WSR 23-24-034
PERMANENT RULES
OFFICE OF THE
INSURANCE COMMISSIONER

[Insurance Commissioner Matter R 2023-07—Filed November 30, 2023, 7:20 a.m.]

Effective Date of Rule: January 1, 2024.

Purpose: The insurance commissioner is adopting consolidated health care rules due to the recent passage of insurance related legislation. Currently, multiple provisions of health care and insurance regulations in WAC need updated by the office of the insurance commissioner (OIC) to be consistent with enacted legislation codified in RCW. These rules will facilitate implementation of the legislation by ensuring that all affected health care and insurance entities understand their rights and obligations under the new legal framework.

Citation of Rules Affected by this Order: New WAC 284-43-5937 and 284-46-110; and amending WAC 284-43-0160, 284-43-7220, 284-44-046, 284-50-270, 284-170-130, and 284-180-460.

Statutory Authority for Adoption: RCW 48.02.060 (to effectuate chapter 314, Laws of 2011; chapter 8, Laws of 2023; chapter 107, Laws of 2023; chapter 194, Laws of 2023; chapter 245, Laws of 2023; chapter 366, Laws of 2023; and chapter 382, Laws of 2023), as well as RCW 48.43.735, 48.44.050, 48.46.200, 48.200.040, and 48.200.900.

Adopted under notice filed as WSR 23-21-102 on October 18, 2023.

Changes Other than Editing from Proposed to Adopted Version: WAC 284-43-5937(1) has been revised to remove the reference to and requirement of hearing instrument coverage regardless of network status. WAC 284-43-5937(4) has been updated to clarify that health carriers shall provide in network coverage for hearing instruments.

As enacted, there is nothing in RCW 48.43.135 that requires carriers to provide coverage of hearing instruments from nonparticipating providers. Given the rule making's purpose to clarify and interpret within the scope of agency authority, it is reasonable for OIC to determine that out-of-network coverage is not required. Further, some carriers may offer plans that do not include an out-of-network benefit; by limiting mandated coverage to participating providers only, this allows carriers to provide a baseline level of coverage for hearing instruments at a predictable cost. Finally, if the law is interpreted to mandate out-of-network coverage, then the proposed rule language may have inadvertently placed consumers in the middle of billing disputes or increased premiums to account for the carrier's cost of paying nonnegotiated rates to providers.

A final cost-benefit analysis is available by contacting Simon Casson, P.O. Box 40260, Olympia, WA 98504, phone 360-725-7038, fax 360-586-3109, email Simon.Casson@oic.wa.gov, website https://www.insurance.wa.gov/consolidated-health-care-rulemaking-r-2023-07.

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 2, Amended 6, Repealed 0.

Number of Sections Adopted at the 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 0, Amended 0, Repealed 0.

Date Adopted: November 30, 2023.

Mike Kreidler
Insurance Commissioner

OTS-4934.2

AMENDATORY SECTION (Amending WSR 20-24-040, filed 11/23/20, effective 12/24/20)

WAC 284-43-0160 Definitions. Except as defined in other subchapters and unless the context requires otherwise, the following definitions shall apply throughout this chapter.

(1) "Adverse determination" has the same meaning as the definition of adverse benefit determination in RCW 48.43.005, and includes:

(a) The determination includes any decision by a health carrier's designee utilization review organization that a request for a benefit under the health carrier's health benefit plan does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part for the benefit;

(b) The denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit based on a determination by a health carrier or its designee utilization review organization of a covered person's eligibility to participate in the health carrier's health benefit plan;

(c) Any prospective review or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment in whole or in part for a benefit;

(d) A rescission of coverage determination; or

(e) A carrier's denial of an application for coverage.

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

(3) "Behavioral health agency" means an agency licensed or certified under RCW 71.24.037.

(4) "Clinical review criteria" means the written screens or screening procedures, decision rules, medical protocols, or clinical practice guidelines used by the carrier as an element in the evaluation of medical necessity and appropriateness of requested admissions, procedures, and services, including prescription drug benefits, under the auspices of the applicable plan. Clinical approval criteria has the same meaning as clinical review criteria.

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

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

(7) "Emergency fill" means a limited dispensed amount of medication that allows time for the processing of a preauthorization request. Emergency fill only applies to those circumstances where a patient presents at a contracted pharmacy with an immediate therapeutic need for a prescribed medication that requires a prior authorization.

