Chapter 284-43 WAC
HEALTH CARRIERS AND HEALTH PLANS

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WAC

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284-43-0310 Association health plan compliance with statutory or regulatory changes. [Statutory Authority: RCW 48.02.060. WSR 16-14-106 (Matter No. R 2016-11), § 284-43-0310, filed 7/6/16, effective 8/6/16. WSR 16-01-081, recodified as § 284-43-0310, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.43.700, 48.43.715, 48.44.050, 48.46.200, and 45 C.F.R. 150.101(2). WSR 14-01-039 (Matter No. R 2013-13), § 284-170-955, filed 12/11/13, effective 1/11/14.] Amended and decodified by WSR 19-22-032, filed 10/30/19, effective 11/30/19. Statutory Authority: RCW 48.02.060 and 48.43.733. Recodified as § 284-43-8130.

284-43-0330 Transition of plans purchased by association members. [Statutory Authority: RCW 48.02.060. WSR 16-14-106 (Matter No. R 2016-11), § 284-43-0330, filed 7/6/16, effective 8/6/16. WSR 16-01-081, recodified as § 284-43-0330, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.43.700, 48.43.715, 48.44.050, 48.46.200, and 45 C.F.R. 150.101(2). WSR 14-01-039 (Matter No. R 2013-13), § 284-170-958, filed 12/11/13, effective 1/11/14.] Amended and decodified by WSR 19-22-032, filed 10/30/19, effective 11/30/19. Statutory Authority: RCW 48.02.060 and 48.43.733. Recodified as § 284-43-8140.

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 Repealed by WSR 98-04-005 (Matter No. R 97-3), filed 1/22/98, effective 2/22/98.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

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 Repealed by WSR 98-04-005 (Matter No. R 97-3), filed 1/22/98, effective 2/22/98.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

284-43-110 Purpose. [Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. WSR 98-04-005 (Matter No. R 97-3), § 284-43-110, filed 1/22/98, effective 2/22/98.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-0110.

284-43-120 Applicability and scope. [Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.030, 48.46.200. WSR 00-04-034 (Matter No. R 99-2), § 284-43-120, filed 1/24/00, effective 2/24/00. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. WSR 98-04-005 (Matter No. R 97-3), § 284-43-120, filed 1/22/98, effective 2/22/98.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-0120.

284-43-125 Compliance with state and federal laws. [Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.030, 48.46.200. WSR 00-04-034 (Matter No. R 99-2), § 284-43-125, filed 1/24/00, effective 2/24/00.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-0140.

284-43-130 Definitions. [Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.165.0301, 48.43.525, 48.43.530, 48.44.020, 48.44.050, 48.46.060(2), and 48.46.200. WSR 15-24-074

(Matter No. R 2014-13), § 284-43-130, filed 11/25/15, effective 7/1/16. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.460, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.44.050, 48.46.200, 48.20.450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. §§ 156.230, 156.235, and 156.245. WSR 14-10-017 (Matter No. R 2013-22), § 284-43-130, filed 4/25/14, effective 5/26/14. Statutory Authority: RCW 48.02.060, 48.43.525, 48.43.530, 48.43.535, and The Patient Protection and Affordable Care Act, P.L. 111-148, as amended (2010). WSR 12-23-005 (Matter No. R 2011-11), § 284-43-130, filed 11/7/12, effective 11/20/12. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.100, 48.46.200, 48.43.505, 48.43.510, 48.43.515, 48.43.520, 48.43.525, 48.43.530, 48.43.535. WSR 01-03-033 (Matter No. R 2000-02), § 284-43-130, filed 1/9/01, effective 7/1/01. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.200, 2000 c 79 § 26, and RCW 48.30.040, 48.44.110, 48.46.400. WSR 01-03-032 (Matter No. R 2000-04), § 284-43-130, filed 1/9/01, effective 2/9/01. Statutory Authority: RCW 48.02.060, 48.30.010, 48.44.050, 48.46.200, 48.30.040, 48.44.110 and 48.46.400. WSR 99-19-032 (Matter No. R 98-7), § 284-43-130, filed 9/8/99, effective 10/9/99. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. WSR 98-04-005 (Matter No. R 97-3), § 284-43-130, filed 1/22/98, effective 2/22/98.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-0160.

284-43-200 Network access—General standards. [Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.460, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.44.050, 48.46.200, 48.20.450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. §§ 156.230, 156.235, and 156.245. WSR 14-10-017 (Matter No. R 2013-22), § 284-43-200, filed 4/25/14, effective 5/26/14. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.100, 48.46.200, 48.43.505, 48.43.510, 48.43.515, 48.43.520, 48.43.525, 48.43.530, 48.43.535. WSR 01-03-033 (Matter No. R 2000-02), § 284-43-200, filed 1/9/01, effective 7/1/01. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.030, 48.46.200. WSR 00-04-034 (Matter No. R 99-2), § 284-43-200, filed 1/24/00, effective 3/1/00. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. WSR 98-04-005 (Matter No. R 97-3), § 284-43-200, filed 1/22/98, effective 2/22/98.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-9970.

284-43-201 Alternate access delivery request. [Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.460, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.44.050, 48.46.200, 48.20.450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. §§ 156.230, 156.235, and 156.245. WSR 14-10-017 (Matter No. R 2013-22), § 284-43-201, filed 4/25/14, effective 5/26/14.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-9971.

284-43-202 Maintenance of sufficient provider networks. [Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.43.055, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.43.730, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.200. WSR 16-01-074 (Matter No. R 2014-08), § 284-43-202, filed 12/14/15, effective 1/14/16.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-9972.

284-43-203 Use of subcontracted networks. [Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.460, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.44.050, 48.46.200, 48.20.450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. §§ 156.230, 156.235, and 156.245. WSR 14-10-017 (Matter No. R 2013-22), § 284-43-203, filed 4/25/14, effective 5/26/14.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-9973.

284-43-204 Provider directories. [Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.460, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.44.050, 48.46.200, 48.20.450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. §§ 156.230, 156.235, and 156.245. WSR 14-10-017 (Matter No. R 2013-22), § 284-43-204, filed 4/25/14, effective 5/26/14.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-9974.

284-43-205 Every category of health care providers. [Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.460, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.44.050, 48.46.200, 48.20.450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. §§ 156.230, 156.235, and 156.245. WSR 14-10-017 (Matter No. R 2013-22), § 284-43-205, filed 4/25/14, effective 5/26/14. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050 and 48.46.200. WSR 99-16-036 (Matter No. R 98-20), § 284-43-205, filed 7/28/99, effective 8/28/99.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-9975.

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

284-43-220 Network reports—Format. [Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.460, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.44.050, 48.46.200, 48.20.450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. §§ 156.230, 156.235, and 156.245. WSR 14-10-017 (Matter No. R 2013-22), § 284-43-220, filed 4/25/14, effective 5/26/14. Statutory Authority: RCW 48.02.060, 48.43.510 and 48.43.515. WSR 11-07-015 (Matter No. R 2011-01), § 284-43-220, filed 3/8/11, effective 4/8/11. Statutory Authority: RCW 48.02.060. WSR 08-17-037 (Matter No. R 2008-17), § 284-43-220, filed 8/13/08, effective 9/13/08. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.43.515, 48.44.050, 48.46.030, 48.46.200, 48.42.100, 48.43.515, 48.46.030. WSR 03-09-142 (Matter No. R 2003-01), § 284-43-220, filed 4/23/03, effective 5/24/03. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.030, 48.46.200. WSR 00-04-034 (Matter No. R 99-2), § 284-43-220, filed 1/24/00, effective 1/1/01. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. WSR 98-04-005 (Matter No. R

97-3), § 284-43-220, filed 1/22/98, effective 2/22/98.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-9976.

284-43-221 Essential community providers for exchange plans—Definition. [Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.20.450, 48.43.515, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. 156.230, 156.235, and 156.245. WSR 14-22-007, § 284-43-221, filed 10/23/14, effective 11/23/14. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.460, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.44.050, 48.46.200, 48.20.450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. §§ 156.230, 156.235, and 156.245. WSR 14-10-017 (Matter No. R 2013-22), § 284-43-221, filed 4/25/14, effective 5/26/14.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-9977.

284-43-222 Essential community providers for exchange plans—Network access. [Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.20.450, 48.43.515, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. 156.230, 156.235, and 156.245. WSR 14-22-007, § 284-43-222, filed 10/23/14, effective 11/23/14. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.460, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.44.050, 48.46.200, 48.20.450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. §§ 156.230, 156.235, and 156.245. WSR 14-10-017 (Matter No. R 2013-22), § 284-43-222, filed 4/25/14, effective 5/26/14.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-9978.

284-43-225 Issuer recordkeeping—Provider networks. [Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.43.055, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.43.730, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.200. WSR 16-01-074 (Matter No. R 2014-08), § 284-43-225, filed 12/14/15, effective 1/14/16.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-9979.

284-43-229 Tiered provider networks. [Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.460, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.44.050, 48.46.200, 48.20.450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. §§ 156.230, 156.235, and 156.245. WSR 14-10-017 (Matter No. R 2013-22), § 284-43-229, filed 4/25/14, effective 5/26/14.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-9980.

284-43-230 Assessment of access. [Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.460, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.44.050, 48.46.200, 48.20.450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. §§ 156.230, 156.235, and 156.245. WSR 14-10-017 (Matter No. R 2013-22), § 284-43-230, filed 4/25/14, effective 5/26/14.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-9981.

284-43-250 Issuer standards for women's right to directly access certain health care practitioners for women's health care services. [Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.460, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.44.050, 48.46.200, 48.20.450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. §§ 156.230, 156.235, and 156.245. WSR 14-10-017 (Matter No. R 2013-22), § 284-43-250, filed 4/25/14, effective 5/26/14. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.030, 48.46.200. WSR 00-04-034 (Matter No. R 99-2), § 284-43-250, filed 1/24/00, effective 2/24/00. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. WSR 98-04-005 (Matter No. R 97-3), § 284-43-250, filed 1/22/98, effective 2/22/98.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-9982.

284-43-251 Enrollee's access to providers. [Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.43.055, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.43.730, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.200. WSR 16-01-074 (Matter No. R 2014-08), § 284-43-251, filed 12/14/15, effective 1/14/16. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.100, 48.46.200, 48.43.505, 48.43.510, 48.43.515, 48.43.520, 48.43.525, 48.43.530, 48.43.535. WSR 01-03-033 (Matter No. R 2000-02), § 284-43-251, filed 1/9/01, effective 7/1/01.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-9983.

284-43-252 Hospital emergency service departments and practice groups. [Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.460, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.44.050, 48.46.200, 48.20.450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. §§ 156.230, 156.235, and 156.245. WSR 14-10-017 (Matter No. R 2013-22), § 284-43-252, filed 4/25/14, effective 5/26/14.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-9984.

284-43-260 Standards for temporary substitution of contracted network providers—"Locum tenens" providers. [Statutory Authority: RCW 48.02.060 and 48.43.515. WSR 08-01-025 (Matter No. R 2005-04), § 284-43-260, filed 12/10/07, effective 1/10/08.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-9985.

284-43-262 Rule concerning contracted network providers called to active duty military service. [Statutory Authority: RCW 48.02.060 and 48.43.515. WSR 08-01-025 (Matter No. R 2005-04), § 284-43-262, filed 12/10/07, effective 1/10/08.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-9986.

284-43-300 Provider and facility contracts with issuers—Generally. [Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.43.055, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.43.730, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.200. WSR 16-01-074 (Matter No. R 2014-08), § 284-43-300, filed 12/14/15, effective 1/14/16. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. WSR 98-04-005 (Matter No. R 97-3), § 284-43-300, filed 1/22/98, effective 2/22/98.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-9990.

284-43-310 Selection of participating providers—Credentialing and unfair discrimination. [Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.43.055, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.43.730, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.200. WSR 16-01-074 (Matter No. R 2014-08), § 284-43-310, filed 12/14/15, effective 1/14/16. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. WSR

98-04-005 (Matter No. R 97-3), § 284-43-310, filed 1/22/98, effective 2/22/98.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-9991.

284-43-320 Provider contracts—Standards—Hold harmless provisions. [Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.43.055, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.43.730, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.200. WSR 16-01-074 (Matter No. R 2014-08), § 284-43-320, filed 12/14/15, effective 1/14/16. Statutory Authority: RCW 48.02.060, 48.30.010, 48.43.055, 48.44.050, 48.44.070, 48.46.030, 48.46.200 and 48.46.243. WSR 99-21-016 (Matter No. R 98-21), § 284-43-320, filed 10/11/99, effective 11/11/99. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. WSR 98-04-005 (Matter No. R 97-3), § 284-43-320, filed 1/22/98, effective 2/22/98.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-9992.

284-43-321 Provider contracts—Terms and conditions of payment. [Statutory Authority: RCW 48.02.060, 48.30.010, 48.43.055, 48.44.050, 48.44.070, 48.46.030, 48.46.200 and 48.46.243. WSR 99-21-016 (Matter No. R 98-21), § 284-43-321, filed 10/11/99, effective 11/11/99.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-9993.

284-43-3210 External review of adverse benefit determinations. [WSR 16-01-081, recodified as § 284-43-3210, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060 and 48.43.530. WSR 15-24-072 (Matter No. R 2015-12), § 284-43-550, filed 11/25/15, effective 12/26/15. Statutory Authority: RCW 48.02.060, 48.43.525, 48.43.530, 48.43.535, and The Patient Protection and Affordable Care Act, P.L. 111-148, as amended (2010). WSR 12-23-005 (Matter No. R 2011-11), § 284-43-550, filed 11/7/12, effective 11/20/12.] Repealed by WSR 16-23-168 (Matter No. R 2016-17), filed 11/23/16, effective 1/1/17. Statutory Authority: RCW 48.02.060, 48.43.535, and 48.43.537.

284-43-322 Provider contracts—Dispute resolution process. [Statutory Authority: RCW 48.02.060, 48.30.010, 48.43.055, 48.44.050, 48.44.070, 48.46.030, 48.46.200 and 48.46.243. WSR 99-21-016 (Matter No. R 98-21), § 284-43-322, filed 10/11/99, effective 11/11/99.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-9994.

284-43-323 Pharmacy identification cards. [Statutory Authority: RCW 48.02.060, 48.43.023, 48.44.050, 48.46.200. WSR 03-07-006 (Matter No. R 2002-04), § 284-43-323, filed 3/6/03, effective 4/6/03.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-9995.

284-43-324 Provider contracts—Audit guidelines. [Statutory Authority: RCW 48.02.060, 48.30.010, 48.43.055, 48.44.050, 48.44.070, 48.46.030, 48.46.200 and 48.46.243. WSR 99-21-016 (Matter No. R 98-21), § 284-43-324, filed 10/11/99, effective 11/11/99.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-9996.

284-43-325 Pharmacy claims—Rejections, notifications and disclosures. [Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.165.0301, 48.43.525, 48.43.530, 48.44.020, 48.44.050, 48.46.060(2), and 48.46.200. WSR 15-24-074 (Matter No. R 2014-13), § 284-43-325, filed 11/25/15, effective 7/1/16.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-9997.

284-43-330 Participating provider—Filing and approval. [Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.43.055, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.43.730, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.200. WSR 16-01-074 (Matter No. R 2014-08), § 284-43-330, filed 12/14/15, effective 1/14/16. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.030, 48.46.200, and 2013 c 277 § 1. WSR 13-16-045 (Matter No. R 2012-24), § 284-43-330, filed 7/31/13, effective 8/31/13. Statutory Authority: RCW 48.02.060, 48.30.010, 48.43.055, 48.44.050, 48.44.070, 48.46.030, 48.46.200 and 48.46.243. WSR 99-21-016 (Matter No. R 98-21), § 284-43-330, filed 10/11/99, effective 11/11/99. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. WSR 98-04-005 (Matter No. R 97-3), § 284-43-330, filed 1/22/98, effective 2/22/98.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-9998.

284-43-331 Effective date. [Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.460, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.44.050, 48.46.200, 48.20.450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. §§ 156.230, 156.235, and 156.245. WSR 14-10-017 (Matter No. R 2013-22), § 284-43-331, filed 4/25/14, effective 5/26/14. Statutory Authority: RCW 48.02.060, 48.30.010, 48.43.055, 48.44.050, 48.44.070, 48.46.030, 48.46.200 and 48.46.243. WSR 99-21-016 (Matter No. R 98-21), § 284-43-331, filed 10/11/99, effective 11/11/99.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-9999.

284-43-340 Effective date. [Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. WSR 98-04-005 (Matter No. R 97-3), § 284-43-340, filed 1/22/98, effective 2/22/98.] Repealed by WSR 14-10-017 (Matter No. R 2013-22), filed 4/25/14, effective 5/26/14. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.460, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.44.050, 48.46.200, 48.20.450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. §§ 156.230, 156.235, and 156.245.

284-43-4060 Independent review of adverse determinations. [WSR 16-01-081, recodified as § 284-43-4060, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060 and 48.43.530. WSR 15-24-072 (Matter No. R 2015-12), § 284-43-630, filed 11/25/15, effective 12/26/15. Statutory Authority: RCW 48.02.060 and 48.53.535(10). WSR 08-07-101 (Matter R 2006-11), § 284-43-630, filed 3/19/08, effective 4/19/08. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.100, 48.46.200, 48.43.505, 48.43.510, 48.43.515, 48.43.520, 48.43.525, 48.43.530, 48.43.535. WSR 01-03-033 (Matter No. R 2000-02), § 284-43-630, filed 1/9/01, effective 7/1/01.] Repealed by WSR 16-23-168 (Matter No. R 2016-17), filed 11/23/16, effective 1/1/17. Statutory Authority: RCW 48.02.060, 48.43.535, and 48.43.537.

284-43-410 Health care services utilization review—Generally. [Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.165.0301, 48.43.525, 48.43.530, 48.44.020, 48.44.050, 48.46.060(2), and 48.46.200. WSR 15-24-074 (Matter No. R 2014-13), § 284-43-410, filed 11/25/15, effective 7/1/16. Statutory Authority: RCW 48.02.060, 48.43.530, P.L. 111-148 (2010, as amended) and regulations issued on June 24, 2011, amending 45 C.F.R. Part 147. WSR 11-24-004 (Matter No. R 2011-18), § 284-43-410, filed 11/28/11, effective 12/29/11. Statutory Authority: RCW 48.02.060 and 48.43.520. WSR 10-23-051 (Matter No. R 2009-19), § 284-43-410, filed 11/10/10, effective 12/11/10. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.100, 48.46.200, 48.43.505, 48.43.510, 48.43.515, 48.43.520, 48.43.525, 48.43.530, 48.43.535. WSR 01-03-033 (Matter No. R 2000-02), § 284-43-410, filed 1/9/01, effective 7/1/01.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-2000.

284-43-420 Drug utilization review—Generally. [Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.165.0301, 48.43.525, 48.43.530, 48.44.020, 48.44.050, 48.46.060(2), and 48.46.200. WSR 15-24-074 (Matter No. R 2014-13), § 284-43-420, filed 11/25/15, effective 7/1/16.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-2020.

284-43-500 Scope and intent. [Statutory Authority: RCW 48.02.060, 48.43.525, 48.43.530, 48.43.535, and The Patient Protection and Affordable Care Act, P.L. 111-148, as amended (2010). WSR 12-23-005 (Matter No. R 2011-11), § 284-43-500, filed 11/7/12, effective 11/20/12.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-3000.

284-43-5040 Coverage for pharmacy services. [Statutory Authority: RCW 48.02.060. WSR 16-14-106 (Matter No. R 2016-11), § 284-43-5040, filed 7/6/16, effective 8/6/16. WSR 16-01-081, recodified as § 284-43-5040, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.200, 2000 c 79 § 26, and RCW 48.30.040, 48.44.110, 48.46.400. WSR 01-03-032 (Matter No. R 2000-04), § 284-43-815, filed 1/9/01, effective 2/9/01.] Repealed by WSR 17-01-166 (Matter No. R 2016-16), filed 12/21/16, effective 12/31/17. Statutory Authority: RCW 48.02.060, 48.43.510.

284-43-505 Definitions. [Statutory Authority: RCW 48.02.060, 48.43.525, 48.43.530, 48.43.535, and The Patient Protection and Affordable Care Act, P.L. 111-148, as amended (2010). WSR 12-23-005 (Matter No. R 2011-11), § 284-43-505, filed 11/7/12, effective 11/20/12.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-3010.

284-43-510 Review of adverse benefit determinations—Generally. [Statutory Authority: RCW 48.02.060, 48.43.525, 48.43.530, 48.43.535, and The Patient Protection and Affordable Care Act, P.L. 111-148, as amended (2010). WSR 12-23-005 (Matter No. R 2011-11), § 284-43-510, filed 11/7/12, effective 11/20/12.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-3030.

284-43-511 Explanation of right to review. [Statutory Authority: RCW 48.02.060, 48.43.525, 48.43.530, 48.43.535, and The Patient Protection and Affordable Care Act, P.L. 111-148, as amended (2010). WSR 12-23-005 (Matter No. R 2011-11), § 284-43-511, filed 11/7/12, effective 11/20/12.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-3050.

284-43-515 Notice and explanation of adverse benefit determination—General requirements. [Statutory Authority: RCW 48.02.060, 48.43.525, 48.43.530, 48.43.535, and The Patient Protection and Affordable Care Act, P.L. 111-148, as amended (2010). WSR 12-23-005 (Matter No. R 2011-11), § 284-43-515, filed 11/7/12, effective 11/20/12.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-3070.

284-43-520 Electronic disclosure and communication by carriers. [Statutory Authority: RCW 48.02.060, 48.43.525, 48.43.530, 48.43.535, and The Patient Protection and Affordable Care Act, P.L. 111-148, as amended (2010). WSR 12-23-005 (Matter No. R 2011-11), § 284-43-520, filed 11/7/12, effective 11/20/12.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-3090.

284-43-525 Internal review of adverse benefit determinations. [Statutory Authority: RCW 48.02.060, 48.43.525, 48.43.530, 48.43.535, and The Patient Protection and Affordable Care Act, P.L. 111-148, as amended (2010). WSR 12-23-005 (Matter No. R 2011-11), § 284-43-525, filed 11/7/12, effective 11/20/12.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-3110.

284-43-530 Exhaustion of internal review remedies. [Statutory Authority: RCW 48.02.060, 48.43.525, 48.43.530, 48.43.535, and The Patient Protection and Affordable Care Act, P.L. 111-148, as amended (2010). WSR 12-23-005 (Matter No. R 2011-11), § 284-43-530, filed 11/7/12, effective 11/20/12.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-3130.

284-43-535 Notice of internal review determination. [Statutory Authority: RCW 48.02.060, 48.43.525, 48.43.530, 48.43.535, and The Patient Protection and Affordable Care Act, P.L. 111-148, as amended (2010). WSR 12-23-005 (Matter No. R 2011-11), § 284-43-535, filed 11/7/12, effective 11/20/12.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-3150.

