220-20-015)(1)). It is unlawful in any area to use, operate, or carry aboard a commercial fishing vessel a licensed net or combination of such nets, whether fished singly or separately, in excess of the maximum lawful size or length prescribed for a single net in that area, except as otherwise provided for in the rules and regulations of the department (WAC 220-20-122(1)). Nets not specifically authorized for use in these areas **may be onboard** a vessel if properly stored (WAC 220-33-001)(2)). Nets that are fished at any time between official sunset and official sunrise must have **lighted buoys** on both ends of the net unless the net is attached to the boat. If the net is attached to the boat, then one lighted buoy on the opposite end of the net from the boat is required.

d) **Allowable Possession:** Salmon, shad, and white sturgeon. The sturgeon landing limit is four fish in the winter season and two fish in the spring season. The sturgeon landing limit acts to limit the number of white sturgeon possessed or sold by each participating vessel during each calendar week (Sunday through Saturday) that the fishery is open.

e) **Miscellaneous**: Transportation or possession of fish outside the fishing area (except to the sampling station) is unlawful until WDFW staff has biologically sampled individual catches. After sampling, fishers will be issued a transportation permit by WDFW staff. **During the winter season, fishers are required to call 360-795-0319** to confirm the place and time of sampling. In the spring season, a sampling station will be established at WDFW's Oneida Road boat ramp, about 0.5 miles upstream of the lower Deep River area boundary (USCG navigation marker #16).

f) **24-hour** quick reporting is in effect for Washington buyers. (WAC 220-69-240) (14)(d)).

2. Tongue Point/South Channel

a) **Dates:** Monday and Thursday nights from April 25 through June 14, 2013. Open hours are 7:00 PM to 7:00 AM.

b) **Area:** Tongue Point fishing area includes all waters bounded by a line extended from the upstream (southern most) pier (#1) at the Tongue Point Job Corps facility, through navigation marker #6 to Mott Island (new spring lower deadline); a line from a marker at the southeast end of Mott Island, northeasterly to a marker on the northwest tip of Lois Island; and a line from a marker on the southwest end of Lois Island, westerly to a marker on the Oregon shore.

The South Channel area includes all waters bounded by a line from a marker on John Day Point through the green USCG buoy #7 to a marker on the southwest end of Lois Island, upstream to an upper boundary line from a marker on Settler Point, northwesterly to the flashing red USCG marker #10, and northwesterly to a marker on Burnside Island defining the upstream terminus of South Channel.

c) **Gear**: Gillnets. 9 3/4-inch maximum mesh. In the Tongue Point fishing area, gear restricted to a maximum net length of 250 fathoms, and weight not to exceed two pounds on any one fathom. In the South Channel fishing area, gear restricted to a maximum net length of 100 fathoms, no weight restriction on leadline, and use of additional weights or anchors attached directly to the leadline is allowed.

Nets not specifically authorized for use in these areas **may be onboard** a vessel if properly stored (WAC 220-33-001)(2)). Nets that are fished at any time between official sunset and official sunrise must have **lighted buoys** on both ends of the net unless the net is attached to the boat. If the net is attached to the boat, then one lighted buoy on the opposite end of the net from the boat is required.

d) **Allowable Possession:** Salmon, shad, and white sturgeon. The sturgeon landing limit is two fish. The sturgeon landing limit acts to limit the number of white sturgeon possessed or sold by each participating vessel during each calendar week (Sunday through Saturday) that the fishery is open.

e) **Miscellaneous:** Fishers are required to call 971-230-8247 and leave a message including name, catch, and where and when fish will be sold. Permanent transportation rules in effect.

f) **24-hour** quick reporting is in effect for Washington buyers. (WAC 220-69-240) (14)(d)).

3. Blind Slough/Knappa Slough Select Area

a) **Area:** Winter season: Blind Slough open. Spring season: Blind Slough and Knappa Slough areas are both

open. From May 2 until further notice, the lower boundary of the Knappa Slough fishing area is extended downstream to boundary lines defined by markers on the west end of Minaker Island to markers on Karlson Island and the Oregon Shore (fall season boundary).

b) **Dates:** Winter Season: Monday and Thursday nights immediately through April 2, 2013. Open hours are 7:00 PM to 7:00 AM.