(8) "Emergency medical condition" ((~~means the emergent and acute onset of a symptom or symptoms, including severe pain or emotional distress, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical, mental health or substance use disorder treatment attention, if failure to provide medical, mental health or substance use disorder treatment attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy~~)) has the meaning set forth in RCW 48.43.005.

(9) "Emergency services" has the meaning set forth in RCW 48.43.005.

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

(11) "Expedited prior authorization request" ((~~means any request by a provider or facility for approval of a service where the passage of time could seriously jeopardize the life or health of the enrollee, seriously jeopardize the enrollee's ability to regain maximum function, or, in the opinion of a provider or facility with knowledge of the enrollee's medical condition, would subject the enrollee to severe pain that cannot be adequately managed without the service that is the subject of the request~~)) has the meaning set forth in RCW 48.43.830.

(12) "Facility" means an institution providing health care services including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory, and imaging centers, and rehabilitation and other therapeutic settings, and as defined in RCW 48.43.005.

(13) "Formulary" means a listing of drugs used within a health plan. A formulary must include drugs covered under an enrollee's medical benefit.

(14) "Grievance" has the meaning set forth in RCW 48.43.005.

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

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

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

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

(17) "Health carrier" or "carrier" means a disability insurance company regulated under chapter 48.20 or 48.21 RCW, a health care

service contractor as defined in RCW 48.44.010, and a health maintenance organization as defined in RCW 48.46.020, and includes "issuers" as that term is used in the Patient Protection and Affordable Care Act (P.L. 111-148, as amended (2010)).

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

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

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

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

(d) Disability income;

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

(f) Workers' compensation coverage;

(g) Accident only coverage;

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

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

(j) Dental only and vision only coverage; and

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

(19) "Immediate therapeutic needs" means those needs where passage of time without treatment would result in imminent emergency care, hospital admission or might seriously jeopardize the life or health of the patient or others in contact with the patient.

(20) "Indian health care provider" means:

(a) The Indian Health Service, an agency operated by the U.S. Department of Health and Human Services established by the Indian Health Care Improvement Act, Section 601, 25 U.S.C. §1661;

(b) An Indian tribe, as defined in the Indian Health Care Improvement Act, Section 4(14), 25 U.S.C. §1603(14), that operates a health program under a contract or compact to carry out programs of the Indian Health Service pursuant to the Indian Self-Determination and Education Assistance Act (ISDEAA), 25 U.S.C. §450 et seq.;

(c) A tribal organization, as defined in the Indian Health Care Improvement Act, Section 4(26), 25 U.S.C. §1603(26), that operates a health program under a contract or compact to carry out programs of the Indian Health Service pursuant to the ISDEAA, 25 U.S.C. §450 et seq.;

(d) An Indian tribe, as defined in the Indian Health Care Improvement Act, Section 4(14), 25 U.S.C. §1603(14), or tribal organization, as defined in the Indian Health Care Improvement Act, Section 4(26), 25 U.S.C. §1603(26), that operates a health program with funding provided in whole or part pursuant to 25 U.S.C. §47 (commonly known as the Buy Indian Act); or

(e) An urban Indian organization that operates a health program with funds in whole or part provided by Indian Health Service under a grant or contract awarded pursuant to Title V of the Indian Health Care Improvement Act, Section 4(29), 25 U.S.C. §1603(29).

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

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

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

(24) "Mental health services" means in-patient or out-patient treatment including, but not limited to, partial hospitalization, residential treatment, out-patient facility-based treatment, intensive outpatient treatment, emergency services, or prescription drugs to manage, stabilize or ameliorate the effects of a mental disorder listed in the most current version of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* published by the American Psychiatric Association, including diagnoses and treatment for substance use disorder.

(25) "Network" means the group of participating providers and facilities providing health care services to a particular health plan or line of business (individual, small, or large group). A health plan network for issuers offering more than one health plan may be smaller in number than the total number of participating providers and facilities for all plans offered by the carrier.

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

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

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

(29) "Predetermination request" means a voluntary request from an enrollee or provider or facility for a carrier or its designated or contracted representative to determine if a service is a benefit, in relation to the applicable plan.