284-43-540 Expedited review. [Statutory Authority: RCW 48.02.060, 48.43.525, 48.43.530, 48.43.535, and The Patient Protection and Affordable Care Act, P.L. 111-148, as amended (2010). WSR 12-23-005 (Matter No. R 2011-11), § 284-43-540, filed 11/7/12, effective 11/20/12.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-3170.

284-43-545 Concurrent expedited review of adverse benefit determinations. [Statutory Authority: RCW 48.02.060, 48.43.525, 48.43.530, 48.43.535, and The Patient Protection and Affordable Care Act, P.L. 111-148, as amended (2010). WSR 12-23-005 (Matter No. R 2011-11), § 284-43-545, filed 11/7/12, effective 11/20/12.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-3190.

284-43-550 External review of adverse benefit determinations. [Statutory Authority: RCW 48.02.060 and 48.43.530. WSR 15-24-072 (Matter No. R 2015-12), § 284-43-550, filed 11/25/15, effective 12/26/15. Statutory Authority: RCW 48.02.060, 48.43.525, 48.43.530, 48.43.535, and The Patient Protection and Affordable Care Act, P.L. 111-148, as amended (2010). WSR

12-23-005 (Matter No. R 2011-11), § 284-43-550, filed 11/7/12, effective 11/20/12.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-3210.

284-43-5600 Essential health benefits package benchmark reference plan. [WSR 16-01-081, recodified as § 284-43-5600, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.21.241, 48.21.320, 48.44.460, 48.44.341, 48.46.291, 48.46.530, and 48.43.715. WSR 15-20-042 (Matter No. R 2015-02), § 284-43-865, filed 9/29/15, effective 9/29/15. Statutory Authority: 2012 c 87 and RCW 48.02.060. WSR 12-19-099 (Matter No. R 2012-19), § 284-43-865, filed 9/19/12, effective 10/20/12.] Repealed by WSR 26-01-148 (Matter R 2025-12), filed 12/19/25, effective 1/19/26. Statutory Authority: RCW 48.02.060, 48.49.110, 2024 c 366, 2025 c 25, and 2025 c 171.

284-43-5620 Plan design. [Statutory Authority: RCW 48.02.060. WSR 16-14-106 (Matter No. R 2016-11), § 284-43-5620, filed 7/6/16, effective 8/6/16. WSR 16-01-081, recodified as § 284-43-5620, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.21.241, 48.21.320, 48.44.460, 48.44.341, 48.46.291, 48.46.530, and 48.43.715. WSR 15-20-042 (Matter No. R 2015-02), § 284-43-877, filed 9/29/15, effective 9/29/15. Statutory Authority: RCW 48.02.060 and 48.43.715. WSR 14-06-069 (Matter No. R 2013-28), § 284-43-877, filed 3/3/14, effective 4/3/14. Statutory Authority: RCW 48.02.060, 48.21.241, 48.21.320, 48.44.050, 48.44.341, 48.44.460, 48.46.200, 48.46.291, 48.46.530, 48.43.715, and Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010) (PPACA), as amended by the Health Care and Education Reconciliation Act (HCERA), Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010), in particular § 1302 of PPACA, § 10104 (b)(1) (HCERA). WSR 13-15-025 (Matter No. R 2012-17), § 284-43-877, filed 7/9/13, effective 7/10/13.] Repealed by WSR 26-01-148 (Matter R 2025-12), filed 12/19/25, effective 1/19/26. Statutory Authority: RCW 48.02.060, 48.49.110, 2024 c 366, 2025 c 25, and 2025 c 171.

284-43-5640 Essential health benefit categories. [WSR 16-01-081, recodified as § 284-43-5640, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.21.241, 48.21.320, 48.44.460, 48.44.341, 48.46.291, 48.46.530, and 48.43.715. WSR 15-20-042 (Matter No. R 2015-02), § 284-43-878, filed 9/29/15, effective 9/29/15. Statutory Authority: RCW 48.02.060 and 48.43.715. WSR 14-15-012 (Matter No. R 2014-03), § 284-43-878, filed 7/3/14, effective 7/3/14. Statutory Authority: RCW 48.02.060, 48.21.241, 48.21.320, 48.44.050, 48.44.341, 48.44.460, 48.46.200, 48.46.291, 48.46.530, 48.43.715, and Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010) (PPACA), as amended by the Health Care and Education Reconciliation Act (HCERA), Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010), in particular § 1302 of PPACA, § 10104 (b)(1) (HCERA). WSR 13-15-025 (Matter No. R 2012-17), § 284-43-878, filed 7/9/13, effective 7/10/13.] Repealed by WSR 26-01-148 (Matter R 2025-12), filed 12/19/25, effective 1/19/26. Statutory Authority: RCW 48.02.060, 48.49.110, 2024 c 366, 2025 c 25, and 2025 c 171.

284-43-5700 Essential health benefit category—Pediatric oral services. [Statutory Authority: RCW 48.02.060. WSR 16-14-106 (Matter No. R 2016-11), § 284-43-5700, filed 7/6/16, effective 8/6/16. WSR 16-01-081, recodified as § 284-43-5700, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.21.241, 48.21.320, 48.44.460, 48.44.341, 48.46.291, 48.46.530, and 48.43.715. WSR 15-20-042 (Matter No. R 2015-02), § 284-43-879, filed 9/29/15, effective 9/29/15. Statutory Authority: RCW 48.02.060 and 48.43.715. WSR 14-09-080 (Matter No. R 2013-19), § 284-43-879, filed 4/18/14, effective 5/19/14. Statutory Authority: RCW 48.02.060, 48.21.241, 48.21.320, 48.44.050, 48.44.341, 48.44.460, 48.46.200, 48.46.291, 48.46.530, 48.43.715, and Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010) (PPACA), as amended by the Health Care and Education Reconciliation Act (HCERA), Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010), in particular § 1302 of PPACA, § 10104 (b)(1) (HCERA). WSR 13-15-025 (Matter No. R 2012-17), § 284-43-879, filed 7/9/13, effective 7/10/13.] Repealed by WSR 26-01-148 (Matter R 2025-12), filed 12/19/25, effective 1/19/26. Statutory Authority: RCW 48.02.060, 48.49.110, 2024 c 366, 2025 c 25, and 2025 c 171.

284-43-5780 Pediatric vision services. [Statutory Authority: RCW 48.02.060. WSR 16-14-106 (Matter No. R 2016-11), § 284-43-5780, filed 7/6/16, effective 8/6/16. WSR 16-01-081, recodified as § 284-43-5780, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.21.241, 48.21.320, 48.44.460, 48.44.341, 48.46.291, 48.46.530, and 48.43.715. WSR 15-20-042 (Matter No. R 2015-02), § 284-43-880, filed 9/29/15, effective 9/29/15. Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. WSR 14-23-092 (Matter No. R 2014-04), § 284-43-880, filed 11/19/14, effective 12/20/14. Statutory Authority: RCW 48.02.060, 48.21.241, 48.21.320, 48.44.050, 48.44.341, 48.44.460, 48.46.200, 48.46.291, 48.46.530, 48.43.715, and Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010) (PPACA), as amended by the Health Care and Education Reconciliation Act (HCERA), Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010), in particular § 1302 of PPACA, § 10104 (b)(1) (HCERA). WSR 13-15-025 (Matter No. R 2012-17), § 284-43-880, filed 7/9/13, effective 7/10/13.] Repealed by WSR 26-01-148 (Matter R 2025-12), filed 12/19/25, effective 1/19/26. Statutory Authority: RCW 48.02.060, 48.49.110, 2024 c 366, 2025 c 25, and 2025 c 171.

284-43-6060 General contents of all filings. [WSR 16-01-081, recodified as § 284-43-6060, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.18.110, 48.44.020, 48.44.050, 48.46.060, 48.46.200. WSR 08-20-071 (Matter No. R 2008-08), § 284-43-925, filed 9/25/08, effective 10/26/08. Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. WSR 05-07-006 (Matter No. R 2004-05), § 284-43-925, filed 3/3/05, effective 4/3/05. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066. WSR 98-04-011 (Matter No. R 97-2), § 284-43-925, filed 1/23/98, effective 3/1/98.] Amended and decodified by WSR 16-23-019 (Matter No. R 2016-06), filed 11/4/16, effective 12/5/16. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, and 2016 c 156. Recodified as § 284-43-6580.

284-43-6080 Issuer filing of attestation form, transparency tools. [WSR 16-01-081, recodified as § 284-43-6080, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.43.340, and 48.44.050. WSR 15-21-095 (Matter No. R 2015-03), § 284-43-927, filed 10/21/15, effective 1/1/16.] Decodified by WSR 16-23-019 (Matter No. R 2016-06), filed 11/4/16, effective 12/5/16. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, and 2016 c 156. Recodified as § 284-43-6600.

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

284-43-611 Application of subchapter F. [Statutory Authority: RCW 48.02.060, 48.43.525, 48.43.530, 48.43.535, and The Patient Protection and Affordable Care Act, P.L. 111-148, as amended (2010). WSR 12-23-005 (Matter No. R 2011-11), § 284-43-611, filed 11/7/12, effective 11/20/12.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-4000.

284-43-6120 Experience records. [WSR 16-01-081, recodified as § 284-43-6120, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. WSR 05-07-006 (Matter No. R 2004-05), § 284-43-935, filed 3/3/05, effective 4/3/05. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066. WSR 98-04-011 (Matter No. R 97-2), § 284-43-935, filed 1/23/98, effective 3/1/98.] Decodified by WSR 16-23-019 (Matter No. R 2016-06), filed 11/4/16, effective 12/5/16. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, and 2016 c 156. Recodified as § 284-43-6620.

284-43-6140 Evaluating experience data. [WSR 16-01-081, recodified as § 284-43-6140, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. WSR 05-07-006 (Matter No. R 2004-05), § 284-43-940, filed 3/3/05, effective 4/3/05. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066. WSR 98-04-011 (Matter No. R 97-2), § 284-43-940, filed 1/23/98, effective 3/1/98.] Decodified by WSR 16-23-019 (Matter No. R 2016-06), filed 11/4/16, effective 12/5/16. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, and 2016 c 156. Recodified as § 284-43-6640.

284-43-615 Grievance and complaint procedures—Generally. [Statutory Authority: RCW 48.02.060, 48.43.525, 48.43.530, 48.43.535, and The Patient Protection and Affordable Care Act, P.L. 111-148, as amended (2010). WSR 12-23-005 (Matter No. R 2011-11), § 284-43-615, filed 11/7/12, effective 11/20/12. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.100, 48.46.200, 48.43.505, 48.43.510, 48.43.515, 48.43.520, 48.43.525, 48.43.530, 48.43.535. WSR 01-03-033 (Matter No. R 2000-02), § 284-43-615, filed 1/9/01, effective 7/1/01.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-4020.

284-43-6160 Summary for individual and small group contract filings. [WSR 16-01-081, recodified as § 284-43-6160, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.18.110, 48.44.020, 48.44.050, 48.46.060, 48.46.200. WSR 08-20-071 (Matter No. R 2008-08), § 284-43-945, filed 9/25/08, effective 10/26/08. Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. WSR 05-07-006 (Matter No. R 2004-05), § 284-43-945, filed 3/3/05, effective 4/3/05. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066. WSR 98-04-011 (Matter No. R 97-2), § 284-43-945, filed 1/23/98, effective 3/1/98.] Decodified by WSR 16-23-019 (Matter No. R 2016-06), filed 11/4/16, effective 12/5/16. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, and 2016 c 156. Recodified as § 284-43-6660.

284-43-620 Procedures for review and appeal of adverse determinations. [Statutory Authority: RCW 48.02.060, 48.43.525, 48.43.530, 48.43.535, and The Patient Protection and Affordable Care Act, P.L. 111-148, as amended (2010). WSR 12-23-005 (Matter No. R 2011-11), § 284-43-620, filed 11/7/12, effective 11/20/12. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.100, 48.46.200, 48.43.505, 48.43.510, 48.43.515, 48.43.520, 48.43.525, 48.43.530, 48.43.535. WSR 01-03-033 (Matter No. R 2000-02), § 284-43-620, filed 1/9/01, effective 7/1/01. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.43.055, 48.44.050, 48.46.100 and 48.46.200. WSR 99-24-075 (Matter No. R 98-17), § 284-43-620, filed 11/29/99, effective 12/30/99.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-4040.

284-43-6200 Geographic rating area factor development. [WSR 16-01-081, recodified as § 284-43-6200, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, and 45 C.F.R. 147.102. WSR 13-11-003 (Matter No. R 2013-01), § 284-170-250, filed 5/1/13, effective 6/1/13.] Amended and decodified by WSR 16-23-019 (Matter No. R 2016-06), filed 11/4/16, effective 12/5/16. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, and 2016 c 156. Recodified as § 284-43-6680.

284-43-6220 Geographic rating area designation. [WSR 16-01-081, recodified as § 284-43-6220, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, and 45 C.F.R. 147.102. WSR 13-11-003 (Matter No. R 2013-01), § 284-170-252, filed 5/1/13, effective 6/1/13.] Decodified by WSR 16-23-019 (Matter No. R 2016-06), filed 11/4/16, effective 12/5/16. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, and 2016 c 156. Recodified as § 284-43-6700.

284-43-630 Independent review of adverse determinations. [Statutory Authority: RCW 48.02.060 and 48.43.530. WSR 15-24-072 (Matter No. R 2015-12), § 284-43-630, filed 11/25/15, effective 12/26/15. Statutory Authority: RCW 48.02.060 and 48.53.535(10). WSR 08-07-101 (Matter R 2006-11), § 284-43-630, filed 3/19/08, effective 4/19/08. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.100, 48.46.200, 48.43.505, 48.43.510, 48.43.515, 48.43.520, 48.43.525, 48.43.530, 48.43.535. WSR 01-03-033 (Matter No. R 2000-02), § 284-43-630, filed 1/9/01, effective 7/1/01.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-4060.

284-43-700 Purpose. [Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. WSR 98-04-005 (Matter No. R 97-3), § 284-43-700, filed 1/22/98, effective 2/22/98.] Repealed by WSR 08-09-022 (Matter No. R 2008-01), filed 4/7/08, effective 5/8/08. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.44.050, 48.46.030, 48.46.200.

284-43-710 Portability of health insurance benefits. [Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.030, 48.46.200. WSR 00-04-034 (Matter No. R 99-2), § 284-43-710, filed 1/24/00, effective 2/24/00. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. WSR 98-04-005 (Matter No. R 97-3), § 284-43-710, filed 1/22/98, effective 2/22/98.] Repealed by WSR 08-09-022 (Matter No. R 2008-01), filed 4/7/08, effective 5/8/08. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.44.050, 48.46.030, 48.46.200.

284-43-711 Definition. [Statutory Authority: RCW 48.02.060, 48.43.525, 48.43.530, 48.43.535, and The Patient Protection and Affordable Care Act, P.L. 111-148, as amended (2010). WSR 12-23-005 (Matter No. R 2011-11), § 284-43-711, filed 11/7/12, effective 11/20/12.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-4500.

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

284-43-721 Grievance process—Generally. [Statutory Authority: RCW 48.02.060, 48.43.525, 48.43.530, 48.43.535, and The Patient Protection and Affordable Care Act, P.L. 111-148, as amended (2010). WSR 12-23-005 (Matter No. R 2011-11), § 284-43-721, filed 11/7/12, effective 11/20/12.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-4520.

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

284-43-800 Recognizing the exercise of conscience by purchasers of basic health plan services and ensuring access for all enrollees to such services. [Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. WSR 98-04-005 (Matter No. R 97-3), § 284-43-800, filed 1/22/98, effective 2/22/98.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-5020.

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

284-43-815 Coverage for pharmacy services. [Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.200, 2000 c 79 § 26, and RCW 48.30.040, 48.44.110, 48.46.400. WSR 01-03-032 (Matter No. R 2000-04), § 284-43-815, filed 1/9/01, effective 2/9/01.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-5040.

284-43-816 General prescription drug benefit requirements. [Statutory Authority: RCW 48.02.060, 48.02.062, 48.18.140, 48.43.525, 48.44.050, 48.44.440(2), 48.44.460(2), 48.46.200, and 48.46.510. WSR 12-21-019 (Matter No. R 2012-03), § 284-43-816, filed 10/8/12, effective 11/8/12.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-5060.

284-43-817 Prescription drug benefit design. [Statutory Authority: RCW 48.02.060, 48.02.062, 48.18.140, 48.43.525, 48.44.050, 48.44.440(2), 48.44.460(2), 48.46.200, and 48.46.510. WSR 12-21-019 (Matter No. R 2012-03), § 284-43-817, filed 10/8/12, effective 11/8/12.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-5080.

284-43-818 Formulary changes. [Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.165.0301, 48.43.525, 48.43.530, 48.44.020, 48.44.050, 48.46.060(2), and 48.46.200. WSR 15-24-074 (Matter No. R 2014-13), § 284-43-818, filed 11/25/15, effective 7/1/16. Statutory Authority: RCW 48.02.060, 48.02.062, 48.18.140, 48.43.525, 48.44.050, 48.44.440(2), 48.44.460(2), 48.46.200, and 48.46.510. WSR 12-21-019 (Matter No. R 2012-03), § 284-43-818, filed 10/8/12, effective 11/8/12.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-5100.

284-43-819 Cost-sharing for prescription drugs. [Statutory Authority: RCW 48.02.060, 48.02.062, 48.18.140, 48.43.525, 48.44.050, 48.44.440(2), 48.44.460(2), 48.46.200, and 48.46.510. WSR 12-21-019 (Matter No. R 2012-03), § 284-43-819, filed 10/8/12, effective 11/8/12.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-5110.

284-43-820 Health plan disclosure requirements. [Statutory Authority: RCW 48.02.060 and 48.43.510. WSR 10-02-068 (Matter No. R 2008-16), § 284-43-820, filed 1/4/10, effective 2/4/10. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.100, 48.46.200, 48.43.505, 48.43.510, 48.43.515, 48.43.520, 48.43.525, 48.43.530, 48.43.535. WSR 01-03-033 (Matter No. R 2000-02), § 284-43-820, filed 1/9/01, effective 7/1/01.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-5130.

284-43-821 Maternity and pregnancy-related exclusions, limitations and conditions in individual plans. [Statutory Authority: 2000 c 79 and RCW 48.43.041, 48.44.020, and 48.46.060. WSR 01-03-035 (Matter No. R 2000-03), § 284-43-821, filed 1/9/01, effective 7/1/01.] Repealed

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

284-43-822 Unfair practice relating to health coverage. [Statutory Authority: RCW 48.02.060, 48.18.480, 48.20.450, 48.20.460, 48.21.045, 48.30.010, 48.30.300, 48.41.110, 48.41.170, 48.42.010, 48.42.040, 48.42.100, 48.43.012, 48.43.025, 48.43.035, 48.43.041, 48.43.115, 48.43.520, 48.44.020, 48.44.023, 48.44.050, 48.44.220, 48.46.060, 48.46.066, 48.46.110, 48.46.200, 49.60.010, 49.60.030, 49.60.120, 49.60.178, 49.60.220. WSR 01-19-001 (Matter No. R 2001-02), § 284-43-822, filed 9/5/01, effective 10/6/01.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-5150.

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

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

284-43-825 Prescription drug benefit disclosures. [Statutory Authority: RCW 48.02.060, 48.02.062, 48.18.140, 48.43.525, 48.44.050, 48.44.440(2), 48.44.460(2), 48.46.200, and 48.46.510. WSR 12-21-019 (Matter No. R 2012-03), § 284-43-825, filed 10/8/12, effective 11/8/12.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-5170.

284-43-840 Anticancer medication. [Statutory Authority: RCW 48.02.060, 48.02.062, 48.18.140, 48.43.525, 48.44.050, 48.44.440(2), 48.44.460(2), 48.46.200, and 48.46.510. WSR 12-21-019 (Matter No. R 2012-03), § 284-43-840, filed 10/8/12, effective 11/8/12.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-5200.

284-43-849 Purpose and scope. [Statutory Authority: RCW 48.02.060, 48.21.241, 48.21.320, 48.44.050, 48.44.341, 48.44.460, 48.46.200, 48.46.291, 48.46.530, 48.43.715, and Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010) (PPACA), as amended by the Health Care and Education Reconciliation Act (HCERA), Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010), in particular § 1302 of PPACA, § 10104 (b)(1) (HCERA). WSR 13-15-025 (Matter No. R 2012-17), § 284-43-849, filed 7/9/13, effective 7/10/13.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-5400.

284-43-850 Clinical trials. [Statutory Authority: RCW 48.02.060. WSR 13-03-038 (Matter No. R 2012-25), § 284-43-850, filed 1/9/13, effective 2/9/13. Statutory Authority: RCW 48.02.060, 48.02.062, 48.18.140, 48.43.525, 48.44.050, 48.44.440(2), 48.44.460(2), 48.46.200, and 48.46.510. WSR 12-21-019 (Matter No. R 2012-03), § 284-43-850, filed 10/8/12, effective 11/8/12.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-5420.

284-43-852 Definitions. [Statutory Authority: RCW 48.02.060, 48.21.241, 48.21.320, 48.44.050, 48.44.341, 48.44.460, 48.46.200, 48.46.291, 48.46.530, 48.43.715, and Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010) (PPACA), as amended by the Health Care and Education Reconciliation Act (HCERA), Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010), in particular § 1302 of PPACA, § 10104 (b)(1) (HCERA). WSR 13-15-025 (Matter No. R 2012-17), § 284-43-852, filed 7/9/13, effective 7/10/13.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-5410.

284-43-860 Medical necessity determination. [Statutory Authority: RCW 48.02.060, 48.21.241, 48.21.320, 48.44.050, 48.44.341, 48.44.460, 48.46.200, 48.46.291, 48.46.530, 48.43.715, and Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010) (PPACA), as amended by the Health Care and Education Reconciliation Act (HCERA), Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010), in particular § 1302 of PPACA, § 10104 (b)(1) (HCERA). WSR 13-15-025 (Matter No. R 2012-17), § 284-43-860, filed 7/9/13, effective 7/10/13.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-5440.

284-43-865 Essential health benefits package benchmark reference plan. [Statutory Authority: RCW 48.21.241, 48.21.320, 48.44.460, 48.44.341, 48.46.291, 48.46.530, and 48.43.715. WSR 15-20-042 (Matter No. R 2015-02), § 284-43-865, filed 9/29/15, effective 9/29/15. Statutory Authority: 2012 c 87 and RCW 48.02.060. WSR 12-19-099 (Matter No. R 2012-19), § 284-43-865, filed 9/19/12, effective 10/20/12.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-5600.

284-43-8651 Essential health benefits package benchmark reference plan. [Statutory Authority: RCW 48.21.241, 48.21.320, 48.44.460, 48.44.341, 48.46.291, 48.46.530, and 48.43.715. WSR 15-20-042 (Matter No. R 2015-02), § 284-43-8651, filed 9/29/15, effective 9/29/15.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-5602.