Spring Season: Thursday night, April 18; Tuesday night, April 23; and Monday and Thursday nights from April 25 through June 14, 2013. Open hours are 7:00 PM to 7:00 AM.

c) **Gear:** Gillnets. Winter season: 7-inch minimum mesh. Spring Season: 9 3/4-inch maximum mesh. Nets are restricted to 100 fathoms in length, with no weight restriction on leadline. Use of additional weights or anchors attached directly to the leadline is allowed.

Nets not specifically authorized for use in these areas may be onboard a vessel if properly stored (WAC 220-33-001(2)). Nets that are fished at any time between official sunset and official sunrise must have lighted buoys on both ends of the net unless the net is attached to the boat. If the net is attached to the boat, then one lighted buoy on the opposite end of the net from the boat is required.

d) **Allowable Possession:** Salmon, shad, and white sturgeon. The sturgeon landing limit is four fish in the winter season and two fish in spring season. The sturgeon landing limit acts to limit the number of white sturgeon possessed or sold by each participating vessel during each calendar week (Sunday through Saturday) that the fishery is open.

e) **24-hour** quick reporting is in effect for Washington buyers (WAC 220-69-240) (14)(d)). Permanent transportation rules 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.

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.

REPEALER

The following section of the Washington Administrative Code is repealed effective 7:00 p.m. March 21, 2013:

WAC 220-33-01000W	Columbia River seasons below Bonneville. (13-23)

WSR 13-08-008
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 13-52—Filed March 21, 2013, 4:40 p.m., effective April 11, 2013, 12:01 a.m.]

Effective Date of Rule: April 11, 2013, 12:01 a.m.

Purpose: Amend recreational fishing rules.

Citation of Existing Rules Affected by this Order: Repealing WAC 232-28-61900B; 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: This rule change is necessary to ensure a safe and successful event. The fish will be planted one day prior to the event to better acclimate them before the event. Fish will be placed into netted areas along the shoreline of the pond. On the day of the event, preregistered kids will be allowed to fish within these netted areas. 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: March 21, 2013.

Philip Anderson
Director

NEW SECTION

WAC 232-28-61900B Exceptions to statewide rules—Klineline Pond (Clark Co.) Notwithstanding the provisions of WAC 232-28-619, effective 12:01 a.m. April 11 through April 13, 2013, it is unlawful to fish in those waters of Klineline Pond, except as provided in this section:

(a) Open to fishing 8:00 a.m. to 4:00 p.m. April 12 and 13, 2013, in the netted area, to juvenile anglers participating in the Klineline Kids Fishing Event.

REPEALER

The following section of the Washington Administrative Code is repealed effective April 14, 2013:

WAC 232-28-61900B	Exceptions to statewide rules—Klineline Pond (Clark Co.)

WSR 13-08-009
EMERGENCY RULES
OFFICE OF INSURANCE COMMISSIONER

[Insurance Commissioner No. R 2013-09—Filed March 22, 2013, 9:01 a.m., effective March 22, 2013, 9:01 a.m.]

Effective Date of Rule: Immediately.

Purpose: The National Association of Insurance Commissioners (NAIC) task force on title insurance statistical reporting, after working with the title insurance industry, adopted a guideline for title insurance agents to report financial data to insurance commissioners. The commissioner is considering amending the current rules to adopt the NAIC guideline. This emergency rule postpones the filing deadline under current administrative regulations so that if the rule is amended, title insurance agents and insurers have not incurred unnecessary administrative cost and effort.

Citation of Existing Rules Affected by this Order: Amending WAC 284-29A-110.

Statutory Authority for Adoption: RCW 48.02.060 and 48.29.005.

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 an emergency rule, title insurance agents would be required to submit report[s] for the calendar years 2011 and 2012 to their title insurance company(s) in a manner that is being considered for amendment.

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 1, Repealed 0.

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

Date Adopted: March 22, 2013.

Mike Kreidler
Insurance Commissioner

AMENDATORY SECTION (Amending Matter No. R 2012-10, filed 7/16/12, effective 8/16/12)

WAC 284-29A-110 Title insurance agents must report data to title insurers. (1) Each title insurance agent must report premium, policy count, and expense data annually to each title insurer for which it produces business in the state of Washington by April 1st of each year, except as provided in subsection (4) of this section. These data must be reported following the instructions published by the commissioner on the commissioner's web site at www.insurance.wa.gov. These instructions, called the *Title Insurance Agent Annual Report*, are incorporated into this chapter by reference.