(30) "Preservice requirement" means any requirement that a carrier places on a provider or facility that may limit their ability to deliver a service that requires prior authorization. Examples include limits on the type of provider or facility delivering the service, a service that must be provided before a specific service will be authorized, site of care/place of service, and whether a provider administered medication needs to be obtained from a specialty pharmacy.

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

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

(33) "Premium" means all sums charged, received, or deposited by a health carrier as consideration for a health plan or the continuance of a health plan. Any assessment or any "membership," "policy," "contract," "service," or similar fee or charge made by a health carrier in consideration for a health plan is deemed part of the premium. "Premium" shall not include amounts paid as enrollee point-of-service cost-sharing.

(34) "Prior authorization" means a mandatory process that a carrier or its designated or contracted representative requires a provider or facility to follow to determine if a service is a benefit and meets the requirements for medical necessity, clinical appropriateness, level of care, or effectiveness in relation to the applicable plan. Prior authorization occurs before the service is delivered. For purposes of WAC 284-43-2050 and 284-43-2060, any term used by a carrier or its designated or contracted representative to describe this process is prior authorization. For example, prior authorization has also been referred to as "prospective review," "preauthorization," or "precertification."

(35) "Service area" means the geographic area or areas where a specific product is issued, accepts members or enrollees, and covers provided services. A service area must be defined by the county or counties included unless, for good cause, the commissioner permits limitation of a service area by zip code. Good cause includes geographic barriers within a service area, or other conditions that make offering coverage throughout an entire county unreasonable.

(36) "Small group plan" means a health plan issued to a small employer as defined under RCW 48.43.005(33) comprising from one to ((~~fifty~~)) 50 eligible employees.

(37) "Standard prior authorization request" ((~~means a request by a provider or facility for approval of a service where the request is made in advance of the enrollee obtaining a service that is not required to be expedited~~)) has the meaning set forth in RCW 48.43.830.

(38) "Step therapy protocol" means a drug utilization management prior authorization protocol or program that establishes the specific sequence in which prescription drugs are covered by a health carrier for a medical condition.

(39) "Substance use disorder" means a substance-related or addictive disorder listed in the most current version of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* published by the American Psychiatric Association.

(40) "Substitute drug" means a prescription medication, drug or therapy that a carrier covers based on an exception request. When the exception request is based on therapeutic equivalence, a substitute drug means a therapeutically equivalent substance as defined in chapter 69.41 RCW.

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

(42) "Withdrawal management services" means ((~~twenty-four~~)) 24 hour medically managed or medically monitored detoxification and assessment and treatment referral for adults or adolescents withdrawing

from alcohol or drugs, which may include induction of medications for addiction recovery.

AMENDATORY SECTION (Amending WSR 21-24-032, filed 11/22/21, effective 12/23/21)

WAC 284-43-7220 Coverage required. A health plan must provide coverage for all services and supplies required under RCW 48.43.072 and 48.43.073. A student health plan must also provide coverage for all services and supplies required under RCW 48.43.072 and 48.43.073.

(1) Required coverage of contraceptive services and supplies includes, but is not limited to:

(a) All prescription and over-the-counter contraceptive drugs, devices, and other products approved by the Federal Food and Drug Administration;

(b) Voluntary sterilization procedures; and

(c) The consultations, examinations, procedures, and medical services that are necessary to prescribe, dispense, insert, deliver, distribute, administer, or remove the drugs, devices, and other products or services in (a) and (b) of this subsection.

(2)(a) A health plan or student health plan that provides coverage for maternity care or services must also provide a covered person with substantially equivalent coverage to permit the abortion of a pregnancy. For the coverage to be substantially equivalent, a health plan or student health plan must not apply ((~~cost-sharing or~~)) coverage limitations differently for abortion and related services than for maternity care and its related services 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) Except as provided in (c) of this subsection, for health plans issued or renewed on or after January 1, 2024, a health carrier may not impose cost-sharing for abortion of a pregnancy.

(c) For a health plan that provides coverage for abortion of a pregnancy, and is offered as a qualifying health plan for a health savings account, the health carrier shall establish the plan's cost-sharing for the coverage required by this section at the minimum level necessary to preserve the enrollee's ability to claim tax exempt contributions and withdrawals from the enrollee's health savings account under internal revenue service laws and regulations.

(3) This subchapter does not diminish or affect any rights or responsibilities provided under RCW 48.43.065.