284-43-877 Plan design. [Statutory Authority: RCW 48.21.241, 48.21.320, 48.44.460, 48.44.341, 48.46.291, 48.46.530, and 48.43.715. WSR 15-20-042 (Matter No. R 2015-02), § 284-43-877, filed 9/29/15, effective 9/29/15. Statutory Authority: RCW 48.02.060 and 48.43.715. WSR 14-06-069 (Matter No. R 2013-28), § 284-43-877, filed 3/3/14, effective 4/3/14. Statutory Authority: RCW 48.02.060, 48.21.241, 48.21.320, 48.44.050, 48.44.341, 48.44.460, 48.46.200, 48.46.291, 48.46.530, 48.43.715, and Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010) (PPACA), as amended by the Health Care and Education Reconciliation Act (HCERA), Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010), in particular § 1302 of

PPACA, § 10104 (b)(1) (HCERA). WSR 13-15-025 (Matter No. R 2012-17), § 284-43-877, filed 7/9/13, effective 7/10/13.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-5620.

284-43-8771 Plan design. [Statutory Authority: RCW 48.21.241, 48.21.320, 48.44.460, 48.44.341, 48.46.291, 48.46.530, and 48.43.715. WSR 15-20-042 (Matter No. R 2015-02), § 284-43-8771, filed 9/29/15, effective 9/29/15.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-5622.

284-43-878 Essential health benefit categories. [Statutory Authority: RCW 48.21.241, 48.21.320, 48.44.460, 48.44.341, 48.46.291, 48.46.530, and 48.43.715. WSR 15-20-042 (Matter No. R 2015-02), § 284-43-878, filed 9/29/15, effective 9/29/15. Statutory Authority: RCW 48.02.060 and 48.43.715. WSR 14-15-012 (Matter No. R 2014-03), § 284-43-878, filed 7/3/14, effective 7/3/14. Statutory Authority: RCW 48.02.060, 48.21.241, 48.21.320, 48.44.050, 48.44.341, 48.44.460, 48.46.200, 48.46.291, 48.46.530, 48.43.715, and Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010) (PPACA), as amended by the Health Care and Education Reconciliation Act (HCERA), Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010), in particular § 1302 of PPACA, § 10104 (b)(1) (HCERA). WSR 13-15-025 (Matter No. R 2012-17), § 284-43-878, filed 7/9/13, effective 7/10/13.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-5640.

284-43-8781 Essential health benefit categories. [Statutory Authority: RCW 48.21.241, 48.21.320, 48.44.460, 48.44.341, 48.46.291, 48.46.530, and 48.43.715. WSR 15-20-042 (Matter No. R 2015-02), § 284-43-8781, filed 9/29/15, effective 9/29/15.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-5642.

284-43-879 Essential health benefit category—Pediatric oral services. [Statutory Authority: RCW 48.21.241, 48.21.320, 48.44.460, 48.44.341, 48.46.291, 48.46.530, and 48.43.715. WSR 15-20-042 (Matter No. R 2015-02), § 284-43-879, filed 9/29/15, effective 9/29/15. Statutory Authority: RCW 48.02.060 and 48.43.715. WSR 14-09-080 (Matter No. R 2013-19), § 284-43-879, filed 4/18/14, effective 5/19/14. Statutory Authority: RCW 48.02.060, 48.21.241, 48.21.320, 48.44.050, 48.44.341, 48.44.460, 48.46.200, 48.46.291, 48.46.530, 48.43.715, and Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010) (PPACA), as amended by the Health Care and Education Reconciliation Act (HCERA), Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010), in particular § 1302 of PPACA, § 10104 (b)(1) (HCERA). WSR 13-15-025 (Matter No. R 2012-17), § 284-43-879, filed 7/9/13, effective 7/10/13.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-5700.

284-43-8791 Essential health benefit category—Pediatric oral services. [Statutory Authority: RCW 48.21.241, 48.21.320, 48.44.460, 48.44.341, 48.46.291, 48.46.530, and 48.43.715. WSR 15-20-042 (Matter No. R 2015-02), § 284-43-8791, filed 9/29/15, effective 9/29/15.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-5702.

284-43-880 Pediatric vision services. [Statutory Authority: RCW 48.21.241, 48.21.320, 48.44.460, 48.44.341, 48.46.291, 48.46.530, and 48.43.715. WSR 15-20-042 (Matter No. R 2015-02), § 284-43-880, filed 9/29/15, effective 9/29/15. Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. WSR 14-23-092 (Matter No. R 2014-04), § 284-43-880, filed 11/19/14, effective 12/20/14. Statutory Authority: RCW 48.02.060, 48.21.241, 48.21.320, 48.44.050, 48.44.341, 48.44.460, 48.46.200, 48.46.291, 48.46.530, 48.43.715, and Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010) (PPACA), as amended by the Health Care and Education Reconciliation Act (HCERA), Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010), in particular § 1302 of PPACA, § 10104 (b)(1) (HCERA). WSR 13-15-025 (Matter No. R 2012-17), § 284-43-880, filed 7/9/13, effective 7/10/13.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-5780.

284-43-8801 Pediatric vision services. [Statutory Authority: RCW 48.21.241, 48.21.320, 48.44.460, 48.44.341, 48.46.291, 48.46.530, and 48.43.715. WSR 15-20-042 (Matter No. R 2015-02), § 284-43-8801, filed 9/29/15, effective 9/29/15.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-5782.

284-43-882 Plan cost-sharing and benefit substitutions and limitations. [Statutory Authority: RCW 48.02.060, 48.21.241, 48.21.320, 48.44.050, 48.44.341, 48.44.460, 48.46.200, 48.46.291, 48.46.530, 48.43.715, and Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010) (PPACA), as amended by the Health Care and Education Reconciliation Act (HCERA), Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010), in particular § 1302 of PPACA, § 10104 (b)(1) (HCERA). WSR 13-15-025 (Matter No. R 2012-17), § 284-43-882, filed 7/9/13, effective 7/10/13.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-5800.

284-43-885 Representations regarding coverage. [Statutory Authority: RCW 48.02.060, 48.21.241, 48.21.320, 48.44.050, 48.44.341, 48.44.460, 48.46.200, 48.46.291, 48.46.530, 48.43.715, and Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010) (PPACA), as amended by the Health Care and Education Reconciliation Act (HCERA), Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010), in particular § 1302 of PPACA, § 10104 (b)(1) (HCERA). WSR 13-15-025 (Matter No. R 2012-17), § 284-43-885, filed 7/9/13, effective 7/10/13.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-5820.

284-43-899 Effective date. [Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.100, 48.46.200, 48.43.505, 48.43.510, 48.43.515, 48.43.520, 48.43.525, 48.43.530, 48.43.535. WSR 01-03-033 (Matter No. R 2000-02), § 284-43-899, filed 1/9/01, effective 2/9/01.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-5900.

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

284-43-901 Authority and purpose. [Statutory Authority: RCW 48.02.060, 48.18.110, 48.44.020, 48.44.050, 48.46.060, 48.46.200. WSR 08-20-071 (Matter No. R 2008-08), § 284-43-901, filed 9/25/08, effective 10/26/08.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-6000.

284-43-905 Applicability and scope. [Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. WSR 05-07-006 (Matter No. R 2004-05), § 284-43-905, filed 3/3/05, effective 4/3/05. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066. WSR 98-04-011 (Matter No. R 97-2), § 284-43-905, filed 1/23/98, effective 3/1/98.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-6010.

284-43-910 Definitions. [Statutory Authority: RCW 48.02.060, 48.18.110, 48.44.020, 48.44.050, 48.46.060, 48.46.200. WSR 08-20-071 (Matter No. R 2008-08), § 284-43-910, filed 9/25/08, effective 10/26/08. Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. WSR 05-07-006 (Matter No. R 2004-05), § 284-43-910, filed 3/3/05, effective 4/3/05. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066. WSR 98-04-011 (Matter No. R 97-2), § 284-43-910, filed 1/23/98, effective 3/1/98.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-6020.

284-43-915 Demonstration that benefits provided are not reasonable in relation to the amount charged for a contract per RCW 48.44.020 and 48.46.060. [Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. WSR 05-07-006 (Matter No. R 2004-05), § 284-43-915, filed 3/3/05, effective 4/3/05. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066. WSR 98-04-011 (Matter No. R 97-2), § 284-43-915, filed 1/23/98, effective 3/1/98.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-6040.

284-43-920 When a carrier is required to file. [Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. WSR 05-07-006 (Matter No. R 2004-05), § 284-43-920, filed 3/3/05, effective 4/3/05. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066. WSR 98-04-011 (Matter No. R 97-2), § 284-43-920, filed 1/23/98, effective 3/1/98.] Repealed by WSR 16-03-018 (Matter No. R2015-04), filed 1/8/16, effective 1/8/16. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064, 48.46.066, and 2015 c 19.

284-43-925 General contents of all filings. [Statutory Authority: RCW 48.02.060, 48.18.110, 48.44.020, 48.44.050, 48.46.060, 48.46.200. WSR 08-20-071 (Matter No. R 2008-08), § 284-43-925, filed 9/25/08, effective 10/26/08. Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. WSR 05-07-006 (Matter No. R 2004-05), § 284-43-925, filed 3/3/05, effective 4/3/05. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066. WSR 98-04-011 (Matter No. R 97-2), § 284-43-925, filed 1/23/98, effective 3/1/98.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-6060.

284-43-927 Issuer filing of attestation form, transparency tools. [Statutory Authority: RCW 48.02.060, 48.43.340, and 48.44.050. WSR 15-21-095 (Matter No. R 2015-03), § 284-43-927, filed 10/21/15, effective 1/1/16.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-6080.

284-43-930 Contents of individual and small group filings. [Statutory Authority: RCW 48.02.060, 48.18.110, 48.44.020, 48.44.050, 48.46.060, 48.46.200. WSR 08-20-071 (Matter No. R 2008-08), § 284-43-930, filed 9/25/08, effective 10/26/08. Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. WSR 05-07-006 (Matter No. R 2004-05), § 284-43-930, filed 3/3/05, effective 4/3/05. Statutory Authority: RCW 48.02.060 and 48.92.140. WSR 98-11-089 (Matter No. R 98-8), § 284-43-930, filed 5/20/98, effective 6/20/98. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066. WSR 98-04-011 (Matter No. R 97-2), § 284-43-930, filed 1/23/98, effective 3/1/98.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-6100.

284-43-935 Experience records. [Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. WSR 05-07-006 (Matter No. R 2004-05), § 284-43-935, filed 3/3/05, effective 4/3/05. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066. WSR 98-04-011 (Matter No. R 97-2), § 284-43-935, filed 1/23/98, effective 3/1/98.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-6120.

284-43-940 Evaluating experience data. [Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. WSR 05-07-006 (Matter No. R 2004-05), § 284-43-940, filed 3/3/05, effective 4/3/05. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066. WSR 98-04-011 (Matter No. R 97-2), § 284-43-940, filed 1/23/98, effective 3/1/98.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-6140.

284-43-945 Summary for individual and small group contract filings. [Statutory Authority: RCW 48.02.060, 48.18.110, 48.44.020, 48.44.050, 48.46.060, 48.46.200. WSR 08-20-071 (Matter No. R 2008-08), § 284-43-945, filed 9/25/08, effective 10/26/08. Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. WSR 05-07-006 (Matter No. R 2004-05), § 284-43-945, filed 3/3/05, effective 4/3/05. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066. WSR 98-04-011 (Matter No. R 97-2), § 284-43-945, filed 1/23/98, effective 3/1/98.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-6160.

284-43-950 Summary for group contract filings other than small group contract filings. [Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. WSR 05-07-006 (Matter No. R 2004-05), § 284-43-950, filed 3/3/05, effective 4/3/05. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066. WSR 98-04-011 (Matter No. R 97-2), § 284-43-950, filed 1/23/98, effective 3/1/98.] Repealed by WSR 16-03-018 (Matter No. R2015-04), filed 1/8/16, effective 1/8/16. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064, 48.46.066, and 2015 c 19.

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

284-43-970 Purpose and scope. [Statutory Authority: RCW 48.02.060, 48.18.120(2), 48.20.450, 48.44.050, 48.46.200, and P.L. 111-148 and the interim final regulations issued June 28, 2010, found at Vol. 75 F.R. 37187-37241, and codified in 45 C.F.R. Parts 144, 146 and 147. WSR 11-13-068 (Matter No. R 2010-16), § 284-43-970, filed 6/15/11, effective 7/16/11.] Repealed by WSR 14-08-036 (Matter No. R 2014-01), filed 3/26/14, effective 4/26/14. Statutory Authority: RCW 48.02.060, 48.18.120(2), 48.44.050, 48.46.200 and 45 C.F.R. Parts 144, 146 and 147.

284-43-975 Definitions. [Statutory Authority: RCW 48.02.060, 48.18.120(2), 48.20.450, 48.44.050, 48.46.200, and P.L. 111-148 and the interim final regulations issued June 28, 2010, found at Vol. 75 F.R. 37187-37241, and codified in 45 C.F.R. Parts 144, 146 and 147. WSR 11-13-068 (Matter No. R 2010-16), § 284-43-975, filed 6/15/11, effective 7/16/11.] Repealed by WSR 14-08-036 (Matter No. R 2014-01), filed 3/26/14, effective 4/26/14. Statutory Authority: RCW 48.02.060, 48.18.120(2), 48.44.050, 48.46.200 and 45 C.F.R. Parts 144, 146 and 147.

284-43-980 Preexisting conditions. [Statutory Authority: RCW 48.02.060, 48.18.120(2), 48.20.450, 48.44.050, 48.46.200, and P.L. 111-148 and the interim final regulations issued June 28, 2010, found at Vol. 75 F.R. 37187-37241, and codified in 45 C.F.R. Parts 144, 146 and 147. WSR 11-13-068 (Matter No. R 2010-16), § 284-43-980, filed 6/15/11, effective 7/16/11.] Repealed by WSR 14-08-036 (Matter No. R 2014-01), filed 3/26/14, effective 4/26/14. Statutory Authority: RCW 48.02.060, 48.18.120(2), 48.44.050, 48.46.200 and 45 C.F.R. Parts 144, 146 and 147.

284-43-985 Enrollment of persons under age nineteen. [Statutory Authority: RCW 48.02.060, 48.18.120(2), 48.20.450, 48.44.050, 48.46.200, and P.L. 111-148 and the interim final regulations issued June 28, 2010, found at Vol. 75 F.R. 37187-37241, and codified in 45 C.F.R. Parts 144, 146 and 147. WSR 11-13-068 (Matter No. R 2010-16), § 284-43-985, filed 6/15/11, effective 7/16/11.] Repealed by WSR 14-08-036 (Matter No. R 2014-01), filed 3/26/14, effective 4/26/14. Statutory Authority: RCW 48.02.060, 48.18.120(2), 48.44.050, 48.46.200 and 45 C.F.R. Parts 144, 146 and 147.

284-43-990 Scope and intent—Parity in mental health and substance use disorder benefits. [Statutory Authority: RCW 48.02.060, 48.43.715, 48.44.050, 48.46.200 and Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. 110-343. WSR 14-23-057 (Matter No. R 2012-29), § 284-43-990, filed 11/17/14, effective 12/18/14.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-7000.

284-43-991 Definitions. [Statutory Authority: RCW 48.02.060, 48.43.715, 48.44.050, 48.46.200 and Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. 110-343. WSR 14-23-057 (Matter No. R 2012-29), § 284-43-991, filed 11/17/14, effective 12/18/14.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-7010.

284-43-992 Classification of benefits. [Statutory Authority: RCW 48.02.060, 48.43.715, 48.44.050, 48.46.200 and Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. 110-343. WSR 14-23-057 (Matter No. R 2012-29), § 284-43-992, filed 11/17/14, effective 12/18/14.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-7020.

284-43-993 Measuring health plan benefits—Financial requirements and quantitative treatment limitations. [Statutory Authority: RCW 48.02.060, 48.43.715, 48.44.050, 48.46.200 and Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. 110-343. WSR 14-23-057 (Matter No. R 2012-29), § 284-43-993, filed 11/17/14, effective 12/18/14.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-7040.

284-43-994 Measuring health plan benefits—Nonquantitative treatment limitations. [Statutory Authority: RCW 48.02.060, 48.43.715, 48.44.050, 48.46.200 and Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. 110-343. WSR 14-23-057 (Matter No. R 2012-29), § 284-43-994, filed 11/17/14, effective 12/18/14.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-7060.

284-43-995 Prohibited exclusions. [Statutory Authority: RCW 48.02.060, 48.43.715, 48.44.050, 48.46.200 and Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. 110-343. WSR 14-23-057 (Matter No. R 2012-29), § 284-43-995, filed 11/17/14, effective 12/18/14.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-7080.

284-43-996 Required disclosures. [Statutory Authority: RCW 48.02.060, 48.43.715, 48.44.050, 48.46.200 and Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. 110-343. WSR 14-23-057 (Matter No. R 2012-29), § 284-43-996, filed 11/17/14, effective 12/18/14.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-7100.

284-43-997 Compliance and reporting of quantitative parity analysis. [Statutory Authority: RCW 48.02.060, 48.43.715, 48.44.050, 48.46.200 and Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. 110-343. WSR 14-23-057 (Matter No. R 2012-29), § 284-43-997, filed 11/17/14, effective 12/18/14.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-7120.

284-43-9970 Network access—General standards. [WSR 16-01-081, recodified as § 284-43-9970, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.460, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.44.050, 48.46.200, 48.20.450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. §§ 156.230, 156.235, and 156.245. WSR 14-10-017 (Matter No. R 2013-22), § 284-43-200, filed 4/25/14, effective 5/26/14. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050,

48.46.100, 48.46.200, 48.43.505, 48.43.510, 48.43.515, 48.43.520, 48.43.525, 48.43.530, 48.43.535. WSR 01-03-033 (Matter No. R 2000-02), § 284-43-200, filed 1/9/01, effective 7/1/01. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.030, 48.46.200. WSR 00-04-034 (Matter No. R 99-2), § 284-43-200, filed 1/24/00, effective 3/1/00. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. WSR 98-04-005 (Matter No. R 97-3), § 284-43-200, filed 1/22/98, effective 2/22/98.] Decodified by WSR 16-07-144 (Matter No. R 2016-01), filed 3/23/16, effective 4/23/16. Statutory Authority: RCW 48.02.060. Recodified as § 284-170-200.

284-43-9971 Alternate access delivery request. [WSR 16-01-081, recodified as § 284-43-9971, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.460, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.44.050, 48.46.200, 48.20.450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. §§ 156.230, 156.235, and 156.245. WSR 14-10-017 (Matter No. R 2013-22), § 284-43-201, filed 4/25/14, effective 5/26/14.] Decodified by WSR 16-07-144 (Matter No. R 2016-01), filed 3/23/16, effective 4/23/16. Statutory Authority: RCW 48.02.060. Recodified as § 284-170-210.

284-43-9972 Maintenance of sufficient provider networks. [WSR 16-01-074, recodified as § 284-43-9972, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.43.055, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.43.730, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.200. WSR 16-01-074 (Matter No. R 2014-08), § 284-43-202, filed 12/14/15, effective 1/14/16.] Decodified by WSR 16-07-144 (Matter No. R 2016-01), filed 3/23/16, effective 4/23/16. Statutory Authority: RCW 48.02.060. Recodified as § 284-170-230.

284-43-9973 Use of subcontracted networks. [WSR 16-01-081, recodified as § 284-43-9973, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.460, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.44.050, 48.46.200, 48.20.450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. §§ 156.230, 156.235, and 156.245. WSR 14-10-017 (Matter No. R 2013-22), § 284-43-203, filed 4/25/14, effective 5/26/14.] Decodified by WSR 16-07-144 (Matter No. R 2016-01), filed 3/23/16, effective 4/23/16. Statutory Authority: RCW 48.02.060. Recodified as § 284-170-240.

284-43-9974 Provider directories. [WSR 16-01-081, recodified as § 284-43-9974, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.460, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.44.050, 48.46.200, 48.20.450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. §§ 156.230, 156.235, and 156.245. WSR 14-10-017 (Matter No. R 2013-22), § 284-43-204, filed 4/25/14, effective 5/26/14.] Decodified by WSR 16-07-144 (Matter No. R 2016-01), filed 3/23/16, effective 4/23/16. Statutory Authority: RCW 48.02.060. Recodified as § 284-170-260.

284-43-9975 Every category of health care providers. [WSR 16-01-081, recodified as § 284-43-9975, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.460, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.44.050, 48.46.200, 48.20.450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. §§ 156.230, 156.235, and 156.245. WSR 14-10-017 (Matter No. R 2013-22), § 284-43-205, filed 4/25/14, effective 5/26/14. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050 and 48.46.200. WSR 99-16-036 (Matter No. R 98-20), § 284-43-205, filed 7/28/99, effective 8/28/99.] Decodified by WSR 16-07-144 (Matter No. R 2016-01), filed 3/23/16, effective 4/23/16. Statutory Authority: RCW 48.02.060. Recodified as § 284-170-270.

284-43-9976 Network reports—Format. [WSR 16-01-081, recodified as § 284-43-9976, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.460, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.44.050, 48.46.200, 48.20.450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. §§ 156.230, 156.235, and 156.245. WSR 14-10-017 (Matter No. R 2013-22), § 284-43-220, filed 4/25/14, effective 5/26/14. Statutory Authority: RCW 48.02.060, 48.43.510 and 48.43.515. WSR 11-07-015 (Matter No. R 2011-01), § 284-43-220, filed 3/8/11, effective 4/8/11. Statutory Authority: RCW 48.02.060. WSR 08-17-037 (Matter No. R 2008-17), § 284-43-220, filed 8/13/08, effective 9/13/08. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.43.515, 48.44.050, 48.46.030, 48.46.200, 48.42.100, 48.43.515, 48.46.030. WSR 03-09-142 (Matter No. R 2003-01), § 284-43-220, filed 4/23/03, effective 5/24/03. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.030, 48.46.200. WSR 00-04-034 (Matter No. R 99-2), § 284-43-220, filed 1/24/00, effective 1/1/01. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. WSR 98-04-005 (Matter No. R 97-3), § 284-43-220, filed 1/22/98, effective 2/22/98.] Decodified by WSR 16-07-144 (Matter No. R 2016-01), filed 3/23/16, effective 4/23/16. Statutory Authority: RCW 48.02.060. Recodified as § 284-170-280.

284-43-9977 Essential community providers for exchange plans—Definition. [WSR 16-01-081, recodified as § 284-43-9977, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.20.450, 48.43.515, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. 156.230, 156.235, and 156.245. WSR 14-22-007, § 284-43-221, filed 10/23/14, effective 11/23/14. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.460, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.44.050, 48.46.200, 48.20.450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. §§ 156.230, 156.235, and 156.245. WSR 14-10-017 (Matter No. R 2013-22), § 284-43-221, filed 4/25/14, effective 5/26/14.] Decodified by WSR 16-07-144 (Matter No. R 2016-01), filed 3/23/16, effective 4/23/16. Statutory Authority: RCW 48.02.060. Recodified as § 284-170-300.