(2) Each annual report required by this section must include:

(a) The following premium and policy count data:

(i) Title insurance premiums for all of the agent's business; and

(ii) Title insurance premiums produced for the title insurer to which the report is sent.

(iii) Number of policies issued by all of the title insurers with which the agent does business; and

(iv) Number of policies issued by the title insurer to which the report is sent.

(b) The following expense data related to issuing title insurance policies and commitments for all of the agent's business, excluding all expenses related to escrow and other activities not directly related to title insurance:

(i) Employees' salaries and wages;

(ii) Owners' and partners' salaries and wages representing reasonable compensation for personal services actually performed by owners and partners;

(iii) Employee benefits;

(iv) Rent;

(v) Insurance;

(vi) Legal expense;

(vii) Licenses, taxes, and fees;

(viii) Title plant expense and maintenance;

(ix) Office supplies;

(x) Depreciation;

(xi) Automobile expense;

(xii) Communication expense;

(xiii) Education expense;

(xiv) Bad debts;

(xv) Interest expense;

(xvi) Employee travel and lodging;

(xvii) Loss and loss adjustment expense;

(xviii) Accounting and auditing expense;

(xix) Public relations expense; and

(xx) Other specifically identified expenses.

(c) An explanation that:

(i) Describes how expenses are allocated between the title operations and escrow or other operations of the title insurance agent; and

(ii) Demonstrates that the expenses described in WAC 284-29A-070(2) have been excluded.

(d) The estimated average cost to issue a title insurance commitment.

(3) If a title insurer does not receive a report required under this section by April 1st of each year, the title insurer must notify the commissioner by April 15th. This notice must include the name of the agent that did not send the report on time.

(4) For the 2011 and the 2012 calendar year reports, each title agent must submit the report to the title insurer(s) on or before ((~~April~~)) June 1, 2013.

WSR 13-08-012
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 13-53—Filed March 22, 2013, 4:37 p.m., effective April 1, 2013]

Effective Date of Rule: April 1, 2013.

Purpose: Amend recreational fishing rules.

Citation of Existing Rules Affected by this Order: Amending WAC 220-56-282.

Statutory Authority for Adoption: RCW 77.04.020, 77.12.045, and 77.12.047.

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 two-fish annual personal-use limit rule for white sturgeon, adopted at the March 15, 2013, Washington fish and wildlife commission conference call, is scheduled to take affect [effect] May 1, 2013. The Oregon department of fish and wildlife (ODFW) adopted a two-fish annual personal-use limit for white sturgeon on March 21, 2013, effective April 1, 2013. This emergency rule change is needed to: (1) Promote orderly fisheries and maintain concurrent rules with ODFW in adjacent boundary waters of the Columbia River until the permanent statewide rule takes effect; and (2) align the change in the annual personal-use limit with the Washington department of fish and wildlife license year and the annual personal-use limit catch-reporting period of April 1 through March 31.

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: March 22, 2013.

Philip Anderson
Director

NEW SECTION

WAC 220-56-28200M Sturgeon—Areas, seasons, limits, and unlawful acts. Notwithstanding the provisions of WAC 220-56-282, effective April 1, 2013, until further notice, there is an annual personal-use limit of two white sturgeon, regardless of where the sturgeon were taken.

WSR 13-08-020
EMERGENCY RULES
DEPARTMENT OF HEALTH

[Filed March 26, 2013, 10:07 a.m., effective March 26, 2013, 10:07 a.m.]

Effective Date of Rule: Immediately.

Purpose: WAC 246-980-030, revising the deadline for nonexempt long-term care workers for submitting an application for a home care aide credential.

Citation of Existing Rules Affected by this Order: Amending WAC 246-980-030.

Statutory Authority for Adoption: Chapter 18.88B RCW.

Other Authority: Chapter 74.39A RCW.

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: Elderly and vulnerable adults would be at risk of losing access to personal care services if their home care aides are unable to submit a timely application for a department of health credential. A CR-101 inquiry notice has been filed (WSR 13-01-094) and the department is working with stakeholders on development of proposed 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 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 1, 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 1, Repealed 0.