(4) For purposes of this section, "abortion of a pregnancy" includes medical treatment intended to induce termination of a pregnancy, except for the purpose of producing a live birth, and all medically necessary care associated with completing treatment including, but not limited to, office visits, counseling, diagnostic and laboratory testing, and prescription drugs.

(5) Coverage for abortion of a pregnancy may be subject to terms and conditions generally applicable to the health plan's or student health plan's coverage of maternity care or services.

OTS-4935.5

NEW SECTION

WAC 284-43-5937 Hearing instrument coverage. (1) The purpose of this regulation is to effectuate the provisions of chapter 245, Laws of 2023, by requiring health carriers to include coverage for hearing instruments.

(2) This section applies to health carriers offering nongrandfathered group health plans, other than small group health plans, issued or renewed on or after January 1, 2024.

(3) The hearing instruments and coverage requirements referenced in this section have the same meaning as in RCW 48.43.135.

(4) Health carriers shall provide in network coverage for hearing instruments at no less than $3,000 per ear with hearing loss every 36 months. Any enrollee cost-sharing applied to this coverage must ensure that the amount paid by the health plan will be no less than $3,000 except to the extent required otherwise in RCW 48.43.135(4).

(5) Enrollees can purchase a hearing instrument beyond the cost limitations outlined in this section and coverage must still be provided at no less than $3,000 per ear with hearing loss every 36 months.

(6) The 36-month time period referenced in this section and RCW 48.43.135(3), is specific to the enrollee's current health carrier.

OTS-4936.2

AMENDATORY SECTION (Amending WSR 92-16-009, filed 7/23/92, effective 8/23/92)

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

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

(3) Coverage of mammograms may be subject to standard contract provisions, except the cost-sharing provisions prohibited by RCW 48.43.076, which may be applicable to other diagnostic X-ray benefits ((~~such as deductible or copayment provisions~~)).

(4) For purposes of this section:

(a) "Diagnostic breast examination" means a medically necessary and appropriate examination of the breast, as defined in RCW 48.43.076. Diagnostic breast examinations are used to evaluate an abnormality either seen or suspected from a breast cancer screening examination, or detected by another means of examination.

(b) "Supplemental breast examination" has the meaning set forth in RCW 48.43.076.

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

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

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

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

OTS-4937.3

NEW SECTION

WAC 284-46-110 Mammography coverage. (1) The purpose of this regulation is to effectuate the provisions of RCW 48.43.076, by requiring coverage and prohibiting cost-sharing for certain types of mammography services.

(2) Except as provided in subsection (3) of this section, for nongrandfathered health plans issued or renewed on or after January 1, 2024, that include coverage of supplemental and diagnostic breast examinations, health carriers may not impose cost-sharing for such examinations.

(3) For a health plan that provides coverage of supplemental and diagnostic breast examinations and is offered as a qualifying health plan for a health savings account, the health carrier shall establish the plan's cost-sharing for the coverage of the services described in this section at the minimum level necessary to preserve the enrollee's ability to claim tax exempt contributions from their health savings account under Internal Revenue Service laws and regulations.

(4) For purposes of this section:

(a) "Diagnostic breast examination" means a medically necessary and appropriate examination of the breast, as defined in RCW 48.43.076. Diagnostic breast examinations are used to evaluate an abnormality either seen or suspected from a breast cancer screening examination, or detected by another means of examination.

(b) "Supplemental breast examination" has the meaning set forth in RCW 48.43.076.

(5) Coverage of mammograms may be subject to standard contract provisions, other than the cost-sharing provisions prohibited by RCW 48.43.076, which may be applicable to other diagnostic X-ray benefits.

OTS-4938.2

AMENDATORY SECTION (Amending WSR 92-19-061, filed 9/11/92, effective 10/12/92)

WAC 284-50-270 Mammograms—Coverage requirements and exceptions. (1) The purpose of this regulation is to effectuate the provisions of RCW 48.20.393 and 48.21.225, by establishing definitions for the exceptions to coverage for mammograms. This regulation shall apply to every group and individual disability insurance contract, which is delivered or issued for delivery or renewed in this state on or after September 1, 1992, that provides coverage for hospital or medical expenses.