284-43-9978 Essential community providers for exchange plans—Network access. [WSR 16-01-081, recodified as § 284-43-9978, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.20.450, 48.43.515, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. 156.230, 156.235, and 156.245. WSR 14-22-007, § 284-43-222, filed 10/23/14, effective 11/23/14. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.460, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.44.050, 48.46.200, 48.20.450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. §§ 156.230, 156.235, and 156.245. WSR 14-10-017 (Matter No. R 2013-22), § 284-43-222, filed 4/25/14, effective 5/26/14.] Decodified by WSR

16-07-144 (Matter No. R 2016-01), filed 3/23/16, effective 4/23/16. Statutory Authority: RCW 48.02.060. Recodified as § 284-170-310.

284-43-9979 Issuer recordkeeping—Provider networks. [WSR 16-01-074, recodified as § 284-43-9979, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.43.055, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.43.730, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.200. WSR 16-01-074 (Matter No. R 2014-08), § 284-43-225, filed 12/14/15, effective 1/14/16.] Decodified by WSR 16-07-144 (Matter No. R 2016-01), filed 3/23/16, effective 4/23/16. Statutory Authority: RCW 48.02.060. Recodified as § 284-170-320.

284-43-9980 Tiered provider networks. [WSR 16-01-081, recodified as § 284-43-9980, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.460, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.44.050, 48.46.200, 48.20.450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. §§ 156.230, 156.235, and 156.245. WSR 14-10-017 (Matter No. R 2013-22), § 284-43-229, filed 4/25/14, effective 5/26/14.] Decodified by WSR 16-07-144 (Matter No. R 2016-01), filed 3/23/16, effective 4/23/16. Statutory Authority: RCW 48.02.060. Recodified as § 284-170-330.

284-43-9981 Assessment of access. [WSR 16-01-081, recodified as § 284-43-9981, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.460, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.44.050, 48.46.200, 48.20.450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. §§ 156.230, 156.235, and 156.245. WSR 14-10-017 (Matter No. R 2013-22), § 284-43-230, filed 4/25/14, effective 5/26/14.] Decodified by WSR 16-07-144 (Matter No. R 2016-01), filed 3/23/16, effective 4/23/16. Statutory Authority: RCW 48.02.060. Recodified as § 284-170-340.

284-43-9982 Issuer standards for women's right to directly access certain health care practitioners for women's health care services. [WSR 16-01-081, recodified as § 284-43-9982, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.460, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.44.050, 48.46.200, 48.20.450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. §§ 156.230, 156.235, and 156.245. WSR 14-10-017 (Matter No. R 2013-22), § 284-43-250, filed 4/25/14, effective 5/26/14. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.030, 48.46.200. WSR 00-04-034 (Matter No. R 99-2), § 284-43-250, filed 1/24/00, effective 2/24/00. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. WSR 98-04-005 (Matter No. R 97-3), § 284-43-250, filed 1/22/98, effective 2/22/98.] Decodified by WSR 16-07-144 (Matter No. R 2016-01), filed 3/23/16, effective 4/23/16. Statutory Authority: RCW 48.02.060. Recodified as § 284-170-350.

284-43-9983 Enrollee's access to providers. [WSR 16-01-074, recodified as § 284-43-9983, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.43.055, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.43.730, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.200. WSR 16-01-074 (Matter No. R 2014-08), § 284-43-251, filed 12/14/15, effective 1/14/16. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.100, 48.46.200, 48.43.505, 48.43.510, 48.43.515, 48.43.520, 48.43.525, 48.43.530, 48.43.535. WSR 01-03-033 (Matter No. R 2000-02), § 284-43-251, filed 1/9/01, effective 7/1/01.] Decodified by WSR 16-07-144 (Matter No. R 2016-01), filed 3/23/16, effective 4/23/16. Statutory Authority: RCW 48.02.060. Recodified as § 284-170-360.

284-43-9984 Hospital emergency service departments and practice groups. [WSR 16-01-081, recodified as § 284-43-9984, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.460, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.44.050, 48.46.200, 48.20.450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. §§ 156.230, 156.235, and 156.245. WSR 14-10-017 (Matter No. R 2013-22), § 284-43-252, filed 4/25/14, effective 5/26/14.] Decodified by WSR 16-07-144 (Matter No. R 2016-01), filed 3/23/16, effective 4/23/16. Statutory Authority: RCW 48.02.060. Recodified as § 284-170-370.

284-43-9985 Standards for temporary substitution of contracted network providers—"Locum tenens" providers. [WSR 16-01-081, recodified as § 284-43-9985, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060 and 48.43.515. WSR 08-01-025 (Matter No. R 2005-04), § 284-43-260, filed 12/10/07, effective 1/10/08.] Decodified by WSR 16-07-144 (Matter No. R 2016-01), filed 3/23/16, effective 4/23/16. Statutory Authority: RCW 48.02.060. Recodified as § 284-170-380.

284-43-9986 Rule concerning contracted network providers called to active duty military service. [WSR 16-01-081, recodified as § 284-43-9986, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060 and 48.43.515. WSR 08-01-025 (Matter No. R 2005-04), § 284-43-262, filed 12/10/07, effective 1/10/08.] Decodified by WSR 16-07-144 (Matter No. R 2016-01), filed 3/23/16, effective 4/23/16. Statutory Authority: RCW 48.02.060. Recodified as § 284-170-390.

284-43-9990 Provider and facility contracts with issuers—Generally. [WSR 16-01-074, recodified as § 284-43-9990, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.43.055, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.43.730, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.200. WSR 16-01-074 (Matter No. R 2014-08), § 284-43-300, filed 12/14/15, effective 1/14/16. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. WSR 98-04-005 (Matter No. R 97-3), § 284-43-300, filed 1/22/98, effective 2/22/98.] Decodified by WSR 16-07-144 (Matter No. R 2016-01), filed 3/23/16, effective 4/23/16. Statutory Authority: RCW 48.02.060. Recodified as § 284-170-401.

284-43-9991 Selection of participating providers—Credentialing and unfair discrimination. [WSR 16-01-074, recodified as § 284-43-9991, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.43.055, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.43.730, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.200. WSR 16-01-074 (Matter No. R 2014-08), § 284-43-310, filed 12/14/15, effective 1/14/16. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. WSR 98-04-005

(Matter No. R 97-3), § 284-43-310, filed 1/22/98, effective 2/22/98.] Decodified by WSR 16-07-144 (Matter No. R 2016-01), filed 3/23/16, effective 4/23/16. Statutory Authority: RCW 48.02.060. Recodified as § 284-170-411.

284-43-9992 Provider contracts—Standards—Hold harmless provisions. [WSR 16-01-074, recodified as § 284-43-9992, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.43.055, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.43.730, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.200. WSR 16-01-074 (Matter No. R 2014-08), § 284-43-320, filed 12/14/15, effective 1/14/16. Statutory Authority: RCW 48.02.060, 48.30.010, 48.43.055, 48.44.050, 48.44.070, 48.46.030, 48.46.200 and 48.46.243. WSR 99-21-016 (Matter No. R 98-21), § 284-43-320, filed 10/11/99, effective 11/11/99. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. WSR 98-04-005 (Matter No. R 97-3), § 284-43-320, filed 1/22/98, effective 2/22/98.] Decodified by WSR 16-07-144 (Matter No. R 2016-01), filed 3/23/16, effective 4/23/16. Statutory Authority: RCW 48.02.060. Recodified as § 284-170-421.

284-43-9993 Provider contracts—Terms and conditions of payment. [WSR 16-01-081, recodified as § 284-43-9993, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.30.010, 48.43.055, 48.44.050, 48.44.070, 48.46.030, 48.46.200 and 48.46.243. WSR 99-21-016 (Matter No. R 98-21), § 284-43-321, filed 10/11/99, effective 11/11/99.] Decodified by WSR 16-07-144 (Matter No. R 2016-01), filed 3/23/16, effective 4/23/16. Statutory Authority: RCW 48.02.060.n Recodified as § 284-170-431.

284-43-9994 Provider contracts—Dispute resolution process. [WSR 16-01-081, recodified as § 284-43-9994, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.30.010, 48.43.055, 48.44.050, 48.44.070, 48.46.030, 48.46.200 and 48.46.243. WSR 99-21-016 (Matter No. R 98-21), § 284-43-322, filed 10/11/99, effective 11/11/99.] Decodified by WSR 16-07-144 (Matter No. R 2016-01), filed 3/23/16, effective 4/23/16. Statutory Authority: RCW 48.02.060. Recodified as § 284-170-440.

284-43-9995 Pharmacy identification cards. [WSR 16-01-081, recodified as § 284-43-9995, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.43.023, 48.44.050, 48.46.200. WSR 03-07-006 (Matter No. R 2002-04), § 284-43-323, filed 3/6/03, effective 4/6/03.] Decodified by WSR 16-07-144 (Matter No. R 2016-01), filed 3/23/16, effective 4/23/16. Statutory Authority: RCW 48.02.060. Recodified as § 284-170-450.

284-43-9996 Provider contracts—Audit guidelines. [WSR 16-01-081, recodified as § 284-43-9996, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.30.010, 48.43.055, 48.44.050, 48.44.070, 48.46.030, 48.46.200 and 48.46.243. WSR 99-21-016 (Matter No. R 98-21), § 284-43-324, filed 10/11/99, effective 11/11/99.] Decodified by WSR 16-07-144 (Matter No. R 2016-01), filed 3/23/16, effective 4/23/16. Statutory Authority: RCW 48.02.060. Recodified as § 284-170-460.

284-43-9997 Pharmacy claims—Rejections, notifications and disclosures. [WSR 16-01-081, recodified as § 284-43-9997, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.165.0301, 48.43.525, 48.43.530, 48.44.020, 48.44.050, 48.46.060(2), and 48.46.200. WSR 15-24-074 (Matter No. R 2014-13), § 284-43-325, filed 11/25/15, effective 7/1/16.] Decodified by WSR 16-07-144 (Matter No. R 2016-01), filed 3/23/16, effective 4/23/16. Statutory Authority: RCW 48.02.060. Recodified as § 284-170-470.

284-43-9998 Participating provider—Filing and approval. [WSR 16-01-074, recodified as § 284-43-9998, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.43.055, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.43.730, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.200. WSR 16-01-074 (Matter No. R 2014-08), § 284-43-330, filed 12/14/15, effective 1/14/16. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.030, 48.46.200, and 2013 c 277 § 1. WSR 13-16-045 (Matter No. R 2012-24), § 284-43-330, filed 7/31/13, effective 8/31/13. Statutory Authority: RCW 48.02.060, 48.30.010, 48.43.055, 48.44.050, 48.44.070, 48.46.030, 48.46.200 and 48.46.243. WSR 99-21-016 (Matter No. R 98-21), § 284-43-330, filed 10/11/99, effective 11/11/99. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. WSR 98-04-005 (Matter No. R 97-3), § 284-43-330, filed 1/22/98, effective 2/22/98.] Decodified by WSR 16-07-144(Matter No. R 2016-01), filed 3/23/16, effective 4/23/16. Statutory Authority: RCW 48.02.060. Recodified as § 284-170-480.

284-43-9999 Effective date. [WSR 16-01-081, recodified as § 284-43-9999, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.460, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.44.050, 48.46.200, 48.20.450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. §§ 156.230, 156.235, and 156.245. WSR 14-10-017 (Matter No. R 2013-22), § 284-43-331, filed 4/25/14, effective 5/26/14. Statutory Authority: RCW 48.02.060, 48.30.010, 48.43.055, 48.44.050, 48.44.070, 48.46.030, 48.46.200 and 48.46.243. WSR 99-21-016 (Matter No. R 98-21), § 284-43-331, filed 10/11/99, effective 11/11/99.] Decodified by WSR 16-07-144 (Matter No. R 2016-01), filed 3/23/16, effective 4/23/16. Statutory Authority: RCW 48.02.060. Recodified as § 284-170-490.

SUBCHAPTER A
GENERAL PROVISIONS

WAC 284-43-0110 Purpose. The purpose of this chapter is to establish uniform regulatory standards for health carriers and to create minimum standards for health plans that ensure consumer access to the health care services promised in these health plans.

[WSR 16-01-081, recodified as § 284-43-0110, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. WSR 98-04-005 (Matter No. R 97-3), § 284-43-110, filed 1/22/98, effective 2/22/98.]

WAC 284-43-0120 Applicability and scope. (1) This chapter shall apply to all health plans and all health carriers subject to the jurisdiction of the state of Washington except as otherwise expressly provided in this chapter. Health carriers are responsible for compliance with the provisions of this chapter. A carrier's obligation to comply with the provisions of this chapter is nondelegable. Carriers are responsible for the compliance of any person, health care benefit manager, or other organization acting on behalf of or at the direction of the carrier, or acting pursuant to carrier standards or requirements concerning the coverage of, payment for, or provision of health care services.

(2) A carrier may not offer as a defense to a violation of any provision of this chapter that the violation arose from the act or omission of a participating provider or facility, network administrator, claims administrator, health care benefit manager, or other person acting on behalf of or at the direction of the carrier, or acting pursuant to carrier standards or requirements under a contract with the carrier rather than from the direct act or omission of the carrier. Nothing in this chapter shall be construed to permit the direct regulation of health care providers or facilities by the office of the insurance commissioner.

[Statutory Authority: RCW 48.02.060, 48.43.0961, 2023 c 325, 48.43.735, 2024 c 215, 48.43.047, 2024 c 314, and 89 F.R. 37522. WSR 24-24-067 (Matter R 2024-05), s 284-43-0120, filed 11/27/24, effective 12/28/24. WSR 16-01-081, recodified as § 284-43-0120, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.030, 48.46.200. WSR 00-04-034 (Matter No. R 99-2), § 284-43-120, filed 1/24/00, effective 2/24/00. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. WSR 98-04-005 (Matter No. R 97-3), § 284-43-120, filed 1/22/98, effective 2/22/98.]

WAC 284-43-0140 Compliance with state and federal laws. Health carriers shall comply with all Washington state and federal laws relating to the acts and practices of carriers and laws relating to health plan benefits.

[WSR 16-01-081, recodified as § 284-43-0140, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.030, 48.46.200. WSR 00-04-034 (Matter No. R 99-2), § 284-43-125, filed 1/24/00, effective 2/24/00.]

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" 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" 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 48.83 or 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.

(l) Supplemental long-term care insurance governed by chapter 48.212 RCW.

(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) "Refill" means a second or subsequent filling of a previously issued prescription.

(36) "Serious mental illness" means a mental disorder, as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association, that results in serious functional impairment that substantially interferes with or limits one or more major life activities.

(37) "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.

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

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

(40) "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.

(41) "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.

(42) "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.

(43) "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.

(44) "Withdrawal management services" means 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.

[Statutory Authority: RCW 48.02.060 (3)(a), 48.85.030(1), 48.212.140, 48.212.150, 48.212.170, 48.212.200, and 48.85.030. WSR 26-05-001 (Matter R 2025-06), s 284-43-0160, filed 2/4/26, effective 3/7/26. Statutory Authority: RCW 48.02.060, 48.43.0961, 2023 c 325, 48.43.735, 2024 c 215, 48.43.047, 2024 c 314, and 89 F.R. 37522. WSR 24-24-067 (Matter R 2024-05), s 284-43-0160, filed 11/27/24, effective 12/28/24. Statutory Authority: RCW 48.02.060, 48.43.735, 48.44.050, 48.46.200, 48.200.040, and 48.200.900. WSR 23-24-034 (Matter R 2023-07), § 284-43-0160, filed 11/30/23, effective 1/1/24. Statutory Authority: RCW 48.02.060, 48.20.460, 48.43.0128, 48.44.050, and 48.46.200. WSR 20-24-040, § 284-43-0160, filed 11/23/20, effective 12/24/20. Statutory Authority: RCW 48.02.060, 48.43.510, 48.43.515, 48.43.520, 48.43.525, 48.43.530, and 48.165.030. WSR 17-12-069 (Matter No. R 2016-19), § 284-43-0160, filed 6/5/17, effective 7/6/17. Statutory Authority: RCW 48.02.060, 48.43.510. WSR 17-01-166 (Matter No. R 2016-16), § 284-43-0160, filed 12/21/16, effective 7/1/17. WSR 16-01-081, recodified as § 284-43-0160, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.165.0301, 48.43.525, 48.43.530, 48.44.020, 48.44.050, 48.46.060(2), and 48.46.200. WSR 15-24-074 (Matter No. R 2014-13), § 284-43-130, filed 11/25/15, effective 7/1/16. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.460, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.44.050, 48.46.200, 48.20.450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. §§ 156.230, 156.235, and 156.245. WSR 14-10-017 (Matter No. R 2013-22), § 284-43-130, filed 4/25/14, effective

5/26/14. Statutory Authority: RCW 48.02.060, 48.43.525, 48.43.530, 48.43.535, and The Patient Protection and Affordable Care Act, P.L. 111-148, as amended (2010). WSR 12-23-005 (Matter No. R 2011-11), § 284-43-130, filed 11/7/12, effective 11/20/12. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.100, 48.46.200, 48.43.505, 48.43.510, 48.43.515, 48.43.520, 48.43.525, 48.43.530, 48.43.535. WSR 01-03-033 (Matter No. R 2000-02), § 284-43-130, filed 1/9/01, effective 7/1/01. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.200, 2000 c 79 § 26, and RCW 48.30.040, 48.44.110, 48.46.400. WSR 01-03-032 (Matter No. R 2000-04), § 284-43-130, filed 1/9/01, effective 2/9/01. Statutory Authority: RCW 48.02.060, 48.30.010, 48.44.050, 48.46.200, 48.30.040, 48.44.110 and 48.46.400. WSR 99-19-032 (Matter No. R 98-7), § 284-43-130, filed 9/8/99, effective 10/9/99. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. WSR 98-04-005 (Matter No. R 97-3), § 284-43-130, filed 1/22/98, effective 2/22/98.]

SUBCHAPTER B1
PLAN MANAGEMENT

WAC 284-43-0200 Deadline for filing individual health plans, small group health plans, and stand-alone dental plans. This section applies to all individual health plans, small group health plans, and stand-alone dental plans that provide pediatric dental benefits as one of the essential health benefits. Each year, issuers must file with the commissioner a complete rate and form filing for the next calendar year on or before the deadline set by the commissioner. The commissioner must announce and post the filing deadline no later than March 31st of each year. Issuers will be permitted to amend filings only at the direction of the commissioner. Filings not timely submitted will be rejected without review.

[WSR 16-01-081, recodified as § 284-43-0200, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.18.100, 48.43.340, 48.43.715, 48.44.050, and 48.46.200. WSR 14-07-047 (Matter No. R 2013-27), § 284-170-870, filed 3/13/14, effective 4/13/14.]

WAC 284-43-0210 Transitional reinsurance program. (1) Issuers of health benefit plans in Washington state, and third party administrators of health benefit coverage offered in Washington, must participate as contributing entities in the transitional reinsurance program established pursuant to RCW 48.43.720.

(2) The U.S. Department of Health and Human Services (HHS) will operate the transitional health plan reinsurance program for the state of Washington. The program ceases operation on June 30, 2017, for payment of claims incurred through December 31, 2016.

(3) Contributing entities are not required to remit reinsurance contributions for the following types of coverage:

(a) Coverage only for accident, or disability income insurance, or any combination thereof;

(b) Coverage issued as a supplement to liability insurance;

(c) Liability insurance, including general liability insurance and automobile liability insurance;

(d) Workers' compensation or similar insurance;

(e) Automobile medical payment insurance;

(f) Credit-only insurance;

(g) Coverage for on-site medical clinics;

(h) Limited scope dental or vision benefits;

(i) Benefits for long-term care, nursing home care, home health care, community-based care or any combination thereof;

(j) Benefits provided under a health flexible spending arrangement as defined in Internal Revenue Code, Section 106 (c)(2) ("Health FSA") if other group health plan coverage, not limited to excepted benefits, is made available for the year to the class of participants by reason of their employment, and the Health FSA is structured so that the maximum benefit payable to any participant in the class for a year cannot exceed two times the participant's salary reduction election under the arrangement for the year (or, if greater, cannot exceed five hundred dollars plus the amount of the participant's salary reduction election). For this purpose, any amount that an employee can elect to receive as taxable income but elects to apply to the Health FSA is considered a salary reduction election (regardless of whether the amount is characterized as salary or as a credit under the Health FSA);

(k) Coverage for a specified disease or illness, if offered as independent, noncoordinated benefits;

(l) Hospital indemnity or other fixed indemnity insurance if offered as independent, noncoordinated benefits;

(m) Medicare supplemental health insurance, and similar supplemental coverage provided to coverage under a group health plan, provided such coverage is offered as a separate insurance policy;

(n) Other similar insurance coverage under which benefits for medical care are secondary or incidental to other insurance benefits, or that qualify as HIPAA-excepted benefits;

(o) Medicare advantage, medicaid, or any federal coverage program except multistate Office of Personnel Management plans;

(p) Washington state health insurance pool and the Preexisting Condition Insurance Plan - Washington.

(4) As part of its rate filing, a carrier must identify the reinsurance payments received for each nongrandfathered individual health benefit plan for the prior plan or policy year.

(5) This rule expires September 1, 2017.

[WSR 16-01-081, recodified as § 284-43-0210, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.43.720. WSR 13-05-024 (Matter No. R 2012-09), § 284-170-001, filed 2/11/13, effective 3/14/13.]

WAC 284-43-0230 Risk adjustment program. (1) An issuer of a nongrandfathered individual or small group health plan in Washington state must participate in the permanent risk adjustment program, established pursuant to RCW 48.43.720.

(2) U.S. Department of Health and Human Services (HHS) will administer the risk adjustment program for 2014-2015. Issuers must comply with HHS requirements for the risk adjustment program.

(3) Beginning September 1, 2015, or on the date established by the HHS, the commissioner will annually publish a notice of benefit

and payment parameters, and include a statement of intent regarding whether the state or HHS will administer the risk adjustment program for the ensuring benefit year.

The commissioner will determine the form of the notice, which will be consistent with the form required by HHS.

(4) The commissioner will establish an advisory group to provide advice regarding whether the state should operate the risk adjustment program for a future period of benefit year or years.

(a) The advisory group consists of representatives from issuers who participate in the risk adjustment program, the health benefit exchange, and if under contract or otherwise established by the legislature, the designated administrative entity for the state risk adjustment program. If an issuer wishes to participate in the advisory group, it must notify the commissioner in writing of its designated participant not later than May 1st of each year.

(b) The advisory group will meet at the commissioner's discretion.

(5) If HHS does not provide the commissioner with the data submitted by issuers, for a benefit year during which HHS administers the program, within thirty days of its submission to HHS, an issuer must submit to an actuarial firm designated by the commissioner the same data that it submits to HHS for the risk adjustment program. Corrected data must also be submitted. All issuers participating in the risk adjustment program in Washington state, not just those participating in the advisory group, must conform to this requirement.

(a) The data may only be used to perform modeling to assist the advisory group and commissioner in the annual decision-making process described in this section. Modeling done using the data must deidentify both issuers and any enrollees. Each advisory group participant is entitled to review all modeling reports, and upon request, learn which deidentified issuer represents their data set. The actuarial firm may not otherwise disclose the identity of data set sources.