Date Adopted: March 25, 2013.

Mary C. Selecky
Secretary

AMENDATORY SECTION (Amending WSR 10-15-103, filed 7/20/10, effective 1/1/11)

WAC 246-980-030 Can a nonexempt long-term care worker work before obtaining certification as a home care aide? (1) A nonexempt long-term care worker may provide care before receiving certification as a home care aide if all the following conditions are met:

(a) Before providing care, the long-term care worker must complete the training required by RCW 74.39A.073 (4)(a) and (b).

(b) The long-term care worker must submit an application for home care aide certification to the department within ((~~three~~)) fourteen days of hire. An application is considered

to be submitted on the date it is post-marked or, for applications submitted in person or on-line, the date it is accepted by the department.

(2) The long-term care worker may not work for more than one hundred fifty calendar days from their date of hire without obtaining certification.

WSR 13-08-034
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 13-54—Filed March 27, 2013, 2:57 p.m., effective April 1, 2013]

Effective Date of Rule: April 1, 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 Washington fish and wildlife commission approved new fishing regulations that increased the daily bag limit for walleye in Lake Roosevelt and the lower Spokane River, to allow for increased harvest on an overabundant Lake Roosevelt walleye population. The commission also changed the fishing season for walleye on the lower Spokane River to year-round. This regulation change also increases walleye harvest opportunity, by allowing anglers to take advantage of early-season walleye fishing and harvest opportunities in identified locations. The emergency regulation will continue until further notice in the lower San Poil River. These emergency rules are interim until permanent rules take effect.

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: March 27, 2013.

Joe Stohr
for Philip Anderson
Director

NEW SECTION

WAC 232-28-61900C Exceptions to statewide rules—Lake Roosevelt, and San Poil and Spokane rivers. Notwithstanding the provisions of WAC 232-28-619:

(1) Effective April 1, 2013, until further notice, the daily limit is 16 walleye, with no size restriction, in the following waters:

(a) Lake Roosevelt; and

(b) Spokane River from the mouth (SR 25 Bridge) to 400' below Little Falls Dam.

(2) Effective April 1, 2013, until further notice, it is permissible to fish for walleye in waters of the lower San Poil River from Boundary Line A upstream to Boundary Line C. Daily limit is 16 walleye, with no size restriction.

WSR 13-08-045
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 13-57—Filed March 28, 2013, 2:44 p.m., effective March 28, 2013, 2:44 p.m.]

Effective Date of Rule: Immediately.

Purpose: Amend commercial fishing rules.

Citation of Existing Rules Affected by this Order: Repealing WAC 220-52-04600J; and amending WAC 220-56-046.

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 3, subareas 1, 2 and 3. The fishery has reached the ending date agreed to in the Region 3 management plans. This regulation outlines a three-day gear recovery period for Region 3-2 following the closure. This emergency regulation also maintains the closure of Region 2 West and Region 2 East where the Puget Sound state commercial fishery has reached its allocation and ending dates. With the implementation of this regulation, the only remaining Puget Sound state commercial area open for fishing will be Region 1, where current pot limits are set at 100 pots per license per buoy tag number. 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 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: March 28, 2013.

Philip Anderson
Director

NEW SECTION

WAC 220-52-04600L 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) The following areas are closed to commercial crab fishing:

(a) Effective immediately, 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 immediately, 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 7:00 PM, Sunday, March 31st, 2013, until further notice, Crab Management Region 3, subarea 1. This region includes Marine Fish-Shellfish Management and Catch Reporting Areas 23A and 23B.

(d) Effective 7:00 PM, Sunday, March 31st, 2013, until further notice, Crab Management Region 3, subarea 3. This region includes Marine Fish-Shellfish Management and Catch Reporting Areas 23C and 29.

(e) 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.

(f) 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.

(g) Effective 7:00 PM, Sunday, March 31st, 2013, until further notice, Crab Management Region 3, subarea 2. This region includes Marine Fish-Shellfish Management and Catch Reporting Areas 23D, 25A, and 25E.

(i) Crab fishers in Region 3, subarea 2 will be allowed a gear removal period after March 31, 2013. Fishers may continue to store crab gear in catch areas 23D, 25A, and 25E, but all gear must be off the water by 7:00 PM, Wednesday, April 3, 2013. No crab may be retained, possessed, or landed from these catch areas after March 31, 2013.