(2) For the purposes of RCW 48.20.393 and 48.21.225 and this regulation, supplemental contracts covering specified disease shall be defined to mean and include only those contracts or policies which provide benefits to a policyholder only in the event that the policyholder contracts the disease or diseases specifically named in the policy. Also for the purposes of RCW 48.20.393 and 48.21.225 and this regulation, supplemental contracts covering limited benefits shall be defined to mean and include only those contracts providing only one of the following benefits: Hospital indemnity, accident only coverage, dental care, vision care, mental health care, chemical dependency care, pharmaceutical care, and podiatric care.

(3) Coverage of mammograms may be subject to standard policy provisions, other than the cost-sharing provisions prohibited by RCW 48.43.076, which may be applicable to other diagnostic X-ray benefits ((~~such as deductible or copayment provisions~~)).

(4) For purposes of RCW 48.20.393 and 48.21.225 and this regulation, a contract is "renewed" when it is continued beyond the earliest date, after September 1, 1992, upon which, at the insurer's sole option:

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

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

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

(5) For purposes of this section:

(a) "Diagnostic breast examination" means a medically necessary and appropriate examination of the breast, as defined in RCW 48.43.076. Diagnostic breast examinations are used to evaluate an ab-

normality either seen or suspected from a breast cancer screening examination, or detected by another means of examination.

(b) "Supplemental breast examination" has the meaning set forth in RCW 48.43.076.

OTS-4939.1

AMENDATORY SECTION (Amending WSR 22-22-104, filed 11/2/22, effective 12/3/22)

WAC 284-170-130 Definitions. Except as defined in other subchapters and unless the context requires otherwise, the following definitions shall apply throughout this chapter.

(1) "Adverse determination" has the same meaning as the definition of adverse benefit determination in RCW 48.43.005, and includes:

(a) The determination includes any decision by a health carrier's designee utilization review organization that a request for a benefit under the health carrier's health benefit plan does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part for the benefit;

(b) The denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit based on a determination by a health carrier or its designee utilization review organization of a covered person's eligibility to participate in the health carrier's health benefit plan;

(c) Any prospective review or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment in whole or in part for a benefit;

(d) A rescission of coverage determination; or

(e) A carrier's denial of an application for coverage.

(2) "Allowed amount" has the meaning set forth in RCW 48.43.005.

(3)(a) "Audio-only telemedicine" means the delivery of health care services through the use of audio-only technology, permitting real-time communication between the patient at the originating site and the provider, for the purpose of diagnosis, consultation, or treatment.

(b) "Audio-only telemedicine" does not include:

(i) The use of facsimile, email, or text messages, unless the use of text-like messaging is necessary to ensure effective communication with individuals who have a hearing, speech, or other disability; or

(ii) The delivery of health care services that are customarily delivered by audio-only technology and customarily not billed as separate services by the provider, such as the sharing of laboratory results.

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

(5) "Clinical review criteria" means the written screens, or screening procedures, decision rules, medical protocols, or clinical practice guidelines used by the carrier as an element in the evaluation of medical necessity and appropriateness of requested admissions, procedures, and services, including prescription drug benefits, under the auspices of the applicable health plan. Clinical approval criteria has the same meaning as clinical review criteria.

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

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

(8) "Disciplining authority" has the meaning set forth in RCW 18.130.020.

(9) "Distant site" has the meaning set forth in RCW 48.43.735.

(10) "Emergency medical condition" ((~~means the emergent and acute onset of a symptom or symptoms, including severe pain or emotional distress, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical, mental health, or substance use disorder treatment attention, if failure to provide medical, mental health, or substance use disorder treatment attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy~~)) has the meaning set forth in RCW 48.43.005.

(11) "Emergency services" has the meaning set forth in RCW 48.43.005.

(12) "Enrollee point-of-service cost-sharing" or "cost-sharing" has the meaning set forth in RCW 48.43.005.