(b) The actuarial firm and each issuer must execute all necessary privacy and security agreements to ensure the confidentiality and privacy of personal health information, establish remedies for unauthorized release or distribution of the data that are consistent with state and federal law, provide for the retention of the data for not less than ten years, and for the destruction of the data after a ten year period of time.

The commissioner will prepare a template agreement for use by the actuarial firm and submitting issuers. The agreement must be identical for each issuer, unless the commissioner specifically agrees to an exception or change requested by an issuer or the actuarial firm for good cause. The commissioner will resolve disputes between the actuarial firm and an issuer.

(c) Where necessary to ensure that data is credible and useful to the modeling, the actuarial firm may issue specific data definition related to requested data submission, and may require submission of additional data to the data submitted to HHS.

(6) Each issuer must accurately report risk adjustment payments received or made under the risk adjustment program as part of a non-grandfathered individual or small group's rate filing.

(7) An issuer that does not submit data to either HHS or the actuarial firm pursuant to this rule, or otherwise fails to comply with the risk adjustment program requirements, is subject to enforcement under Title 48 RCW.

[WSR 16-01-081, recodified as § 284-43-0230, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.43.720. WSR 13-05-025 (Matter No. R 2012-12), § 284-170-002, filed 2/11/13, effective 3/14/13.]

WAC 284-43-0250 Grandfathered health plan status. (1) An issuer must retain in its files all necessary documentation to support its determination that a purchaser's plan is grandfathered. The information must be sufficient to demonstrate that the issuer's determination of grandfathered status is credible. For purposes of this section, "grandfathered plan" means a health plan that meets the requirements of this section and as defined in RCW 48.43.005.

(2) An issuer's documentation supporting grandfathered plan designation must be made available to the commissioner or the U.S. Department of Health and Human Services for review and examination upon request. Beginning with the effective date of this section, for fully insured health plans designated as grandfathered, an issuer must retain the records for a period of not less than ten years. For each plan, the records supporting the issuer's determination must also be made available to participants and beneficiaries upon request.

(3) An issuer's documentation must establish for each grandfathered plan that since March 23, 2010:

(a) The plan was not amended to eliminate all or substantially all the benefits to diagnose or treat a particular condition. A list of all plan benefit amendments that eliminate benefits and the date of the amendment is the minimum level of acceptable documentation that must be available to support this criteria;

(b) The percentage of fixed amount cost-sharing percentage requirements, if applicable, for the plan were not increased when measured from March 23, 2010. A list of each cost-sharing percentage that has been in place for a grandfathered group's plan, beginning with the cost-sharing percentage on March 23, 2010, is the minimum level of acceptable documentation that must be available to support this criteria;

(c) The fixed cost-sharing requirements other than copayments did not increase by a total percentage measured from March 23, 2010, to the date of change that is more than the sum of medical inflation plus fifteen percent. A list of the fixed cost-sharing requirements other than copayments that apply to a grandfathered group's plan beginning on March 23, 2010, and a record of any increase, the date and the amount of the increase, is the minimum level of documentation that must be available to support this criteria;

(d) Copayments did not increase by an amount that exceeds the greater of:

(i) A total percentage measured from March 23, 2010, to the date of change that is more than the sum of medical inflation plus fifteen percent; or

(ii) Five dollars, adjusted annually for medical inflation measured from March 23, 2010. A record of all copayments beginning on March 23, 2010, applicable to a grandfathered group plan, and any changes in the copayment since that date is the minimum level of documentation that must be available to support this criterion.

(e) The employer's contribution rate toward any tier of coverage for any class of similarly situated individuals did not decrease by more than five percent below the contribution rate in place on March

23, 2010, expressed as a percentage of the total cost of coverage. The total cost of coverage must be determined using the methodology for determining applicable COBRA premiums. If the employer's contribution rate is based on a formula such as hours worked, a decrease of more than five percent in the employer's contributions under the formula will cause the plan to lose grandfathered status. The issuer must retain a record of the employer's contribution rate for each tier of coverage, and any changes in that contribution rate, beginning March 23, 2010, as the minimum level of documentation that must be available to support this criteria;

(f) On or after March 23, 2010, the plan was not amended to impose an overall annual limit on the dollar value of benefits that was not in the applicable plan documents on March 23, 2010;

(g) On or after March 23, 2010, the plan was not amended to adopt an overall annual limit at a dollar value that is lower than the dollar value of the lifetime limit for all benefits that was in effect on March 23, 2010; and

(h) The plan was not amended to decrease the dollar value of the annual limit, regardless of whether the plan or health insurance coverage also imposes an overall lifetime limit on the dollar value of all benefits.

(4) In addition to documentation establishing that none of the prohibited changes described in subsection (3) of this section have occurred, an issuer must also make available to the commissioner upon request the following information for each grandfathered plan:

(a) Enrollment records of new employees and members added to the plan after March 23, 2010;

(b) Underwriting rules and guidelines applied to enrollees on or after March 23, 2010; and

(c) Proof of notification to the individual or group of its plan's grandfathered status designation for each year for which the status is claimed.

(5) A change made to a plan before March 23, 2010, but that became effective after March 23, 2010, is permitted without negating a plan's grandfathered status if the change was adopted pursuant to a legally binding contract, state insurance department filing or written plan amendment. If the plan change resulted from a merger, acquisition or similar business action where one of the principal purposes is covering new individuals from the merged or acquired group under a grandfathered health plan, the plan may not be designated as grandfathered.

(6) An issuer may delegate the administrative functions related to documenting or determining grandfathered status designation to a third party. Such delegation does not relieve the issuer of its obligation to ensure that the designation is correctly made, that replacement plans are issued in a timely and compliant manner as required by state or federal law, and that all requisite documentation is kept by the issuer.

(7) If the commissioner determines that an issuer incorrectly designated a group plan as grandfathered, the plan is nongrandfathered, and must be discontinued and replaced with a plan that complies with all relevant market requirements within thirty days. This section does not preclude additional enforcement action.

(8) An issuer must designate on its filings whether a plan is grandfathered or nongrandfathered as required by the Washington state system for electronic rate and form filing (SERFF) filing instructions.

[WSR 16-01-081, recodified as § 284-43-0250, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.43.700, 48.43.715, 48.44.050, 48.46.200, and 45 C.F.R. 150.101(2). WSR 14-01-039 (Matter No. R 2013-13), § 284-170-950, filed 12/11/13, effective 1/11/14.]

WAC 284-43-0270 Market conduct requirements related to grandfathered status. (1) An issuer may allow a group covered by grandfathered health insurance coverage to add new employees to its health benefit plan, and move employees between benefit options at open enrollment without affecting grandfathered status, as long as the group's plan does not change in any way that triggers the loss of grandfathered status as set forth in 45 C.F.R. 147.140 and WAC 284-43-0250.

(2) An issuer must provide a statement in the plan materials provided to participants or beneficiaries describing the benefits provided under the plan, explaining that the group health plan believes it is a grandfathered health plan within the meaning of Section 1251 of the Affordable Care Act, and include contact information for questions and complaints that conforms to the model notice language found in 45 C.F.R. 147.140.

(3) An issuer must not restrict group eligibility to purchase a nongrandfathered plan offered through an association or member-governed group because the group is not affiliated with or does not participate in the association or member-governed group, unless the association or member-governed group meets the requirements of WAC 284-43-0330(1).

(4) WAC 284-43-0250 through 284-43-0330 does not prohibit an issuer from discontinuing a grandfathered plan design and replacing it with a nongrandfathered plan.

(5) An issuer must not limit eligibility based on health status for either grandfathered or nongrandfathered health plans.

[Statutory Authority: RCW 48.02.060. WSR 16-14-106 (Matter No. R 2016-11), § 284-43-0270, filed 7/6/16, effective 8/6/16. WSR 16-01-081, recodified as § 284-43-0270, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.43.700, 48.43.715, 48.44.050, 48.46.200, and 45 C.F.R. 150.101(2). WSR 14-01-039 (Matter No. R 2013-13), § 284-170-952, filed 12/11/13, effective 1/11/14.]

WAC 284-43-0290 Small group coverage market transition requirements. (1) For all nongrandfathered small group plans issued and in effect prior to January 1, 2014, in 2014 issuers must replace issued nongrandfathered small group health benefit plans with health benefit plans approved by the commissioner as follows:

(a) An issuer may elect to withdraw a product pursuant to RCW 48.43.035, and discontinue each health benefit plan in force under that product on the same date, requiring groups to select a replacement plan to be effective on the date of discontinuation; or

(b) An issuer may discontinue a small group's coverage at renewal and offer the full range of plans the issuer offers in the small group market as replacement options, to take effect on the small group's renewal date. For small groups covered by nongrandfathered health benefit plans purchased based on an association or member-governed group

affiliation or membership, the requirements of WAC 284-43-0310 and 284-43-0330 apply;

(c) If an issuer does not have a replacement plan approved by the commissioner to offer in place of the discontinued plan, the issuer must assist each enrollee in identifying a replacement option offered by another issuer.

(2) If an issuer selects the replacement option described in subsection (1)(b) of this section, the issuer must provide the small group plan sponsor with written notice of the discontinuation and replacement options not later than ninety days before the renewal date for the small group's coverage. The commissioner may, for good cause shown, permit a shorter notice period for providing the replacement option information to a group. The written notice must contain the following information:

(a) Specific descriptions of the replacement plans for which the small group and its enrollees are eligible, both on or off the health benefit exchange. At the issuer's discretion, rate information may but is not required to be, included in the notice describing the replacement plans, provided subsequent rating information is provided with renewal;

(b) Electronic link information to the summary of benefits and explanation of coverage for each replacement plan option;

(c) Contact information to access assistance from the issuer in selecting the replacement plan option or answering enrollee questions about the replacement plans made available to them by their employer.

(3) For either replacement option set forth in subsection (1) of this section, the issuer must provide a separate written notice to each enrollee notifying the enrollee that their small group plan coverage will be discontinued and replaced. The notice must be provided not later than ninety days prior to the discontinuation and replacement date.

(4) If an issuer has electronic mail contact information for the small group plan sponsor or the enrollees, the written notice may be provided electronically. The issuer must be able to document to the commissioner's satisfaction both the content and timing of transmission. The issuer must send written notice by U.S. mail to a sponsor or enrollee for whom the electronic mail message was rejected.

(5) An issuer may offer small groups the option to voluntarily discontinue and replace their coverage prior to their renewal date.

(a) An issuer must not selectively offer early renewal to small groups, but must make this option universally available.

(b) An issuer must not alter or change a small group's renewal date to lengthen the period of time before discontinuation and replacement occurs in 2014. For example, if a small group's renewal date is March 31st of each year, the issuer may not adjust the small group's benefit year in 2013 to effect a renewal date of November 30th.

(6) This section applies to each health benefit plan that provides coverage based on receipt of claims for services, even if the coverage falls under one of the categories excepted from the definition of "health plan" as set forth in RCW 48.43.005 (26)(i) and (l). This section does not apply to a health benefit plan that provides per diem or single payment coverage based on a triggering event or diagnosis regardless of the medical necessity of the type or range of services received by an enrollee.

[Statutory Authority: RCW 48.02.060. WSR 16-14-106 (Matter No. R 2016-11), § 284-43-0290, filed 7/6/16, effective 8/6/16. WSR 16-01-081, recodified as § 284-43-0290, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.43.700, 48.43.715, 48.44.050, 48.46.200, and 45 C.F.R. 150.101(2). WSR 14-01-039 (Matter No. R 2013-13), § 284-170-954, filed 12/11/13, effective 1/11/14.]

WAC 284-43-0350 Individual coverage market transition requirements. (1) For all nongrandfathered individual health benefit plans issued and in effect prior to January 1, 2014, during 2014 issuers must replace the plans with health benefit plans approved by the commissioner as follows:

(a) An issuer may elect to withdraw a product, pursuant to RCW 48.43.038, and discontinue each health benefit plan in force under that product on the same date, requiring selection of a replacement plan to be effective on the date of discontinuation; or

(b) An issuer may discontinue an individual's coverage and offer the full range of plans the issuer offers in the individual market as replacement options. The replacement coverage must take effect on the individual's renewal date.

(c) If an issuer does not have a replacement plan approved by the commissioner to offer in place of the discontinued plan, the issuer must assist each enrollee in identifying a replacement option offered by another issuer.

(2) If an issuer selects the replacement option described in subsection (1)(b) of this section, not fewer than ninety days before the renewal date for the coverage, the issuer must provide the individual and each enrollee under the health benefit plan with written notice of the discontinuation and replacement options. The commissioner may, for good cause shown, permit a shorter notice period for providing the replacement option information to a group. The written notice must contain the following information:

(a) Specific descriptions of the replacement plans for which the enrollees are eligible, both on or off the health benefit exchange;

(b) Electronic link information to the summary of benefits and explanation of coverage for each replacement plan option;

(c) Contact information for assistance from the issuer in selecting the replacement plan option or answering enrollee questions about the replacement plans;

(d) If a renewal date is later than January 1, 2014, the issuer's ninety day discontinuation and replacement notice must notify the individual and any other enrollees on the plan of the shortened plan year for 2014 under the replacement coverage.

(3) For either replacement option set forth in subsection (1) of this section, the issuer must provide a separate written notice to each enrollee notifying the enrollee that their existing coverage will be discontinued and replaced. The notice must be provided not later than ninety days prior to the discontinuation and replacement date.

(4) If an issuer has electronic mail contact information for the enrollees, the notice may be provided electronically. The issuer must be able to document to the commissioner's satisfaction both the content and timing of transmission. The issuer must send written notice by U.S. mail to an enrollee for whom the electronic mail message was rejected.

(5) This section applies to each health benefit plan that provides coverage based on receipt of claims for services, even if the coverage falls under one of the categories excepted from the definition of "health plan" as set forth in RCW 48.43.005 (26)(i) and (l). This section does not apply to a health benefit plan that provides per diem or single payment coverage based on a triggering event or diagnosis regardless of the medical necessity of the type or range of services received by an enrollee.

(6) Between September 1st and September 30th of each year, an issuer must provide written notice to each enrollee under an individual health benefit plan of the availability of health benefit exchange coverage, and contact information for the health benefit exchange.

[WSR 16-01-081, recodified as § 284-43-0350, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.43.700, 48.43.715, 48.44.050, 48.46.200, and 45 C.F.R. 150.101(2). WSR 14-01-039 (Matter No. R 2013-13), § 284-170-959, filed 12/11/13, effective 1/11/14.]

SUBCHAPTER B2
CONFIDENTIALITY OF INSURANCE COMMUNICATIONS

WAC 284-43-0400 Purpose and scope. (1) The purpose of this subchapter is to establish uniform regulatory standards for health carriers and to create minimum standards for carriers to adopt policies and procedures that conform administrative, business, and operational practices to protect an enrollee's right to privacy and right to confidential health care services granted under state or federal laws.

(2) This subchapter applies to all health carriers except as otherwise expressly provided in this subchapter. Health carriers are responsible for compliance with the provisions of this subchapter and are responsible for the compliance of any person or organization acting on behalf of or at the direction of the carrier, or acting pursuant to carrier standards or requirements concerning the coverage of, payment for, or administration of health care benefits. A carrier may not offer as a defense to a violation of any provision of this subchapter that the violation arose from the act or omission of a participating provider or facility, network administrator, claims administrator, health care benefit manager, or other person acting on behalf of or at the direction of the carrier, or acting pursuant to carrier standards or requirements under a contract with the carrier rather than from the direct act or omission of the carrier.

[Statutory Authority: RCW 48.02.060, 48.43.505, and 48.43.5051. WSR 20-24-120, § 284-43-0400, filed 12/2/20, effective 1/2/21.]

WAC 284-43-0410 Definitions. (1) "Communications subject to confidentiality" means written, verbal, or electronic communication regarding sensitive health care services, and all health care services if a protected individual has requested to limited disclosure including:

(a) Bills and attempts to collect payment, except for premium billing that does not contain any health information;

(b) A notice of adverse benefit determination;

(c) An explanation of benefits notice;

(d) A carrier's request for additional information regarding a claim;

(e) A notice of contested claim;

(f) The name and address of a provider, a description of services provided, and other visit information; and

(g) Any written, oral, or electronic communication from a carrier that contains protected health information.

(2) "Protected individual" has the same meaning as the definition of protected individual in RCW 48.43.005.

(3) "Sensitive health care services" has the same meaning as the definition of sensitive health care services in RCW 48.43.005.

[Statutory Authority: RCW 48.02.060, 48.43.505, and 48.43.5051. WSR 20-24-120, § 284-43-0410, filed 12/2/20, effective 1/2/21.]

WAC 284-43-0420 Sensitive health care services. (1) A health carrier must direct all communication regarding sensitive health care services, including communications subject to confidentiality, directly to the protected individual. To facilitate communication of these services, a carrier must allow the protected individual to select their preferred communication format unless the format is otherwise specified by law or regulation and may provide sensitive health services communications to the protected individual by:

(a) Health care portal that is only accessible to the protected individual;

(b) Email address, if provided by the protected individual;

(c) Telephone of the protected individual; or

(d) Mail to the address requested by a protected individual, and if no address has been requested, then mail to the known address if the communication and envelope are addressed only to the protected individual.

(2) When a protected individual provides their express written consent or verbal authorization on a recorded line, a health carrier may disclose information concerning sensitive health care services for that protected individual as specified by the protected individual.

(3) A health carrier must establish a process for informing enrollees, including protected individuals, of how communications regarding sensitive health care services are managed, including the process to update the protected individual's contact information.

(a) Health carriers must post a confidentiality request form clearly and conspicuously on its website for individuals to change their communication preferences regarding sensitive health information, such as updating their address, or to select another means of communication. When carriers post the form on their website, or make the form available through other means, the form must accompany clear instructions about how a protected individual or enrollee may submit the form including other means available to change the contact information regarding sensitive health care information. If carriers utilize their own confidentiality request form, then carriers must also provide a link to the form specified for use and made available on the office of the insurance commissioner's website. Carriers must accept the form specified by the commissioner when submitted by an enrollee, authorized representative, or provider acting on behalf of the enrollee.

(b) Health carriers must implement the request and any subsequent request for changes within three business days from receipt of the re-

quest. If a request is incomplete or missing information, the carrier must implement as much of the request as possible, and contact the enrollee to obtain a complete request within three business days.

(4) For the purposes of appealing an adverse benefit determination, a protected individual may request that a health carrier direct sensitive health care communications and communications subject to confidentiality to another individual including, but not limited to, the policyholder, primary subscriber, or health care provider.

(5) Confidentiality of sensitive health care services does not prevent a health carrier from communicating with a provider, health care benefit manager, third-party administrator, another carrier and other HIPAA covered entities when necessary to process claims, state or federal mandated reporting, or for other activities necessary to ensure coverage including, but not limited to, coordination of benefits. If a carrier needs to communicate with a health care benefit manager or third-party administrator, then the health care benefit manager or third-party administrator must first ensure continued confidentiality, including continuing to communicate with the protected individual using their selected method of communication. If a carrier has a need to discuss services with another carrier or insurer, they must notify the other carrier or insurer of these requirements or ensure that they are aware of these requirements and any existing confidentiality requests.

(6) Communications and confidentiality required by this section must be provided according to the terms and requirements set forth in RCW 48.43.505.

[Statutory Authority: RCW 48.02.060, 48.43.505, and 48.43.5051. WSR 20-24-120, § 284-43-0420, filed 12/2/20, effective 1/2/21.]

WAC 284-43-0430 Requests regarding confidentiality and to limit disclosure. (1) When requested by an enrollee, a health carrier must limit disclosure of that enrollee's information, including personal health information and communications subjected to confidentiality. Once limited, a health carrier must communicate directly with the enrollee through the identified physical address, email, telephone number, or carrier portal.

(2) Health carriers must establish a process for informing enrollees, including protected individuals, of the ability to request confidentiality, limit disclosure, and update their contact information. Enrollees must be able to provide a request telephonically, or submit it by email or online, such as through a portal or on the carrier's web page.

(a) Health carriers must post a confidentiality request form clearly and conspicuously on their website for individuals limit disclosure or to change their limits regarding communication preferences, such as updating their address, or selecting another means of communication. When carriers post the form on their website, or make the form available through other means, carriers must ensure that the form is accompanied by clear instructions about how a protected individual or enrollee may submit the form and the process, including other means available to change the enrollee's contact information. If carriers utilize their own confidentiality request form, then carriers must also provide a link to the form specified for use and made available on the office of the insurance commissioner's website. Carriers must accept the form specified by the commissioner when submitted by an en-

rollee, authorized representative, or provider acting on behalf of the enrollee.

(b) Carriers must implement the request and any subsequent request for changes within three business days from receipt of the request. If a request is incomplete or missing information, the carrier must implement as much of the request as possible, and contact the enrollee to obtain a complete request within three business days.

(c) The request must remain in effect until the enrollee revokes or modifies the request in writing.

(3) Requests to limit disclosure do not prevent a health carrier from communicating with a provider, health care benefit manager, third-party administrator, another carrier and other HIPAA covered entities when necessary to process claims, state or federal mandated reporting, or for other activities necessary to ensure coverage including, but not limited to, coordination of benefits. If a carrier needs to communicate with a health care benefit manager or third-party administrator, then the benefit manager or third-party administrator must first ensure continued confidentiality, including continuing to communicate with the enrollee using their selected method of communication. If a carrier has a need to discuss services with another carrier or insurer, they must notify the other carrier or insurer of these requirements or ensure that they are aware of these requirements and any existing confidentiality requests.

(4) Confidentiality required by this section must be provided according to the terms and requirements set forth in RCW 48.43.505.

(5) Carriers must have processes and procedures in place to track information related to confidentiality requests made under the requirements of this subchapter and RCW 48.43.505, including the number of requests received by the carrier and the related time frames for processing the request. Carriers will submit this information to the commissioner when requested.

[Statutory Authority: RCW 48.02.060, 48.43.505, and 48.43.5051. WSR 20-24-120, § 284-43-0430, filed 12/2/20, effective 1/2/21.]

SUBCHAPTER C
OPEN AND SPECIAL ENROLLMENT REQUIREMENTS

WAC 284-43-1020 Special enrollment requirements for small group plans. (1) A "special enrollment period" means a period of time outside the initial or annual group renewal period during which an individual applicant may enroll if the individual has experienced a qualifying event. An issuer must make periods for special enrollment in its small group plans available to an otherwise eligible applicant if the applicant has experienced one of the qualifying events identified in this section.

(2) A qualifying event for special enrollment in small group plans offered on or off the health benefit exchange is one of the following:

(a) The loss of minimum essential benefits, including loss of employer sponsored insurance coverage, or of the coverage of a person under whose policy they were enrolled, unless the loss is based on the individual's voluntary termination of employer sponsored coverage, the misrepresentation of a material fact affecting coverage or for fraud related to the terminated health coverage;

(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 permanent 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 birth, placement for adoption or adoption of the applicant for whom coverage is sought;

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

(g) Loss of individual or group coverage purchased on the health benefit exchange due to an error on the part of the exchange, the issuer or the U.S. Department of Health and Human Services;

(h) Marriage or entering into a domestic partnership, including eligibility as a dependent of an individual marrying or entering into a domestic partnership.