REPEALER

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

WAC 220-52-04600J	Puget Sound crab fishery—Seasons and areas (13-32)

WSR 13-08-048
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 13-56—Filed March 28, 2013, 5:07 a.m., effective March 28, 2013, 5:07 a.m.]

Effective Date of Rule: Immediately.

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 fish and wildlife commission, on March 3, 2013, approved sport fishing proposal #54, "Open a trout fishery from the mouth to Highway 536 (Memorial Bridge) from March 28 through May 31. Anglers must use hooks with a 1/2-inch gap (approximately a size 2 hook) and follow selective gear rules." This emergency regulation is necessary to open this fishery, as the 2013-2014 pamphlet will not go into effect until May 1, 2013.

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: March 28, 2013.

Philip Anderson
Director

NEW SECTION

WAC 232-28-61900E Exceptions to statewide rules—Skagit River. Notwithstanding the provisions of WAC 232-28-619, effective March 28 through May 31, 2013, it is permissible to fish for gamefish in waters of the Skagit River from the mouth to Highway 536 at Mt. Vernon (Memorial Highway). Selective gear rules are in effect; maximum hook size of 1/2-inch gap allowed. Catch and release, except that trout minimum size is 14 inches, with a daily limit 2. Dolly Varden/Bull trout minimum size is 20 inches and may be retained as part of the trout daily limit.

WSR 13-08-057
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 13-55—Filed March 29, 2013, 3:36 p.m., effective April 1, 2013]

Effective Date of Rule: April 1, 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 fish and wildlife commission, on March 3, 2013, approved sport fishing rule proposal #7 allowing internal combustion motors to be attached to floating devices when fishing Washburn Island Pond. This emergency rule will allow internal combustion motors to be attached to floating devices when Washburn Island Pond opens for fishing on April 1, 2013, until the permanent rule takes effect.

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: March 29, 2013.

Philip Anderson
Director

NEW SECTION

WAC 232-28-61900D Exceptions to statewide rules—Washburn Island Pond. Notwithstanding the provisions of WAC 232-28-619, effective April 1, 2013, until further notice, it is permissible to have internal combustion motors attached to floating devices in the waters of Washburn Island Pond. However, it is unlawful for a person who is fishing in Washburn Island Pond to operate an internal combustion motor while it is attached to any floating device the person may be fishing from.

WSR 13-08-072
EMERGENCY RULES
OFFICE OF INSURANCE COMMISSIONER

[Insurance Commissioner Matter No. R 2013-10—Filed April 2, 2013, 9:13 a.m., effective April 2, 2013, 9:13 a.m.]

Effective Date of Rule: Immediately.

Purpose: Establish consistent market requirements for open and special enrollment periods for nongrandfathered individual and small group plans.

Statutory Authority for Adoption: RCW 48.02.060, 48.18.120(2), 48.20.450, 48.43.720, 48.44.050, and 48.46.200.

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: Beginning October 1, 2013, the health benefit exchange will conduct open enrollment for health plans offered on the exchange. The first year, open enrollment closes in March 2014; subsequently it will end earlier. Beginning January 1, 2014, health plan issuers must enroll all applicants, whether the applicant seeks coverage during open enrollment (on or off the exchange) or off-exchange at any time during the calendar year. This creates a risk of adverse selection for the off-exchange markets, because someone with a specific health care need can enroll, receive the service, and disenroll, unless open enrollment periods are established that parallel the exchange's time frames. Carriers need to know this standard now to file forms with the commissioner for 2014.

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 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 2, Amended 0, Repealed 0.

Date Adopted: April 2, 2013.

Mike Kreidler
Insurance Commissioner

NEW SECTION

WAC 284-170-400 Small group market open enrollment. (1) Issuers participating in the small group market must not condition or otherwise limit enrollment based on preexisting conditions. An issuer may only vary eligibility requirements that limit access to enrollment between plans purchased on and off the exchange consistent with this section or to limit eligibility to comply with the exchange's qualified enrollee requirements.

(2) An issuer may limit enrollment to specific time periods during the year. If an issuer elects to open enrollment for nongrandfathered small group health plans only during specific times, the following requirements apply:

(a) For health plans offered on the exchange, the issuer must comply with the open enrollment periods established by the health benefit exchange.