(13) "Established relationship" means the provider providing audio-only telemedicine has access to sufficient health records to ensure safe, effective, and appropriate care services and:

(a) For health care services included in the essential health benefits category of mental health and substance use disorder services, including behavioral health treatment:

(i) The covered person has had, within the past three years, at least one in-person appointment, or at least one real-time interactive appointment using both audio and video technology, with:

(A) The provider providing audio-only telemedicine;

(B) A provider employed at the same medical group, at the same clinic, or by the same integrated delivery system operated by a carrier licensed under chapter 48.44 or 48.46 RCW as the provider providing audio-only telemedicine; or

(C) A locum tenens or other provider who is the designated back up or substitute provider for the provider providing audio-only telemedicine who is on leave and is not associated with an established medical group, clinic, or integrated delivery system operated by a carrier licensed under chapter 48.44 or 48.46 RCW; or

(ii) The covered person was referred to the provider providing audio-only telemedicine by another provider who has:

(A) Had, within the past three years, at least one in-person appointment, or at least one real-time interactive appointment using both audio and video technology, with the covered person; and

(B) Provided relevant medical information to the provider providing audio-only telemedicine.

(C) A referral includes circumstances in which the provider who has had at least one in-person appointment, or at least one real-time interactive appointment using both audio and video technology, with the covered person participates in the audio-only telemedicine encounter with the provider to whom the covered person has been referred.

(b) For any other health care service:

(i) The covered person has had, within the past two years, at least one in-person appointment, or, until ((~~January~~)) July 1, 2024, at least one real-time interactive appointment using both audio and video technology, with:

(A) The provider providing audio-only telemedicine; or

(B) A provider employed at the same medical group, at the same clinic, or by the same integrated delivery system operated by a carrier licensed under chapter 48.44 or 48.46 RCW as the provider providing audio-only telemedicine; or

(C) A locum tenens or other provider who is the designated back up or substitute provider for the provider providing audio-only telemedicine who is on leave and is not associated with an established medical group, clinic, or integrated delivery system operated by a carrier licensed under chapter 48.44 or 48.46 RCW; or

(ii) The covered person was referred to the provider providing audio-only telemedicine by another provider who has:

(A) Had, within the past two years, at least one in-person appointment or, until ((~~January~~)) July 1, 2024, at least one real-time interactive appointment using both audio and video technology, with the covered person; and

(B) Provided relevant medical information to the provider providing audio-only telemedicine.

(C) A referral includes circumstances in which the provider who has had at least one in-person appointment, or, until ((~~January~~)) July 1, 2024, at least one real-time interactive appointment using both audio and video technology, with the covered person participating in the audio-only telemedicine encounter with the provider to whom the covered person has been referred.

(14) "Expedited prior authorization request" has the meaning set forth in RCW 48.43.830.

(15) "Facility" means an institution providing health care services including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory, and imaging centers, and rehabilitation and other therapeutic settings, and as defined in RCW 48.43.005.

((~~(15)~~)) (16) "Formulary" means a listing of drugs used within a health plan.

((~~(16)~~)) (17) "Grievance" has the meaning set forth in RCW 48.43.005.

((~~(17)~~)) (18) "Health care provider" or "provider" means:

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

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

((~~(18)~~)) (19) "Health care service" or "health service" means that service offered or provided by health care facilities and health care providers relating to the prevention, cure, or treatment of illness, injury, or disease.

((~~(19)~~)) (20) "Health carrier" or "carrier" means a disability insurance company regulated under chapter 48.20 or 48.21 RCW, a health care service contractor as defined in RCW 48.44.010, and a health maintenance organization as defined in RCW 48.46.020, and includes "issuers" as that term is used in The Patient Protection and Affordable Care Act (P.L. 111-148, as amended (2010)).

((~~(20)~~)) (21) "Health plan" or "plan" means any individual or group policy, contract, or agreement offered by a health carrier to provide, arrange, reimburse, or pay for health care service except the following:

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

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

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

(d) Disability income;

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

(f) Workers' compensation coverage;

(g) Accident only coverage;

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

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

(j) Dental only and vision only coverage; and

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

((~~(21)~~)) (22) "Hospital" has the meaning set forth in RCW 48.43.735.