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

(4) An issuer may require reasonable proof or documentation that an individual seeking special enrollment has experienced a qualifying event.

(5) An issuer must offer a special enrollee each benefit package available to members of the group who enrolled when first eligible. A special enrollee cannot be required to pay more for coverage than other members of the group who enrolled in the same coverage when first eligible. Any difference in benefits or cost-sharing requirements constitutes a different benefit package.

(6) An issuer must include detailed information about special enrollment options and rights in its health plan documents provided pursuant to WAC 284-43-5130, and in any policy or certificate of coverage provided to an employer, plan sponsor, or enrollee. The notice must be substantially similar to the model notice provided by the U.S. Department of Labor or the U.S. Department of Health and Human Services.

(7) For children who experience a qualifying event, if the selected plan is not the plan on which the parent is then enrolled, or if the parent does not have coverage, the issuer must permit the parent to enroll when the child seeks enrollment for dependent coverage. An enrolling child must have access to any benefit package offered to employees, even if that requires the issuer to permit the parent to switch benefit packages.

[Statutory Authority: RCW 48.02.060. WSR 16-14-106 (Matter No. R 2016-11), § 284-43-1020, filed 7/6/16, effective 8/6/16. WSR 16-01-081, recodified as § 284-43-1020, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.18.120(2), 48.20.450, 48.43.0211, 48.43.720(3), 48.44.050, 48.46.200, 45 C.F.R. §§ 147.104, 147.106, 155.420, and 155.725. WSR 14-01-042 (Matter No. R 2013-02), § 284-170-410, filed 12/11/13, effective 1/1/14.]

WAC 284-43-1040 Special enrollment periods for small group qualified health plans. (1) Issuers of small group qualified health plans must comply with the additional special enrollment period requirements set forth in 45 C.F.R. 155.420 (b)(2) and 45 C.F.R. 155.725.

(2) In addition to meeting the requirements set forth in WAC 284-43-1020, issuers must include in qualified health plan contract forms and required disclosure documents an explanation of special enrollment rights if one of the following triggering events occurs:

(a) In addition to the requirements for adopted, placed for adoption, and newborn children, the same special enrollment right accrues for foster children and children placed in foster care;

(b) The individual demonstrates to the health benefit exchange that the qualified health plan in which they are enrolled violated a material provision of the coverage contract in relation to the individual;

(c) An individual's enrollment in or nonenrollment in a qualified health plan is unintentional, inadvertent or erroneous, and is the result of the error, misinterpretation or inaction of an officer, employee or agent of the health benefit exchange of the U.S. Department of Health and Human Services, as determined by the health benefit exchange upon evaluation;

(d) In addition to the special enrollment event in WAC 284-43-1020 (2)(d), a change in the individual's residence as the result of a permanent move results in new eligibility for previously unavailable qualified health plans;

(e) For qualified individuals who are an Indian, as defined by Section 4 of the Indian Health Care Improvement Act, enrollment in a qualified health plan or change from one qualified health plan to another must be permitted one time per month, without requiring an additional special enrollment triggering event.

(3) If the health benefit exchange establishes earlier effective dates for special enrollment periods, pursuant to 45 C.F.R. 155.420, an issuer must include in its plan documents and required disclosures an explanation of the effective date for special enrollment periods.

[Statutory Authority: RCW 48.02.060. WSR 16-14-106 (Matter No. R 2016-11), § 284-43-1040, filed 7/6/16, effective 8/6/16. WSR 16-01-081, recodified as § 284-43-1040, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.18.120(2), 48.20.450, 48.43.0211, 48.43.720(3), 48.44.050, 48.46.200, 45 C.F.R. §§ 147.104, 147.106, 155.420, and 155.725. WSR 14-01-042 (Matter No. R 2013-02), § 284-170-412, filed 12/11/13, effective 1/1/14.]

WAC 284-43-1060 Duration and effective dates of small group special enrollment periods. (1) This section applies to nongrandfathered small group plans offered on or off the health benefit exchange.

(2) Special enrollment periods must not be shorter than sixty days from the date of the qualifying event.

(3) The effective date of coverage for those enrolling in a small group plan through a special enrollment period is the first date of the next month after the application for coverage is received, unless one of the following exceptions applies:

(a) For special enrollment of newborn, adopted or placed for adoption children, the date of birth, date of adoption or date of placement for adoption becomes the first effective date of coverage;

(b) For applicants enrolling after the fifteenth of the month, the issuer must begin coverage not later than the first date of the second month after the application is received, unless the applicant is enrolling due to marriage or the commencement of a domestic partnership. An issuer may establish an earlier effective date at their

discretion. An issuer may establish an earlier effective date at their discretion;

(c) For applicants enrolling because of marriage or the commencement of a domestic partnership, when notice of the marriage or domestic partnership is received within sixty days of the marriage or commencement of the domestic partnership, either as spouse, domestic partner or as a dependent child, coverage must begin no later than the first date of the month immediately following the date of marriage or domestic partnership.

(4) An issuer must not refuse to enroll an applicant who applies within sixty days of the qualifying event, if the applicant would be eligible had the application been received during open enrollment.

[WSR 16-01-081, recodified as § 284-43-1060, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.18.120(2), 48.20.450, 48.43.0211, 48.43.720(3), 48.44.050, 48.46.200, 45 C.F.R. §§ 147.104, 147.106, 155.420, and 155.725. WSR 14-01-042 (Matter No. R 2013-02), § 284-170-415, filed 12/11/13, effective 1/1/14.]

WAC 284-43-1080 Individual market open enrollment requirements. (1) For purposes of this section, "open enrollment" means a specific period of time each year during which enrollment in a health benefit plan is permitted. This section applies to plans offered in the individual market.

(2) An issuer must limit the dates for enrollment in plans offered on the individual market off the health benefit exchange to the same time period for open enrollment established by the health benefit exchange.

(3) An issuer must prominently display information on its website about open enrollment periods and special enrollment periods applicable to its plans offered either on or off the health benefit exchange.

(a) The website information about enrollment periods must provide a consumer with the ability to access or request and receive an application packet for enrollment at any time.

(b) The displayed information must include details written in plain language explaining what constitutes a qualifying event for special enrollment.

(4) Written notice of open enrollment must be provided to enrolled persons at some point between September 1st and September 30th of each year.

[WSR 16-01-081, recodified as § 284-43-1080, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.18.120(2), 48.44.050, 48.46.200 and 45 C.F.R. Parts 144, 146 and 147. WSR 14-08-036 (Matter No. R 2014-01), § 284-170-420, filed 3/26/14, effective 4/26/14. Statutory Authority: RCW 48.02.060, 48.18.120(2), 48.20.450, 48.43.0211, 48.43.720(3), 48.44.050, 48.46.200, 45 C.F.R. §§ 147.104, 147.106, 155.420, and 155.725. WSR 14-01-042 (Matter No. R 2013-02), § 284-170-420, filed 12/11/13, effective 1/1/14.]

WAC 284-43-1100 Individual market special enrollment requirements. (1) For a nongrandfathered individual health plan offered on or off the health benefit exchange, an issuer must make a special enrollment period of not less than sixty days available to any person who experiences a qualifying event, permitting enrollment in an indi-

vidual health benefit plan outside the open enrollment period. This requirement applies to plans offered on the health benefit exchange that cover pediatric oral benefits offered as essential health benefits necessary to satisfy minimum essential coverage requirements.

(2) A qualifying event means the occurrence of one of the following:

(a) The loss of minimum essential coverage, including employer sponsored insurance coverage due to action by either the employer or the issuer or due to the individual's loss of eligibility for the employer sponsored coverage, or the loss of the individual or group coverage of a person under whose policy they were enrolled, unless the loss is based on the individual's misrepresentation of a material fact affecting coverage or for fraud related to the discontinued health coverage;

(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 permanent 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 birth, placement for or adoption of the person for whom coverage is sought. For newborns, coverage must be effective from the moment of birth; for those adopted or placed for adoption, coverage must be effective from the date of adoption or placement for adoption, whichever occurs first;

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

(g) Coverage is discontinued in a qualified health plan by the health benefit exchange pursuant to 45 C.F.R. 155.430 and the three month grace period for continuation of coverage has expired;

(h) Exhaustion of COBRA coverage due to failure of the employer to remit premium;

(i) Loss of COBRA coverage where the individual has exceeded the lifetime limit in the plan and no other COBRA coverage is available;

(j) If the person discontinues coverage under a health plan offered pursuant to chapter 48.41 RCW;

(k) Loss of coverage as a dependent on a group plan due to age;

(l) Marriage or entering into a domestic partnership, including eligibility as a dependent of an individual marrying or entering into a domestic partnership.

(3) If the special enrollee had prior coverage, an issuer must offer a special enrollee each of the benefit packages available to individuals who enrolled during the open enrollment period within the same metal tier or level at which the person was previously enrolled. Any difference in benefits or cost-sharing requirements for different individuals constitutes a different benefit package.

(a) A special enrollee cannot be required to pay more for coverage than a similarly situated individual who enrolls during open enrollment.

(b) An issuer may limit a special enrollee who was enrolled in a catastrophic plan as defined in RCW 48.43.005(8) to the plans available during open enrollment at either the bronze or silver level.

(c) An issuer may restrict a special enrollee whose eligibility is based on their status as a dependent to the same metal tier for the plan on which the primary subscriber is enrolled.

(4) An issuer may require reasonable proof or documentation that an individual seeking special enrollment has experienced a qualifying event.

[WSR 16-01-081, recodified as § 284-43-1100, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.18.120(2), 48.20.450, 48.43.0211, 48.43.720(3), 48.44.050, 48.46.200, 45 C.F.R. §§ 147.104, 147.106, 155.420, and 155.725. WSR 14-01-042 (Matter No. R 2013-02), § 284-170-425, filed 12/11/13, effective 1/1/14.]

WAC 284-43-1120 Individual market special enrollment period requirements for qualified health plans. (1) An issuer offering individual qualified health plans on the health benefit exchange must make special enrollment opportunities, subject to the same terms and conditions specified in WAC 284-43-1100, available to applicants who experience a qualifying event.

(2) In addition to the special enrollment qualifying events set forth in WAC 284-43-1100, the following special enrollment opportunities must be made available for individual plans offered on the health benefit exchange:

(a) For qualified individuals who are an Indian, as defined by Section 4 of the Indian Health Care Improvement Act, enrollment in a qualified health plan or change from one qualified health plan to another must be permitted one time per month, without requiring an additional special enrollment triggering event;

(b) The applicant demonstrates to the health benefit exchange that the qualified health plan in which they are enrolled violated a material provision of the coverage contract in relation to the individual;

(c) If applicant lost prior coverage due to errors by the health benefit exchange staff or the U.S. Department of Health and Human Services;

(d) The applicant, or his or her dependent, not previously a citizen, national or lawfully present individual, gains such status. For purposes of this subsection, "dependent" means a dependent as defined in RCW 48.43.005;

(e) The individual becomes newly eligible or newly ineligible for advance payment of premium tax credits, has a change in eligibility for cost-sharing reductions, or the individual's dependent becomes newly eligible. For purposes of (e) and (f) of this subsection, "dependent" means dependent as defined in 26 C.F.R. 54.9801-2;

(f) The individual or their dependent who is currently enrolled in employer sponsored coverage is determined newly eligible for advance payment of premium tax credit pursuant to the criteria established in 45 C.F.R. 155.420 (d)(6)(iii);

(g) In addition to the special enrollment event in WAC 284-43-1100 (2)(d), a change in the individual's residence as the result of a permanent move results in new eligibility for previously unavailable qualified health plans.

(3) An individual who experiences a qualifying event and whose prior coverage was on a catastrophic health plan as defined in RCW 48.43.005 (8)(c)(i) may be limited by the exchange to enrollment in a bronze or silver level plan.

(4) This section must not be interpreted or applied to preclude or limit the health benefit exchange's rights to automatically enroll qualified individuals based on good cause, exceptional circumstances as defined by the health benefit exchange or as required by the U.S. Department of Health and Human Services.

(5) Issuers must comply with the special enrollment event requirements established for qualified health plans offered on the health benefit exchange in 45 C.F.R. 155.420. If the health benefit exchange establishes earlier effective dates for special enrollment periods, pursuant to 45 C.F.R. 155.420, an issuer must include in its plan documents and required disclosures an explanation of the effective date for special enrollment periods.

[Statutory Authority: RCW 48.02.060. WSR 16-14-106 (Matter No. R 2016-11), § 284-43-1120, filed 7/6/16, effective 8/6/16. WSR 16-01-081, recodified as § 284-43-1120, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.18.120(2), 48.20.450, 48.43.0211, 48.43.720(3), 48.44.050, 48.46.200, 45 C.F.R. §§ 147.104, 147.106, 155.420, and 155.725. WSR 14-01-042 (Matter No. R 2013-02), § 284-170-430, filed 12/11/13, effective 1/1/14.]

WAC 284-43-1140 Duration, notice requirements and effective dates of coverage for individual market special enrollment periods. (1) Special enrollment periods must not be shorter than sixty days from the date of the qualifying event.

(2) The effective date of coverage for those enrolling in an individual health plan through a special enrollment period is the first date of the next month after the premium is received by the issuer, unless one of the following exceptions applies:

(a) For those enrolling after the fifteenth of the month, the issuer must begin coverage not later than the first date of the second month after the application is received. Issuers may establish an earlier effective date at their discretion;

(b) For special enrollment of newborn, adopted or placed for adoption children, the date of birth, date of adoption or date of placement for adoption, as applicable, becomes the first effective date of coverage. The same requirement applies to foster children or children placed for foster care on qualified health plans;

(c) For special enrollment based on marriage or the beginning of a domestic partnership, and for special enrollment based on loss of minimum essential coverage, coverage must begin on the first day of the next month.

(3) For individual plans offered either on or off the health benefit exchange, an issuer must include detailed information about special enrollment options and rights in its health plan documents provided pursuant to WAC 284-43-5130, and in the policy, contract or certificate of coverage provided to an employer, plan sponsor or enrollee. The notice must be substantially similar to the model notice provided by the U.S. Department of Health and Human Services.

[Statutory Authority: RCW 48.02.060, 48.18.120(2), 48.20.450, 48.44.050, and 48.46.200. WSR 17-01-145 (Matter No. R 2016-21), § 284-43-1140, filed 12/20/16, effective 1/20/17. Statutory Authority: RCW 48.02.060. WSR 16-14-106 (Matter No. R 2016-11), § 284-43-1140, filed 7/6/16, effective 8/6/16. WSR 16-01-081, recodified as § 284-43-1140, filed 12/14/15, effective 12/14/15. Statutory Authority:

RCW 48.02.060, 48.18.120(2), 48.20.450, 48.43.0211, 48.43.720(3), 48.44.050, 48.46.200, 45 C.F.R. §§ 147.104, 147.106, 155.420, and 155.725. WSR 14-01-042 (Matter No. R 2013-02), § 284-170-435, filed 12/11/13, effective 1/1/14.]

SUBCHAPTER D
PRIOR AUTHORIZATION AND UTILIZATION REVIEW

WAC 284-43-2000 Health care services utilization review—Generally. (1) Unless provided otherwise in this chapter or chapter 284-170 WAC with respect to utilization review of prescription drug services, this section governs issuer utilization review programs.

(2) These definitions apply to this section:

(a) "Concurrent care review request" means:

(i) Any request for an extension of a previously authorized inpatient stay or a previously authorized ongoing outpatient service, e.g., physical therapy, home health, etc.; and

(ii) Any request for authorization of continued withdrawal management or extension of inpatient or residential substance use disorder treatment services, including during the period of time that a behavioral health agency is arranging a transfer to an appropriate facility or lower level of care following an initial period of treatment under RCW 48.43.761.

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

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

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

(5) Each issuer when conducting utilization review must:

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

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

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

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

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

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

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

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

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

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

(6) Each issuer must reimburse reasonable costs of medical record duplication for reviews.

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

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

(b) If the review request from the provider or facility is not accompanied by all necessary information, the issuer must tell the provider or facility what additional information is needed and the deadline for its submission. Upon the sooner of the receipt of all necessary information or the expiration of the deadline for providing information, the time frames for issuer review determination and notification must be no less favorable than federal Department of Labor standards, as follows. For urgent inpatient services that require concurrent review, the time frame is as soon as possible, taking into account the medical exigencies, and no later than twenty-four hours, provided that the request is made at least twenty-four hours prior to the expiration of previously approved period of time or number of treatments. For postservice review requests, within thirty calendar days.

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

(i) Information about whether a request was approved or denied must be made available to the provider or facility, and enrollee. Issuers must at a minimum make the information available on their website or from their call center.

(ii) Whenever there is an adverse determination the issuer must notify the provider or facility and the enrollee. The issuer must inform the parties in advance whether it will provide notification by phone, mail, fax, or other means.

(iii) Whenever the adverse determination relates to a protected individual, as defined in RCW 48.43.005, the issuer must follow RCW 48.43.505.

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

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

(8) Concurrent care review requests related to authorization for coverage of continued withdrawal management or extension of inpatient or residential substance use disorder treatment services also must adhere to the requirements of RCW 48.43.761. In the event of a conflict between RCW 48.43.761 and the requirements of subsections (4) through (8) of this section, RCW 48.43.761 governs.

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

[Statutory Authority: RCW 48.02.060, 48.20.460, 48.43.0128, 48.44.050, and 48.46.200. WSR 20-24-040, § 284-43-2000, filed 11/23/20, effective 12/24/20. Statutory Authority: RCW 48.02.060, 48.43.510, 48.43.515, 48.43.520, 48.43.525, 48.43.530, and 48.165.030. WSR 17-12-069 (Matter No. R 2016-19), § 284-43-2000, filed 6/5/17, effective 1/1/18. Statutory Authority: RCW 48.02.060, 48.43.510, and 48.165.0301. WSR 16-11-074 (Matter No. R 2016-02), § 284-43-2000, filed 5/16/16, effective 1/1/17. WSR 16-01-081, recodified as § 284-43-2000, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.165.0301, 48.43.525, 48.43.530, 48.44.020, 48.44.050, 48.46.060(2), and 48.46.200. WSR 15-24-074 (Matter No. R 2014-13), § 284-43-410, filed 11/25/15, effective 7/1/16. Statutory Authority: RCW 48.02.060, 48.43.530, P.L. 111-148 (2010, as amended) and regulations issued on June 24, 2011, amending 45 C.F.R. Part 147. WSR 11-24-004 (Matter No. R 2011-18), § 284-43-410, filed 11/28/11, effective 12/29/11. Statutory Authority: RCW 48.02.060 and 48.43.520. WSR 10-23-051 (Matter No. R 2009-19), § 284-43-410, filed 11/10/10, effective 12/11/10. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.100, 48.46.200, 48.43.505, 48.43.510, 48.43.515, 48.43.520, 48.43.525, 48.43.530, 48.43.535. WSR 01-03-033 (Matter No. R 2000-02), § 284-43-410, filed 1/9/01, effective 7/1/01.]

WAC 284-43-2020 Drug utilization review—Generally. (1) These definitions apply to the prescription drug utilization management timelines covered in this section only, excluding prescription drug prior authorization timelines, which are covered in WAC 284-43-2050:

(a) "Nonurgent review request" means any request for approval of care or treatment, or a renewal of a previously approved request that is not an urgent care request.

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

(2) Each issuer must maintain a documented drug utilization review program that meets the definitions and requirements of RCW

48.43.400 and 48.43.410. "Utilization review" has the same meaning as defined in RCW 48.43.005. The program must include a method for reviewing and updating criteria. Issuers must make drug review criteria available upon request to a participating provider. Beginning January 1, 2021, an issuer must post its clinical review criteria for prescription drugs and the drug utilization management exception process on its website. An issuer must also require any entity performing prescription drug benefit administration on the issuer's behalf to post the drug utilization management exception process and clinical review criteria used for the issuer's enrollees on the entity's website. The review criteria must be accessible to both providers and enrollees and presented in plain language that is understandable to both providers and enrollees. The clinical review criteria must include all rules and criteria related to the prescription drug utilization management exception process including the specific information and documentation that must be submitted by a health care provider or enrollee to be considered a complete exception request.

(3) The drug utilization review program must meet accepted national certification standards such as those used by the National Committee for Quality Assurance except as otherwise required by this chapter.

(4) The drug utilization review program must have staff who are properly qualified, trained, supervised, and supported by explicit written clinical review criteria and review procedures.

(5) Each issuer must have written procedures to assure that reviews are conducted in a timely manner.

(a) If the review request from a provider or enrollee is not accompanied by all necessary information, the issuer must tell the provider or enrollee what additional information is needed and the deadline for its submission. Upon the sooner of the receipt of all necessary information or the expiration of the deadline for providing information, the time frames for issuer determination and notification must be no less favorable than United States Department of Labor standards, and are as follows:

(i) For urgent care review requests:

(A) Must approve the request within 48 hours if the information provided is sufficient to approve the claim;

(B) Must deny the request within 48 hours if the requested service is not medically necessary and the information provided is sufficient to deny the claim; or

(C) Within 24 hours, if the information provided is not sufficient to approve or deny the claim, the issuer must request that the provider submits additional information to make the utilization management determination:

(I) The issuer must give the provider 48 hours to submit the requested information;

(II) The issuer must then approve or deny the request within 48 hours of the receipt of the requested additional information and include the authorization number in its approval;

(ii) For nonurgent care review requests:

(A) Must approve the request within five calendar days if the information is sufficient to approve the claim and include the authorization number in its approval;

(B) Must deny the request within five calendar days if the requested service is not medically necessary and the information provided is sufficient to deny the claim; or

(C) Within five calendar days, if the information provided is not sufficient to approve or deny the claim, the issuer must request that the provider submits additional information to make the utilization management determination:

(I) The issuer must give the provider five calendar days to submit the requested additional information;

(II) The issuer must then approve or deny the request within four calendar days of the receipt of the additional information and include the authorization number in its approval.

(b) Notification of the utilization management determination must be provided as follows:

(i) Information about whether a request was approved must be made available to the provider;

(ii) Whenever there is an adverse determination resulting in a denial the issuer must notify the requesting provider by one or more of the following methods; phone, fax and/or secure electronic notification, and the covered person in writing or via secure electronic notification. Status information will be communicated to the billing pharmacy, via electronic transaction, upon the issuer's receipt of a claim after the request has been denied. The issuer must transmit these notifications within the time frames specified in (a)(i) and (ii) of this subsection in compliance with United States Department of Labor standards.

(6) When a provider or enrollee requests an exception to an issuer's drug utilization program, the urgent and nonurgent time frames established in RCW 48.43.420, WAC 284-43-2021 and 284-43-2022 shall apply.