(b) For health benefit plans offered off the exchange, the issuer's open enrollment period must:

(i) Be a minimum of forty-five days in length;

(ii) Apply in the same manner and with the same conditions to all plans offered by the issuer in the small group market. An issuer may not establish different open enrollment periods or requirements for specific health benefit plans.

(3) If an issuer uses open enrollment periods, the issuer must make special enrollment periods of not less than sixty days available on the same basis that special enrollment periods are available to enrollees of plans purchased on the exchange.

(a) A triggering event for special enrollment includes:

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

(ii) The loss of eligibility for medicaid or a public program providing health benefits;

(iii) The loss of coverage as the result of dissolution of marriage or termination of a domestic partnership;

(iv) A change in residence, work, or living situation, whether or not within the choice of the individual, where the health plan under which they were covered does not provide coverage in that person's new service area;

(v) The person for whom coverage is sought was born, placed for adoption or adopted within sixty days of the application for enrollment. For newborns, coverage must be effective from the moment of birth;

(vi) A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual;

(b) An annual enrollment period must be held between November 15th and extending through December 15th of each year for small groups whose plan sponsor is unable to comply with a material plan provision relating to employer contribution or group participation rules as required under 45 C.F.R. § 147.104 (b)(1)(i) and 45 C.F.R. § 147.106 (b)(3).

(4) A carrier must prominently display on its web site and include in its health benefit plan, contract or policy or any certificate of coverage information about open enrollment periods and special enrollment periods.

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

(i) Explain that fact prominently on its web site; and

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

(iii) Offer a special enrollee all the benefit packages available to similarly situated individuals who enroll when first eligible. Any difference in benefits or cost-sharing requirements for different individuals constitutes a different benefit package. A special enrollee cannot be required to pay more for coverage than a similarly situated individual who enrolls in the same coverage when first eligible.

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

NEW SECTION

WAC 284-170-410 Individual market open enrollment requirements. (1) Issuers participating in the individual market must not condition or otherwise limit enrollment based on preexisting conditions. An issuer may not vary eligibility requirements that limit access to enrollment between plans purchased on and off the exchange, other than limiting eligibility to comply with the exchange's qualified enrollee requirements or for child-only policies available to those under nineteen.

(2) For purposes of this section, "open enrollment" means a specific period of time during which enrollment in a health benefit plan is permitted.

(3) An issuer must limit the dates for enrollment in plans offered on the individual market to the same time period for open enrollment established by the Washington health benefit exchange. In addition to the open enrollment period established by the exchange, an issuer must hold an open enrollment period between March 15th and April 30th each year for child-only policies available to those under age nineteen.

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

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

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

(c) The loss of coverage as the result of dissolution of marriage or termination of a domestic partnership;

(d) A change in residence, work, or living situation, whether or not within the choice of the individual, where the health plan under which they were covered does not provide coverage in that person's new service area;

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

(f) A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual;

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

(5) An issuer must prominently display on its web site and include in its health benefit plan, contract or policy information about open enrollment periods and special enrollment periods.

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

(b) An issuer must offer a special enrollee all the benefit packages available to similarly situated individuals who enroll when first eligible. Any difference in benefits or cost-sharing requirements for different individuals constitutes a different benefit package. A special enrollee cannot be required to pay more for coverage than a similarly situated individual who enrolls in the same coverage when first eligible.

WSR 13-08-081
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 12-59—Filed April 2, 2013, 3:58 p.m., effective April 20, 2013, 8:00 a.m.]

Effective Date of Rule: April 20, 2013, 8:00 a.m.

Purpose: Amend recreational fishing rules.

Citation of Existing Rules Affected by this Order: Repealing WAC 232-28-61900H; 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: The Grays Harbor Poggie Club is sponsoring a kids' fishing derby at Failor Lake one week prior to the opening of the lowland lake season. In previous years, the derby has been held on opening day for the lowland lake season, but congestion and competition from adult anglers interferes with the kids' enjoyment of the derby and the smooth operations of the derby. An emergency rule is needed to open the lake for the derby one week early. There is insufficient time to adopt a permanent rule.

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: April 2, 2013.