((~~(22)~~)) (23) "Indian health care provider" means:

(a) The Indian Health Service, an agency operated by the U.S. Department of Health and Human Services established by the Indian Health Care Improvement Act, Section 601, 25 U.S.C. Sec. 1661;

(b) An Indian tribe, as defined in the Indian Health Care Improvement Act, Section 4(14), 25 U.S.C. Sec. 1603(14), that operates a health program under a contract or compact to carry out programs of the Indian Health Service pursuant to the Indian Self-Determination and Education Assistance Act (ISDEAA), 25 U.S.C. Sec. 450 et seq.;

(c) A tribal organization, as defined in the Indian Health Care Improvement Act, Section 4(26), 25 U.S.C. Sec. 1603(26), that operates a health program under a contract or compact to carry out programs of the Indian Health Service pursuant to the ISDEAA, 25 U.S.C. Sec. 450 et seq.;

(d) An Indian tribe, as defined in the Indian Health Care Improvement Act, Section 4(14), 25 U.S.C. Sec. 1603(14), or tribal organization, as defined in the Indian Health Care Improvement Act, Section 4(26), 25 U.S.C. Sec. 1603(26), that operates a health program with funding provided in whole or part pursuant to 25 U.S.C. Sec. 47 (commonly known as the Buy Indian Act); or

(e) An urban Indian organization that operates a health program with funds in whole or part provided by Indian Health Service under a

grant or contract awarded pursuant to Title V of the Indian Health Care Improvement Act, Section 4(29), 25 U.S.C. Sec. 1603(29).

((~~(23)~~)) (24) "Managed care plan" means a health plan that coordinates the provision of covered health care services to a covered person through the use of a primary care provider and a network.

((~~(24)~~)) (25) "Medically necessary" or "medical necessity" in regard to mental health services and pharmacy services is a carrier determination as to whether a health service is a covered benefit because the service is consistent with generally recognized standards within a relevant health profession.

((~~(25)~~)) (26) "Mental health provider" means a health care provider or a health care facility authorized by state law to provide mental health services.

((~~(26)~~)) (27) "Mental health services" means in-patient or out-patient treatment including, but not limited to, partial hospitalization, residential treatment, out-patient facility-based treatment, intensive outpatient treatment, emergency services, or prescription drugs to manage, stabilize, or ameliorate the effects of a mental disorder listed in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association, including diagnoses and treatment for substance use disorder.

((~~(27)~~)) (28) "Network" means the group of participating providers and facilities providing health care services to a particular health plan or line of business (individual, small, or large group). A health plan network for issuers offering more than one health plan may be smaller in number than the total number of participating providers and facilities for all plans offered by the carrier.

((~~(28)~~)) (29) "Originating site" means the physical location of a patient receiving health care services through telemedicine, and includes those sites described in WAC 284-170-433.

((~~(29)~~)) (30) "Out-patient therapeutic visit" or "out-patient visit" means a clinical treatment session with a mental health provider of a duration consistent with relevant professional standards used by the carrier to determine medical necessity for the particular service being rendered, as defined in Physicians Current Procedural Terminology, published by the American Medical Association.

((~~(30)~~)) (31) "Participating provider" and "participating facility" mean a facility or provider who, under a contract with the health carrier or with the carrier's contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, from the health carrier rather than from the covered person.

((~~(31)~~)) (32) "Patient consent" means a voluntary and informed decision by a patient, following an explanation by the provider or auxiliary personnel under the general supervision of the provider presented in a manner understandable to the patient that is free of undue influence, fraud or duress, to consent to a provider billing the patient or the patient's health plan for an audio-only telemedicine service under RCW 48.43.735 or WAC 284-170-433.

((~~(32)~~)) (33) "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing.

((~~(33)~~)) (34) "Pharmacy services" means the practice of pharmacy as defined in chapter 18.64 RCW and includes any drugs or devices as defined in chapter 18.64 RCW.

((~~(34)~~)) (35) "Primary care provider" means a participating provider who supervises, coordinates, or provides initial care or continuing care to a covered person, and who may be required by the health carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person.

((~~(35)~~)) (36) "Preexisting condition" means any medical condition, illness, or injury that existed any time prior to the effective date of coverage.

((~~(36)~~)) (37) "Premium" means all sums charged, received, or deposited by a health carrier as consideration for a health plan or the continuance of a health plan. Any assessment or any "membership," "policy," "contract," "service," or similar fee or charge made by a health carrier in consideration for a health plan is deemed part of the premium. "Premium" shall not include amounts paid as enrollee point-of-service cost-sharing.

((~~(37)~~)) (38) "Real time communication" means synchronous and live communication between a provider and a patient. It does not include delayed or recorded messages, such as email, facsimile or voicemail.