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

[Statutory Authority: RCW 48.02.060, 48.43.0161, and 48.43.520. WSR 25-02-084 (Matter R 2024-03), s 284-43-2020, filed 12/27/24, effective 1/27/25. Statutory Authority: RCW 48.02.060, 48.43.400, 48.43.410, and 48.43.420. WSR 20-24-105, § 284-43-2020, filed 12/1/20, effective 1/1/21. WSR 16-01-081, recodified as § 284-43-2020, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.165.0301, 48.43.525, 48.43.530, 48.44.020, 48.44.050, 48.46.060(2), and 48.46.200. WSR 15-24-074 (Matter No. R 2014-13), § 284-43-420, filed 11/25/15, effective 7/1/16.]

WAC 284-43-2021 Prescription drug utilization management exception and substitution process. (1) For purposes of this section and WAC 284-43-2022:

(a) "Emergency fill" means a limited dispensed amount of medication that allows time for the processing of prescription drug utilization management.

(b) "Medically appropriate" means prescription drugs that under the applicable standard of care are appropriate:

(i) To improve or preserve an enrollee's health, life, or function;

(ii) To slow the deterioration of an enrollee's health, life, or function; or

(iii) For the early screening, prevention, evaluation, diagnosis, or treatment of a disease, condition, illness, or injury.

(2) Beginning January 1, 2021, a carrier must establish an exception request program so that enrollees and providers may request substitution of a preferred drug, therapy or medication, and exceptions to prescription drug benefit limitations and procedures under a carrier's drug utilization management program. The process must include both nonurgent and urgent exception request procedures.

(3) A carrier must treat an exception request as urgent when an enrollee is experiencing a health condition that may seriously jeopardize the enrollee's life, health or ability to regain maximum function, or when the enrollee is undergoing a current course of treatment using a nonformulary drug.

(4) A carrier's exception request standards, procedures and the process description must be available to the commissioner for review upon request. A carrier must require any entity the carrier uses to administer its prescription drug benefit or to make coverage decisions for prescription drug, therapy, or medication coverage, to comply with the carrier's exception process requirements. Neither the exception request process criteria nor the type or volume of documentation required to support an exception request may be unreasonably burdensome to the enrollee or their provider.

(5) The exception request procedures must:

(a) Clearly explain the process a provider and enrollee may use to request approval from the carrier, or any entity providing benefit administration, to substitute one drug, therapy or medication for another drug, therapy or medication on both an urgent and nonurgent basis.

(b) Explain how the exception process provides an enrollee with access to drugs, therapies, or medication that are both on and off the carrier's formulary.

(c) Permit an enrollee and their provider to use the exception request process when a formulary's tiering structure changes during the year and an enrollee is using a drug affected by the change.

(d) Permit a request for an exception to utilization management restrictions applied by the carrier or any entity providing benefit administration, such as a requirement for step therapy, dosage limitations, or therapeutic substitution.

(e) Permit substitution coverage for nonspecialty and specialty drugs, biologics, self-administered medication, and off-label prescriptions of medications, which means a prescription of a medication, drug, or therapy for an indication that deviates significantly from the approved U.S. Food and Drug Administration labeling. An indication is defined as a diagnosis, illness, injury, syndrome, condition or other clinical parameter for which a drug may be given. A carrier is not required to permit substitution coverage for vaccines.

(6) A carrier must not establish a special formulary tier or copayment or other cost-sharing requirement that is only applicable to prescription drugs approved for coverage under an exception request. When an enrollee or their provider requests a formulary or tiering exception to obtain a nonpreferred drug that is in a higher cost-sharing tier, a carrier may apply the cost-share for the substituted drug based on the substituted drug's placement on the formulary. For a drug that is not on the formulary, the carrier must apply the enrollee's share of cost to their out-of-pocket maximum calculations. A carrier's prescription drug benefit must include a description of the enrollee's

cost-share obligation for off-formulary coverage of substituted drugs, therapies, or medications accessed through the exception process.

(7) A carrier must not require the enrollee to submit a new exception request for a refill if the enrollee's prescribing physician or other prescriber continues to prescribe the drug and the drug continues to be approved by the U.S. Food and Drug Administration for treating the enrollee's disease or medical condition, or if the drug was prescribed as part of the enrollee's participation in a clinical trial.

(a) If the substituted drug is for an off-label drug use, a carrier may require the enrollee to submit a new exception request when a prescription fill and renewal cycle ends.

(b) A carrier may require an enrollee to try an AB-rated generic equivalent or a biological product that is an interchangeable biological product prior to providing coverage for the equivalent branded prescription drug.

(c) A carrier must consider exception requests for a U.S. Food and Drug Administration approved drug used for purposes other than what is indicated on the official label if the use is medically acceptable. A carrier must take into consideration major drug compendia, authoritative medical literature, and accepted standards of practice when making its decision.

(8) Subject to the terms and conditions of the policy that otherwise limit or exclude coverage, the carrier must grant the exception request if it can determine at least one of the following from the information submitted by a provider or enrollee in support of the exception request:

(a) The enrollee does not tolerate the covered generic or formulary drug or such drug is contraindicated;

(b) The enrollee's provider has determined that the covered generic or formulary drug is not therapeutically efficacious for an enrollee. A carrier may require the provider to submit specific clinical documentation as part of the exception request;

(c) The enrollee's provider has determined clinically efficacious treatment requires a dosage that differs from a carrier's formulary dosage limitation for the covered drug. A carrier may require the provider to submit specific clinical documentation as part of the exception request and must review that documentation prior to making a decision;

(d) The enrollee has tried the required prescription drug or another prescription drug in the same pharmacologic class or a drug with the same mechanism of action and, based on the enrollee's documented history, establishes to their provider's satisfaction that they discontinued use of that drug because it was not therapeutically efficacious, effective, had a diminished effect or caused the enrollee an adverse event. A carrier may not deny an exception request solely on the basis that the enrollee's prior use of the required or preferred drug was not within a specific time frame;

(e) The provider has determined that changing from a currently prescribed drug to a drug required by the carrier's formulary management protocols may cause clinically predictable adverse reactions, or physical or mental harm to the enrollee. A carrier's exception program must include uniform standards for the type of clinical documentation required to establish that an adverse reaction, or physical or mental harm is clinically predictable; or

(f) The drug required by the carrier's formulary management protocols is not in the best interest of the enrollee. To grant an excep-

tion request under this standard, a carrier must require submission of documentation of medical appropriateness, including an explanation of why the provider expects the enrollee's use of the required drug to either create a barrier to the enrollee's adherence to or compliance with their plan of care, to negatively impact a comorbid condition of the enrollee, to cause a clinically predictable negative drug interaction or to decrease the enrollee's ability to achieve or maintain reasonable functional ability in performing daily activities.

(9) A carrier must include specific direction in its process explaining how an enrollee may request coverage for an emergency fill of a substitute drug, therapy or medication. A carrier must cover an emergency fill if the treating health care provider determines that the emergency fill is necessary to keep the enrollee stable while the exception request is being processed.

(a) A carrier is not required to grant an exception request for a substitute drug on the basis that an emergency fill was requested.

(b) The emergency fill exception request process in subchapter D of this chapter provides an exception to the carrier's emergency fill policy as required by WAC 284-170-470(8).

[Statutory Authority: RCW 48.02.060, 48.43.400, 48.43.410, and 48.43.420. WSR 20-24-105, § 284-43-2021, filed 12/1/20, effective 1/1/21.]

WAC 284-43-2022 Time frame for exception and substitution request determinations. (1) A carrier must make an exception request determination in a timely manner as defined in this section. A carrier may not deny the exception request if the enrollee or provider does not receive a response to an exception request within the time frames in this section.

(2) A carrier must maintain a sufficient record of each exception request to establish its compliance with the required exception process and time frames under chapter 284-43 WAC and RCW 48.43.420. Upon the commissioner's request, a carrier must make all records and documentation available and produce all requested documentation from any entity providing benefit administration or exception request decisions on its behalf within the time frame set by the commissioner.

(3) If a provider fails to submit sufficient information for the carrier to approve or deny an exception request, a carrier must notify the provider of the specific information needed within three business days of receiving a nonurgent exception request and one business day of receiving an urgent exception request. A carrier must notify the provider that the documentation is insufficient and must explain what information is missing. A carrier may establish a specific reasonable time frame for submission of the additional information. This time frame must be communicated to the provider or enrollee with a carrier's request for additional information. If the additional information is not received within that time frame, a carrier may deny the request.

(4) When a carrier receives sufficient information to make a decision regarding a nonurgent exception request, a carrier must make its determination and notify the enrollee or the enrollee's designee and the prescribing provider (or other prescriber, as appropriate) no later than three business days following receipt of the request.

(5) When a carrier receives sufficient information to make a decision regarding an urgent exception request, a carrier must make its

determination and notify the enrollee or the enrollee's designee and the prescribing provider (or other prescriber, as appropriate) no later than one business day following receipt of the request.

(6) Use of a carrier's exception process is not a grievance or appeal pursuant to RCW 48.43.530 and 48.43.535. Denial of an exception request is an adverse benefit determination, and an enrollee, their representative provider or facility, or representative may request review of that decision using a carrier's appeal or adverse benefit determination review process.

(7) A carrier's denial of an exception request is subject to the requirements of RCW 48.43.535 and chapter 284-43A WAC, which grants enrollees access to independent external review of carrier decisions to deny, modify, reduce or terminate coverage of or payment for a health care service or if the carrier exceeds the timelines for making an exception request decision and denies coverage. While the external review is conducted, the carrier must cover the drug if the exception request was urgent or was for an emergency fill. If such an exigency ceases, any drug previously covered under such exigency may only be reauthorized through the standard exception request process. If the independent external review reverses the carrier's denial of either an urgent or nonurgent exception request, the carrier must retrospectively cover the nonformulary drug and continue coverage for the duration of the prescription.

(8) A carrier may not penalize or threaten a provider with a reduction in future payment or termination of a participating provider agreement because the provider disputes a carrier's determination with respect to coverage or payment for a substitute drug.

[Statutory Authority: RCW 48.02.060, 48.43.400, 48.43.410, and 48.43.420. WSR 20-24-105, § 284-43-2022, filed 12/1/20, effective 1/1/21.]

WAC 284-43-2050 Prior authorization processes. (1) This section applies to health benefit plans as defined in RCW 48.43.005, contracts for limited health care services as defined in RCW 48.44.035, and stand-alone dental and stand-alone vision plans. This section applies to plans issued or renewed on or after January 1, 2018. Unless stated otherwise, this section does not apply to prescription drug services. For health plans as defined in RCW 48.43.005, carriers must meet the requirements of RCW 48.43.830 in addition to the requirements in this section.

(2) A carrier or its designated or contracted representative must maintain a documented prior authorization program description and use evidence-based clinical review criteria. A carrier or its designated or contracted representative must make determinations in accordance with the carrier's current clinical review criteria and use the medical necessity definition stated in the enrollee's plan. The prior authorization program must include a method for reviewing and updating clinical review criteria. A carrier is obligated to ensure compliance with prior authorization requirements, even if they use a third-party contractor. A carrier is not exempt from these requirements because it relied upon a third-party vendor or subcontracting arrangement for its prior authorization program. A carrier or its designated or contracted representative is not required to use medical evidence or standards in its prior authorization of religious nonmedical treatment or religious nonmedical nursing care.

(3) A prior authorization program must meet standards set forth by a national accreditation organization including, but not limited to, National Committee for Quality Assurance (NCQA), URAC, Joint Commission, and Accreditation Association for Ambulatory Health Care in addition to the requirements of this chapter. A prior authorization program must have staff who are properly qualified, trained, supervised, and supported by explicit written, current clinical review criteria and review procedures.

(4) Effective November 1, 2019, a carrier or its designated or contracted representative must have a current and accurate online prior authorization process. All parts of the process that utilize personally identifiable information must be accessed through a secure online process. The online process must be accessible to a participating provider and facility so that, prior to delivering a service, a provider and facility will have enough information to determine if a service is a benefit under the enrollee's plan and the information necessary to submit a complete prior authorization request. A carrier with an integrated delivery system is not required to comply with this subsection for the employees participating in the integrated delivery system. The online process must provide the information required for a provider or facility to determine for an enrollee's plan for a specific service:

(a) If a service is a benefit;

(b) If a prior authorization request is necessary;

(c) What, if any preservice requirements apply; and

(d) If a prior authorization request is necessary, the following information:

(i) The clinical review criteria used to evaluate the request; and

(ii) Any required documentation.

(5) Effective November 1, 2019, in addition to other methods to process prior authorization requests, a carrier or its designated or contracted representative that requires prior authorization for services must have a secure online process for a participating provider or facility to complete a prior authorization request and upload documentation if necessary. A carrier with an integrated delivery system is not required to comply with this subsection for the employees participating in the integrated delivery system.

(6) Except for an integrated delivery system, a carrier or its designated or contracted representative must have a method that allows an out-of-network provider or facility to:

(a) Have access to any preservice requirements; and

(b) Request a prior authorization if prior authorization is required for an out-of-network provider or facility.

(7) A carrier or its designated or contracted representative that requires prior authorization for any service must allow a provider or facility to submit a request for a prior authorization at all times, including outside normal business hours.

(8) A carrier or its designated or contracted representative is responsible for maintaining a system of documenting information and supporting evidence submitted by a provider or facility while requesting prior authorization. This information must be kept until the claim has been paid or the appeals process has been exhausted.

(a) Upon request of the provider or facility, a carrier or its designated or contracted representative must remit to the provider or facility written acknowledgment of receipt of each document submitted

by a provider or facility during the processing of a prior authorization request.

(b) When information is transmitted telephonically, a carrier or its designated or contracted representative must provide written acknowledgment of the information communicated by the provider or facility.

(9) A carrier or its designated or contracted representative must have written policies and procedures to assure that prior authorization determinations for a participating provider or facility are made within the appropriate time frames.

(a) Time frames must be appropriate to the severity of the enrollee condition and the urgency of the need for treatment, as documented in the prior authorization request.

(b) If the request from the participating provider or facility is not accompanied by all necessary information, the carrier or its designated or contracted representative must inform the provider or facility what additional information is needed and the deadline for its submission as set forth in this section.

(10) For health plans as defined in RCW 48.43.005, the prior authorization time frames for health care services and prescription drugs in RCW 48.43.830 apply.

(a) For purposes of the prior authorization time frames in RCW 48.43.830 and this subsection, the following definitions apply:

(i) "Electronic prior authorization request" means a prior authorization request that is delivered through a two-way communication system that meets the requirements of a secure online prior authorization process or an interoperable electronic process or prior authorization application programming interface.

(ii) "Nonelectronic prior authorization request" means a prior authorization request other than an electronic prior authorization request including, but not limited to, requests delivered through email, a phone call, a text message, a fax, or U.S. mail.

(b) If insufficient information has been provided to the carrier to make a prior authorization determination and the carrier requests additional information from the provider or facility under RCW 48.43.830, the initial prior authorization request time frames in RCW 48.43.830 apply once the carrier has the necessary information to make a determination. Those time frames are as follows:

(i) For electronic standard prior authorization requests, the carrier shall make a decision and notify the provider or facility of the results of the decision within three calendar days, excluding holidays, of receiving the necessary information needed to make the determination.

(ii) For electronic expedited prior authorization requests, the carrier shall make a decision and notify the provider or facility of the results of the decision within one calendar day of receiving the necessary information needed to make the determination.

(iii) For nonelectronic standard prior authorization requests, the carrier shall make a decision and notify the provider or facility of the results of the decision within five calendar days of receiving the necessary information needed to make the determination.

(iv) For nonelectronic expedited prior authorization requests, the carrier shall make a decision and notify the provider or facility of the results of the decision within two calendar days of receiving the necessary information needed to make the determination.

(11) For purposes of compliance with RCW 48.43.830 effective January 21, 2027, health plans must:

(a) Establish and maintain a prior authorization application programming interface that is consistent with final rules issued by the federal Centers for Medicare and Medicaid Services and published in the federal register, and that indicates that a prior authorization denial or authorization of a service less intensive than that included in the original request is an adverse benefit determination and is subject to the carrier's grievance and appeal process under RCW 48.43.535; and

(b) For prior authorization of prescription drugs, a health plan must utilize the fast health care interoperability resources application programming interface for prescription drugs covered under a health plan's medical benefit; and

(c) A carrier may adopt an interoperable electronic process that complies with standards developed by the National Council for Prescription Drug Programs as an alternative to use of the fast health care interoperability resources application programming interface for prior authorization of drugs covered under a health plan's prescription drug benefit.

(12) For limited health care services contracts as defined in RCW 48.44.035, stand-alone dental plans, and stand-alone vision plans, the time frames for carrier prior authorization determination and notification to a participating provider or facility are as follows:

(a) For standard prior authorization requests:

(i) The carrier or its designated or contracted representative must make a decision and provide notification within five calendar days.

(ii) If insufficient information has been provided to a carrier or its designated or contracted representative to make a decision, the carrier or its designated or contracted representative has five calendar days to request additional information from the provider or facility.

(A) The carrier or its designated or contracted representative must give a provider or facility five calendar days to give the necessary information to the carrier or its designated or contracted representative.

(B) The carrier or its designated or contracted representative must then make a decision and give notification within four calendar days of the receipt of the information or the deadline for receiving information, whichever is sooner.

(b) For expedited prior authorization requests:

(i) The carrier or its designated or contracted representative must make a decision and provide notification within two calendar days.

(ii) If insufficient information has been provided to a carrier or its designated or contracted representative to make a decision, the carrier or its designated or contracted representative has one calendar day to request additional information from the provider or facility.

(A) The carrier or its designated or contracted representative must give a provider or facility two calendar days to give the necessary information to the carrier or its designated or contracted representative.

(B) The carrier or its designated or contracted representative must then make a decision and give notification within two calendar days of the receipt of the information or the deadline for receiving information, whichever is sooner.

(iii) If the time frames for the approval of an expedited prior authorization are insufficient for a provider or facility to receive approval prior to the preferred delivery of the service, the prior authorization should be considered an extenuating circumstance as defined in WAC 284-43-2060.

(13) A carrier or its designated or contracted representative when conducting prior authorization must:

(a) Accept any evidence-based information from a provider or facility that will assist in the authorization process;

(b) Collect only the information necessary to authorize the service and maintain a process for the provider or facility to submit such records;

(c) If medical records are requested, require only the section(s) of the medical record necessary in that specific case to determine medical necessity or appropriateness of the service to be delivered, to include admission or extension of stay, frequency or duration of service; and

(d) Base review determinations on the medical information in the enrollee's records and obtained by the carrier up to the time of the review determination.

(14) When a provider or facility makes a request for the prior authorization, the response from the carrier or its designated or contracted representative must state if it is approved or denied. If the request is denied, the response must give the specific reason for the denial in clear and simple language. If the reason for the denial is based on clinical review criteria, the criteria must be provided. Written notice of the decision must be communicated to the provider or facility, and the enrollee. A decision may be provided orally, but subsequent written notice must also be provided. A denial must include the department and credentials of the individual who has the authorizing authority to approve or deny the request. A denial must also include a phone number to contact the authorizing authority and a notice regarding the enrollee's appeal rights and process.

Whenever the prior authorization relates to a protected individual, as defined in RCW 48.43.005, the health carrier must follow RCW 48.43.505.

(15) A prior authorization approval notification for all services must inform the requesting provider or facility, and the enrollee, whether the prior authorization is for a specific provider or facility. The notification must also state if the authorized service may be delivered by an out-of-network provider or facility and if so, disclose to the enrollee the financial implications for receiving services from an out-of-network provider or facility.

Whenever the notification relates to a protected individual, as defined in RCW 48.43.005, the health carrier must follow RCW 48.43.505.

(16) A provider or facility may appeal a prior authorization denial to the carrier or its designated or contracted representative.

(17) Prior authorization determinations shall expire no sooner than 45 days from date of approval. This requirement does not supersede RCW 48.43.039.

(18) In limited circumstances when an enrollee has to change plans due to a carrier's market withdrawal as defined in RCW 48.43.035 (4)(d) and 48.43.038 (3)(d), the subsequent carrier or its designated or contracted representative must recognize the prior authorization of the previous carrier until the new carrier's prior authorization process has been completed and its authorized treatment plan has been ini-

tiated. The subsequent carrier or its designated or contracted representative must ensure that the enrollee receives the previously authorized initial service as an in-network service. Enrollees must present proof of the prior authorization.

(a) For medical services, a carrier or its designated or contracted representative must recognize a prior authorization for at least 30 days or the expiration date of the original prior authorization, whichever is shorter.

(b) For pharmacy services, a carrier or its designated or contracted representative must recognize a prior authorization for the initial fill, or until the prior authorization process of the new carrier or its designated or contracted representative has been completed.

(19) Prior authorization for a facility-to-facility transport that requires prior authorization can be performed after the service is delivered. Authorization can only be based on information available to the carrier or its designated or contracted representative at the time of the prior authorization request.

(20) A carrier or its designated or contracted representative must have a prior authorization process that allows specialists the ability to request a prior authorization for a diagnostic or laboratory service based upon a review of medical records in advance of seeing the enrollee.

(21) A carrier or its designated or contracted representative must have a method that allows an enrollee, provider or facility to make a predetermination request when provided for by the plan.

(22) Predetermination notices must clearly disclose to the enrollee and requesting provider or facility, that the determination is not a prior authorization and does not guarantee services will be covered. The notice must state "A predetermination notice is not a prior authorization and does not guarantee services will be covered." Predetermination notices must be delivered within five calendar days of receipt of the request. Predetermination notices will disclose to a provider or facility for an enrollee's plan:

(a) If a service is a benefit;

(b) If a prior authorization request is necessary;

(c) If any preservice requirements apply;

(d) If a prior authorization request is necessary or if a medical necessity review will be performed after the service has been delivered, the following information:

(i) The clinical review criteria used to evaluate the request; and

(ii) Any required documentation.

(e) Whenever a predetermination notice relates to a protected individual, as defined in RCW 48.43.005, the health carrier must follow RCW 48.43.505.

[Statutory Authority: RCW 48.02.060, 48.49.110, 2024 c 366, 2025 c 25, and 2025 c 171. WSR 26-01-148 (Matter R 2025-12), s 284-43-2050, filed 12/19/25, effective 1/19/26. Statutory Authority: RCW 48.02.060, 48.43.0161, and 48.43.520. WSR 25-02-084 (Matter R 2024-03), s 284-43-2050, filed 12/27/24, effective 1/27/25. Statutory Authority: RCW 48.02.060, 48.43.505, and 48.43.5051. WSR 20-24-120, § 284-43-2050, filed 12/2/20, effective 1/2/21. Statutory Authority: RCW 48.02.060, 48.43.510, 48.43.515, 48.43.520, 48.43.525, 48.43.530, and 48.165.030. WSR 17-12-069 (Matter No. R 2016-19), § 284-43-2050, filed 6/5/17, effective 1/1/18.]

WAC 284-43-2060 Extenuating circumstances in prior authorization. (1) This section applies to health benefit plans as defined in RCW 48.43.005, contracts for limited health care services as defined in RCW 48.44.035, and stand-alone dental and stand-alone vision plans. This section applies to plans issued or renewed on or after January 1, 2018.