Joe Stohr
for Philip Anderson
Director

NEW SECTION

WAC 232-28-61900H Exceptions to statewide rules—Failor Lake (Grays Harbor Co.) Notwithstanding the provisions of WAC 232-28-619, Failor Lake is open to fishing on April 20, 2013, from 8:00 a.m. to noon, for anglers age fourteen years old and younger who are participating in the youth fishing event. Adults may assist children participating in the event, but no child may fish with more than one fishing rod. All other provisions of the permanent rule remain in effect.

REPEALER

The following section of the Washington Administrative Code is repealed, effective 12:01 p.m. on April 20, 2013:

WAC 232-28-61900H	Exceptions to statewide rules—Failor Lake (Grays Harbor Co.)

WSR 13-08-082
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 13-61—Filed April 2, 2013, 4:04 p.m., effective April 8, 2013, 12:01 a.m.]

Effective Date of Rule: April 8, 2013, 12:01 a.m.

Purpose: Amend commercial fishing rules.

Citation of Existing Rules Affected by this Order: Repealing WAC 220-40-03100J; and amending WAC 220-40-031.

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 white sturgeon are available within the Willapa Bay management guideline for a commercial fishery. The fishery will close early if catch approaches the guideline. 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: April 2, 2013.

Joe Stohr
for Philip Anderson
Director

NEW SECTION

WAC 220-40-03100J Willapa Bay spring white sturgeon fishery. Notwithstanding the provisions of WAC 220-40-031, effective April 8 through April 30, 2013, it is unlawful to fish for sturgeon in Willapa Bay for commercial purposes or to possess sturgeon taken from those waters for commercial purposes, except that:

Fishing periods

(1) Gillnet gear may be used to fish for white sturgeon:

Time	Area
12:01 a.m. April 8 through 11:59 p.m. April 30, 2013	Salmon Management and Catch Reporting Area (SMCRA) Area 2T easterly of a line from the most northerly upland at Leadbetter Point (approximately 46° 38' 12" N, 124° 3' 31" W) to the eastern most upland at Toke Point (approximately 46° 42' 18" N, 123° 58' 00" W); and areas 2U, 2R, 2N, and 2M.

The Tokeland Boat Basin is closed to commercial fishing during the openings in SMCRA 2T described in this section. The Tokeland Boat Basin means that portion of SMCRA 2T bounded on the south by the shoreline of the boat basin, on the west by the seawall, and on the north and east by a line from the Tokeland Channel Marker "3" (flashing green, 4-second) to Tokeland Channel Marker "4" to the tip of the seawall.

Gear

(2) Gillnet gear restrictions - All areas:

(a) Drift gillnet gear only. It is unlawful to use set net gear.

(b) April 8 through April 30, 2013 9-inch minimum mesh.

Other

(3) All white sturgeon that do not meet size limit requirements, all salmon, all green sturgeon, and all steelhead must be handled with care to minimize injury to fish and released immediately to the river/bay.

(4) White sturgeon, when lying on their side, are measured from the tip of the nose to the fork of the tail, this measurement is referred to as the fork length. All white sturgeon to be retained must have a fork length measure of no less than 43 inches and no more than 54 inches.

(5) Quick reporting is required (WAC 220-69-240) by 10:00 a.m. the day following landing for wholesale dealers and fishers retailing their fish.

(6) Fishers must take department observers, if requested by WDFW staff, when participating in these openings and provide Notice of Intent via phone, fax, or e-mail to participate in Quick Reporting, WAC 220-69-240, prior to 10:00 a.m. April 8, 2013.

(7) Report ALL encounters with Chinook, green sturgeon and steelhead (your name, date of encounter, and number of species encountered) to the Quick Reporting office via phone at 866.791.1280, via fax at 360.249.1229, or e-mail at harborfishtickets@dfw.wa.gov. Wholesale Dealer may use the 'buyer only' portion of fish tickets and must include their reporting of encounters with each day's Quick Report.

(8) Retrieve any information from spaghetti tags near the dorsal fin on green or white sturgeon. Do NOT remove tags from white sturgeon that may not be retained or green sturgeon. For retained white sturgeon, please submit tags to the Washington Department of Fish and Wildlife, 48 Devonshire Rd., Montesano, WA, 98563.

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 section of the Washington Administrative Code is repealed effective 12:01 a.m. May 1, 2013:

WAC 220-40-03100J	Willapa Bay spring white sturgeon fishery.