((~~(38)~~)) (39) "Same amount of compensation" means providers are reimbursed by a carrier using the same allowed amount for telemedicine services as they would if the service had been provided in-person unless negotiation has been undertaken under RCW 48.43.735 or WAC 284-170-433(2). Where consumer cost-sharing applies to telemedicine services, the consumer's payment combined with the carrier's payment must be the same amount of compensation, or allowed amount, as the carrier would pay the provider if the telemedicine service had been provided in person. Where an alternative payment methodology other than fee-for-service payment would apply to an in-person service, "same amount of compensation" means providers are reimbursed by a carrier using the same alternative payment methodology that would be used for the same service if provided in-person, unless negotiation has been undertaken under RCW 48.43.735 or WAC 284-170-433(2).

((~~(39)~~)) (40) "Service area" means the geographic area or areas where a specific product is issued, accepts members or enrollees, and covers provided services. A service area must be defined by the county or counties included unless, for good cause, the commissioner permits limitation of a service area by zip code. Good cause includes geographic barriers within a service area, or other conditions that make offering coverage throughout an entire county unreasonable.

((~~(40)~~)) (41) "Small group plan" means a health plan issued to a small employer as defined under RCW 48.43.005(34) comprising from one to 50 eligible employees.

((~~(41)~~)) (42) "Standard prior authorization request" has the meaning set forth in RCW 48.43.830.

(43) "Store and forward technology" has the meaning set forth in RCW 48.43.735.

((~~(42)~~)) (44) "Substance use disorder services" means in-patient or out-patient treatment including, but not limited to, partial hospitalization, residential treatment, or out-patient facility-based treatment, intensive outpatient treatment, emergency services, or prescription drugs to manage, stabilize, or ameliorate the effects of a substance use disorder listed in the most current version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) published by the American Psychiatric Association, including diagnoses and treatment for substance use disorder.

((~~(43)~~)) (45) "Substitute drug" means a prescription medication, drug or therapy that a carrier covers based on an exception request. When the exception request is based on therapeutic equivalence, a substitute drug means a therapeutically equivalent substance as defined in chapter 69.41 RCW.

((~~(44)~~)) (46) "Supplementary pharmacy services" or "other pharmacy services" means pharmacy services involving the provision of drug therapy management and other services not required under state and federal law but that may be rendered in connection with dispensing, or that may be used in disease prevention or disease management.

((~~(45)~~)) (47) "Telemedicine" means the delivery of health care services through the use of interactive audio and video technology or audio-only technology, permitting real-time communication between the patient at the originating site and the provider, for the purpose of diagnosis, consultation, or treatment. For purposes of this chapter, "telemedicine" does not include facsimile, email, or text messaging, unless the use of text-like messaging is necessary to ensure effective communication with individuals who have a hearing, speech, or other disability.

OTS-4940.1

AMENDATORY SECTION (Amending WSR 21-02-034, filed 12/29/20, effective 1/1/22)

WAC 284-180-460 Health care benefit manager filings. (1) A health care benefit manager must file all contracts and contract amendments between the health care benefit manager and a health carrier, provider, pharmacy, pharmacy services administration organization, or other health care benefit manager entered into directly or indirectly in support of a contract with a carrier or employee benefits program within ((~~thirty~~)) 30 days following the effective date of the contract or contract amendment. If a health care benefit manager negotiates, amends, or modifies a contract or a compensation agreement that deviates from a filed agreement, then the health care benefit manager must file that negotiated, amended, or modified contract or agreement with the commissioner within ((~~thirty~~)) 30 days following the effective date. The commissioner must receive the filings electronically in accordance with this chapter.

(2) Contracts or contract amendments that were executed prior to July 23, 2023, and remain in force, must be filed with the commissioner no later than 60 days following July 23, 2023.

(3) Health care benefit managers must maintain health care benefit management contracts at its principal place of business in the state, or the health care benefit manager must have access to all contracts and provide copies to facilitate regulatory review upon ((~~twenty~~)) 20 days prior written notice from the commissioner.

((~~(3)~~)) (4) Health care benefit manager contracts and compensation agreements must clearly set forth provider network names and applicable compensation agreements associated with those networks so that the provider or facility can understand their participation as an in-network provider and the reimbursement to be paid. The format of such contracts and agreements may include a list or other format ac-

ceptable to the commissioner so that a reasonable person will understand and be able to identify their participation and the reimbursement to be paid as a contracted provider in each provider network.