(2) A carrier or its designated or contracted representative must have an extenuating circumstances policy which eliminates the administrative requirement for a prior authorization of services when an extenuating circumstance prevents a participating provider or facility from obtaining a required prior authorization before a service is delivered.

(3) For purposes of this section, an extenuating circumstance means an unforeseen event or set of circumstances which adversely affects the ability of a participating provider or facility to request prior authorization prior to service delivery.

(4) When a carrier or its designated contracted representative is notified of the occurrence of an extenuating circumstance by a participating provider or facility, either before a claim is submitted or at the initiation of an appeal, the carrier or its designated or contracted representative must process the claim or appeal without any administrative requirement for a prior authorization.

(5) The following situations are extenuating circumstances and must be included in the extenuating circumstances policy:

(a) A participating provider or facility is unable to identify from which carrier or its designated or contracted representative to request a prior authorization;

(b) A participating provider or facility is unable to anticipate the need for a prior authorization before or while performing a service; and

(c) An enrollee is discharged from a facility and insufficient time exists for institutional or home health care services to receive approval prior to delivery of the service.

(6) A carrier or its designated or contracted representative may require a participating provider or facility to follow certain policies and procedures in order for services to qualify as an extenuating circumstance, such as requirements for documentation or a time frame for claims submission. The policies and procedures that participating providers and facilities must follow in order to submit a claim (or initiate an appeal) for a service that qualifies as an extenuating circumstance must be posted online. Claims and appeals related to an extenuating circumstance may still be reviewed for appropriateness, level of care, effectiveness, benefit coverage and medical necessity under the criteria for the applicable plan, based on the information available to the provider or facility at the time of treatment.

(7) Requirements of WAC 284-43-2000 apply to extenuating circumstances.

(8) This section does not apply to prescription drug services.

[Statutory Authority: RCW 48.02.060, 48.43.510, 48.43.515, 48.43.520, 48.43.525, 48.43.530, 48.165.030. WSR 17-12-069 (Matter No. R 2016-19), § 284-43-2060, filed 6/5/17, effective 1/1/18.]

WAC 284-43-2070 Forms for authorization of inpatient or residential substance use disorder treatment. A carrier must accept the universal format for authorization and reauthorization of inpatient or

residential substance use disorder treatment services developed pursuant to section 9, chapter 366, Laws of 2024. The form will be posted on the insurance commissioner's website. Any new or updated forms will be posted on the insurance commissioner's website at least 30 days prior to their effective date.

[Statutory Authority: RCW 48.02.060, 48.49.110, 2024 c 366, 2025 c 25, and 2025 c 171. WSR 26-01-148 (Matter R 2025-12), s 284-43-2070, filed 12/19/25, effective 1/19/26.]

SUBCHAPTER E
ADVERSE BENEFIT DETERMINATION PROCESS REQUIREMENTS FOR NONGRANDFATHERED PLANS

WAC 284-43-3000 Scope and intent. Carriers and not grandfathered plans must follow the rules in this subchapter in order to comply with the adverse benefit determination process required by RCW 48.43.530 and 48.43.535. These rules apply to any request for a review of an adverse benefit determination made by a carrier or its designee on or after January 1, 2012.

[WSR 16-01-081, recodified as § 284-43-3000, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.43.525, 48.43.530, 48.43.535, and The Patient Protection and Affordable Care Act, P.L. 111-148, as amended (2010). WSR 12-23-005 (Matter No. R 2011-11), § 284-43-500, filed 11/7/12, effective 11/20/12.]

WAC 284-43-3010 Definitions. These definitions apply to the sections in this subchapter, WAC 284-43-3030 through 284-43-3190 and 284-43A-140:

"Adverse benefit determination" has the same meaning as defined in RCW 48.43.005 and WAC 284-43-0160.

"Appellant" means an applicant or a person covered as an enrollee, subscriber, policy holder, participant, or beneficiary of an individual or group health plan, and when designated, their representative. Consistent with the requirements of WAC 284-43-2000, providers seeking expedited review of an adverse benefit determination on behalf of an appellant may act as the appellant's representative even if the appellant has not formally notified the health plan or carrier of the designation.

"External appeal or review" means the request by an appellant for an independent review organization to determine whether the carrier or health plan's internal appeal decisions are correct.

"Internal appeal or review" means an appellant's request for a carrier or health plan to review and reconsider an adverse benefit determination.

[Statutory Authority: RCW 48.02.060, 48.43.535, and 48.43.537. WSR 16-23-168 (Matter No. R 2016-17), § 284-43-3010, filed 11/23/16, effective 1/1/17. Statutory Authority: RCW 48.02.060. WSR 16-14-106 (Matter No. R 2016-11), § 284-43-3010, filed 7/6/16, effective 8/6/16. WSR 16-01-081, recodified as § 284-43-3010, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.43.525, 48.43.530, 48.43.535, and The Patient Protection and Affordable Care Act, P.L.

111-148, as amended (2010). WSR 12-23-005 (Matter No. R 2011-11), § 284-43-505, filed 11/7/12, effective 11/20/12.]

WAC 284-43-3030 Review of adverse benefit determinations—Generally. (1) Each carrier must establish and implement a comprehensive process for the review of adverse benefit determinations. The process must offer an appellant the opportunity for both internal review and external review of an adverse benefit determination. The process must meet accepted national certification standards such as those used by the National Committee for Quality Assurance, except as otherwise required by this chapter.

(2) Neither a carrier nor a health plan may take or threaten to take any punitive action against a provider acting on behalf of or in support of an appellant.

(3) When the appeal is related to services the appellant is currently receiving as an inpatient, or for which a continuous course of treatment is medically necessary, coverage for those services must be continued while an adverse benefit determination is reviewed. Appellants must be notified that they may be responsible for the cost of services if the adverse benefit determination is upheld.

(4) A carrier must accept a request for internal review of an adverse benefit determination if the request is received within one hundred eighty days of the appellant's receipt of a determination under the plan. A carrier must notify an appellant of its receipt of the request within seventy-two hours of receiving the request.

(5) Each carrier and health plan must maintain a log of each adverse benefit determination review, its resolution, and the dates of receipt, notification, and determination.

(a) The carrier must make its review log available to the commissioner upon request in a form accessible by the commissioner. The log must be maintained by the carrier for a six-year period.

(b) Each carrier must identify, evaluate, and make available to the commissioner data and reports on trends in reviews for at least a six-year time frame, including the data on the number of adverse benefit determination reviews, the subject matter of the reviews and their outcome.

(c) When a carrier resolves issues related to an adverse benefit determination over the phone, without receiving a formal request for review, the carrier must include in these resolutions in its review log. A carrier's actions that are not in response to a member's call regarding an adverse benefit determination do not need to be included in the adverse benefit determination review log.

[WSR 16-01-081, recodified as § 284-43-3030, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.43.525, 48.43.530, 48.43.535, and The Patient Protection and Affordable Care Act, P.L. 111-148, as amended (2010). WSR 12-23-005 (Matter No. R 2011-11), § 284-43-510, filed 11/7/12, effective 11/20/12.]

WAC 284-43-3050 Explanation of right to review. A carrier must clearly communicate in writing the right to request a review of an adverse benefit determination.

(1) At a minimum, the notice must be sent at the following times:

(a) Upon request;

(b) As part of the notice of adverse benefit determination;

(c) To new enrollees at the time of enrollment; and

(d) Annually thereafter to enrollees, group administrators, and subcontractors of the carrier.

(e) The notice requirement is satisfied if the description of the internal and external review process is included in or attached to the summary health plan descriptions, policy, certificate, membership booklet, outline of coverage or other evidence of coverage provided to participants, beneficiaries, or enrollees.

(2) Each carrier and health plan must ensure that its network providers receive a written explanation of the manner in which adverse benefit determinations may be reviewed on both an expedited and nonexpedited basis.

(3) Any written explanation of the review process must include information about the availability of Washington's designated ombudsman's office, the services it offers, and contact information. A carrier's notice must also specifically direct appellants to the office of the insurance commissioner's consumer protection division for assistance with questions and complaints.

(4) The review process must be accessible to persons who are limited-English speakers, who have literacy problems, or who have physical or mental disabilities that impede their ability to request review or participate in the review process.

(a) Carriers must conform to federal rules and guidance in effect on January 1, 2017, to provide notice of the process in a culturally and linguistically appropriate manner to those seeking review.

(b) In counties where ten percent or more of the population is literate in a specific non-English language, carriers must include in notices a prominently displayed statement in the relevant language or languages, explaining that oral assistance and a written notice in the non-English language are available upon request. Carriers may rely on the most recent data published by the U.S. Department of Health and Human Services Office of Minority Health to determine which counties and which languages require such notices.

(c) This requirement is satisfied if the National Commission on Quality Assurance certifies the carrier is in compliance with this standard as part of the accreditation process.

(5) Each carrier must consistently assist appellants with understanding the review process. Carriers may not use and health plans may not contain procedures or practices that the commissioner determines discourage an appellant from any type of adverse benefit determination review.

(6) If a carrier reverses its initial adverse benefit determination, which it may at any time during the review process, the carrier or health plan must provide appellant with written or electronic notification of the decision immediately, but in no event more than two business days of making the decision.

[Statutory Authority: RCW 48.02.060, 48.43.012, 48.43.01211, 48.43.0123, 48.43.0124, 48.43.0126, 48.43.0127, 48.43.0128, and 48.43.715. WSR 20-03-114 (Matter No. R 2019-10), § 284-43-3050, filed 1/16/20, effective 2/16/20. WSR 16-01-081, recodified as § 284-43-3050, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.43.525, 48.43.530, 48.43.535, and The Patient Protection and Affordable Care Act, P.L. 111-148, as amended (2010). WSR 12-23-005 (Matter No. R 2011-11), § 284-43-511, filed 11/7/12, effective 11/20/12.]

WAC 284-43-3070 Notice and explanation of adverse benefit determination—General requirements. (1) A carrier must notify enrollees of an adverse benefit determination either electronically or by U.S. mail. The notification must be provided:

(a) To an appellant or their authorized representative;

(b) To the provider if the adverse benefit determination involves the preservice denial of treatment or procedure prescribed by the provider; and

(c) Whenever an adverse benefit determination relates to a protected individual, as defined in RCW 48.43.005, the health carrier must follow RCW 48.43.505.

(2) A carrier or health plan's notice must include the following information, worded in plain language:

(a) The specific reasons for the adverse benefit determination;

(b) The specific health plan policy or contract sections on which the determination is based, including references to the provisions;

(c) The plan's review procedures, including the appellant's right to a copy of the carrier and health plan's records related to the adverse benefit determination;

(d) The time limits applicable to the review;

(e) The right of appellants and their providers to present evidence as part of a review of an adverse benefit determination;

(f) Effective April 1, 2022, through December 31, 2022, the following statement or the statement from (g) of this subsection: "Enrollees may request that a health insurer identify the medical, vocational, or other experts whose advice was obtained in connection with the adverse benefit determination, even if the advice was not relied on in making the determination. Health insurers may satisfy this requirement by providing the job title, a statement as to whether the expert is affiliated with the carrier as an employee, and the expert's specialty, board certification status, or other criteria related to the expert's qualification without providing the expert's name or address.";

(g) No later than January 1, 2023, the following statement: "You can ask a health carrier to identify the experts who were consulted about the adverse benefit determination – even if the expert's advice was not used to make the determination. The carrier is not required to identify the expert by name or provide their address. The carrier can instead provide the expert's job title and specialty, board certification status or other information related to their qualifications and also state whether or not they are employed by the carrier."; and

(h) When the adverse benefit determination concerns gender affirming treatment or services, a confirmation that a health care provider experienced with prescribing or delivering gender affirming treatment has reviewed the determination and confirmed that an adverse benefit determination denying or limiting the service is appropriate and provide information to confirm that the reviewing provider has clinically appropriate expertise prescribing or delivering gender affirming treatment.

(3) If an adverse benefit determination is based on medical necessity, decisions related to experimental treatment, or a similar exclusion or limit involving the exercise of professional judgment, the notification must contain either an explanation of the scientific or clinical basis for the determination, the manner in which the terms of the health plan were applied to the appellant's medical circumstances,

or a statement that such explanation is available free of charge upon request.

(4) A health carrier must not issue an adverse benefit determination concerning gender affirming services or treatment until a health care provider with experience prescribing or delivering gender affirming treatment has reviewed and confirmed the appropriateness of the adverse benefit determination.

(5) If an internal rule, guideline, protocol, or other similar criterion was relied on in making the adverse benefit determination, the notice must contain either the specific rule, guideline, protocol, or other similar criterion; or a statement that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to the appellant on request.

(6) The notice of an adverse benefit determination must include an explanation of the right to review the records of relevant information, including evidence used by the carrier or the carrier's representative that influenced or supported the decision to make the adverse benefit determination.

(a) For purposes of this subsection, "relevant information" means information relied on in making the determination, or that was submitted, considered, or generated in the course of making the determination, regardless of whether the document, record, or information was relied on in making the determination.

(b) Relevant information includes any statement of policy, procedure, or administrative process concerning the denied treatment or benefit, regardless of whether it was relied on in making the determination.

(7) If the carrier and health plan determine that additional information is necessary to perfect the denied claim, the carrier and health plan must provide a description of the additional material or information that they require, with an explanation of why it is necessary, as soon as the need is identified.

(8) An enrollee or covered person may request that a carrier identify the medical, vocational, or other experts whose advice was obtained in connection with the adverse benefit determination, even if the advice was not relied on in making the determination. The carrier may satisfy this requirement by providing the job title, a statement as to whether the expert is affiliated with the carrier as an employee, and the expert's specialty, board certification status, or other criteria related to the expert's qualification without providing the expert's name or address. The carrier must be able to identify for the commissioner upon request the name of each expert whose advice was obtained in connection with the adverse benefit determination.

(9) The notice must include language substantially similar to the following:

> "If you request a review of this adverse benefit determination, (Company name) will continue to provide coverage for the disputed benefit pending outcome of the review if you are currently receiving services or supplies under the disputed benefit. If (Company name) prevails in the appeal, you may be responsible for the cost of coverage received during the review period. The decision at the external review level is binding unless other remedies are available under state or federal law."

[Statutory Authority: RCW 48.02.060 and 48.43.530. WSR 22-20-102 (Matter No. R 2022-04), § 284-43-3070, filed 10/4/22, effective 11/4/22. Statutory Authority: RCW 48.02.060, 48.43.515 and 2021 c 280. WSR 21-24-072 (Matter No. R 2021-14), § 284-43-3070, filed 11/30/21, effective 1/1/22. Statutory Authority: RCW 48.02.060, 48.43.505, and 48.43.5051. WSR 20-24-120, § 284-43-3070, filed 12/2/20, effective 1/2/21. WSR 16-01-081, recodified as § 284-43-3070, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.43.525, 48.43.530, 48.43.535, and The Patient Protection and Affordable Care Act, P.L. 111-148, as amended (2010). WSR 12-23-005 (Matter No. R 2011-11), § 284-43-515, filed 11/7/12, effective 11/20/12.]

WAC 284-43-3090 Electronic disclosure and communication by carriers. (1) Except as otherwise provided by applicable law, rule, or regulation, a carrier furnishing documents through electronic media is deemed to satisfy the notice and disclosure requirements regarding adverse benefit determinations with respect to applicants, covered persons, and appellants or their representative, if the carrier takes appropriate and necessary measures reasonably calculated to ensure that the system for furnishing documents, including ensuring that its measures:

(a) Result in actual receipt of transmitted information (e.g., using return-receipt or notice of undelivered electronic mail features, conducting periodic reviews or surveys to confirm receipt of the transmitted information);

(b) Protect the confidentiality of personal information relating to the individual's accounts and benefits (e.g., incorporating into the system measures designed to preclude unauthorized receipt of or access to such information by individuals other than the individual for whom the information is intended);

(c) Provide notice in electronic or nonelectronic form, at the time a document is furnished electronically, that apprises the recipient of the significance of the document when it is not otherwise reasonably evident as transmitted (e.g., the attached document describes the internal review process used by your plan) and of the right to request and obtain a paper version of such document; and

(d) Furnish the appellant or their representative with a paper version of the electronically furnished documents if requested.

(2) Subsection (1) of this section only applies to the following individuals:

(a) An appellant who affirmatively consents, in electronic or nonelectronic form, to receiving documents through electronic media and has not withdrawn such consent.

(b) In the case of documents to be furnished through the internet or other electronic communication network, one that has affirmatively consented or confirmed consent electronically, in a manner that reasonably demonstrates the individual's ability to access information in the electronic form that will be used to provide the information that is the subject of the consent, and has provided an address for the receipt of electronically furnished documents;

(c) Prior to consenting, is provided, in electronic or nonelectronic form, a clear and conspicuous statement indicating:

(i) The types of documents to which the consent would apply;

(ii) That consent can be withdrawn at any time without charge;

(iii) The procedures for withdrawing consent and for updating the individual's electronic address for receipt of electronically furnished documents or other information;

(iv) The right to request and obtain a paper version of an electronically furnished document, including whether the paper version will be provided free of charge; and

(v) Any hardware and software requirements for accessing and retaining the documents.

(3) Following consent, if a change in hardware or software requirements needed to access or retain electronic documents creates a material risk that the individual will be unable to access or retain electronically furnished documents, the carrier must provide:

(a) A statement of the revised hardware or software requirements for access to and retention of electronically furnished documents;

(b) The individual receiving electronic communications with the right to withdraw consent without charge and without the imposition of any condition or consequence that was not disclosed at the time of the initial consent.

(c) The carrier must request and receive a new consent to the receipt of documents through electronic media, following a hardware or software requirement change as described in this subsection.

[WSR 16-01-081, recodified as § 284-43-3090, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.43.525, 48.43.530, 48.43.535, and The Patient Protection and Affordable Care Act, P.L. 111-148, as amended (2010). WSR 12-23-005 (Matter No. R 2011-11), § 284-43-520, filed 11/7/12, effective 11/20/12.]

WAC 284-43-3110 Internal review of adverse benefit determinations. An appellant seeking review of an adverse benefit determination must use the carrier's review process. Each carrier must include the opportunity for internal review of an adverse benefit determination in its review process. Treating providers may seek expedited review on a patient's behalf, regardless of whether the provider is affiliated with the carrier on a contracted basis.

(1) When a carrier receives a written request for review, the carrier must reconsider the adverse benefit determination. The carrier must notify the appellant of the review decision within fourteen days of receipt of the request for review, unless the adverse benefit determination involves an experimental or investigational treatment. The carrier must notify the appellant of the review decision within twenty days of receipt of the request for review when the adverse benefit determination involves an experimental or investigational treatment.

(2) For good cause, a carrier may extend the time it takes to make a review determination by up to sixteen additional days without the appellant's written consent, and must notify appellant of the extension and the reason for the extension. The carrier may request further extension of its response time only if the appellant consents to a specific request for a further extension, the consent is reduced to writing, and includes a specific agreed-upon date for determination. In its request for the appellant's consent, the carrier must explain that waiver of the response time is not compulsory.

(3) The carrier must provide the appellant with any new or additional evidence or rationale considered, whether relied upon, generated by, or at the direction of the carrier in connection with the claim. The evidence or rationale must be provided free of charge to

the appellant and sufficiently in advance of the date the notice of final internal review must be provided. The purpose of this requirement is to ensure the appellant has a reasonable opportunity to respond prior to that date. If the appellant requests an extension in order to respond to any new or additional rationale or evidence, the carrier and health plan must extend the determination date for a reasonable amount of time, which may not be less than two days.

(4) A carrier's review process must provide the appellant with the opportunity to submit information, documents, written comments, records, evidence, and testimony, including information and records obtained through a second opinion. An appellant has the right to review the carrier and health plan's file and obtain a free copy of all documents, records, and information relevant to any claim that is the subject of the determination being appealed.

(5) The internal review process must include the requirement that the carrier affirmatively review and investigate the appealed determination, and consider all information submitted by the appellant prior to issuing a determination.

(6) Review of adverse determinations must be performed by health care providers or staff who were not involved in the initial decision, and who are not subordinates of the persons involved in the initial decision. If the determination involves, even in part, medical judgment, the reviewer must be or must consult with a health care professional who has appropriate training and experience in the field of medicine encompassing the appellant's condition or disease and make a determination that is within the clinical standard of care for an appellant's disease or condition.

(7) The internal review process for group health plans may be administered so that an appellant must file two internal requests for review prior to bringing a civil action. For individual health plans, a carrier must provide for only one level of internal review before issuing a final determination, and may not require two levels of internal review.

(8) A rescission of coverage is an adverse benefit determination for which review may be requested.

[WSR 16-01-081, recodified as § 284-43-3110, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.43.525, 48.43.530, 48.43.535, and The Patient Protection and Affordable Care Act, P.L. 111-148, as amended (2010). WSR 12-23-005 (Matter No. R 2011-11), § 284-43-525, filed 11/7/12, effective 11/20/12.]

WAC 284-43-3130 Exhaustion of internal review remedies. (1) If a carrier fails to strictly adhere to its requirements with respect to the internal review, the internal review process is deemed exhausted, and the appellant may request external review without receiving an internal review determination from the carrier or the health plan.

(2) A carrier may challenge external review requested under this section on the basis that its violations are de minimis, and do not cause and are not likely to cause, prejudice or harm to the appellant. The carrier or health plan may challenge external review on this basis either in court or to the independent review organization.

(a) This exception applies only if the external reviewer or court determines that the carrier has demonstrated that the violation was for good cause or was due to matters beyond the control of the carrier, and that the violation occurred in the context of an ongoing, good

faith exchange of information between the carrier or health plan and the appellant.

(b) This exception is not available, and the challenge may not be sustained, if the violation is part of a pattern or practice of violations by the carrier or health plan.

(3) The appellant may request a written explanation of the violation from the carrier and the carrier must provide such explanation within ten calendar days, including a specific description of its basis, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted.

(4) If the independent review organization or court determines that the internal review process is not exhausted, based on a carrier or health plan's challenge under this section, the carrier or health plan must provide the appellant with notice that they may resubmit and pursue the internal appeal within a reasonable time, not to exceed ten days, of receiving the independent review organization's determination, or of the entry of the court's final order.

[WSR 16-01-081, recodified as § 284-43-3130, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.43.525, 48.43.530, 48.43.535, and The Patient Protection and Affordable Care Act, P.L. 111-148, as amended (2010). WSR 12-23-005 (Matter No. R 2011-11), § 284-43-530, filed 11/7/12, effective 11/20/12.]

WAC 284-43-3150 Notice of internal review determination. Each carrier's review process must require delivery of written notification of the internal review determination to the appellant. In addition to the requirements of WAC 284-43-3070, the written determination must include:

(1) The actual reasons for the determination;

(2) If applicable, instructions for obtaining further review of the determination, either through a second level of internal review, if applicable, or using the external review process;

(3) The clinical rationale for the decision, which may be in summary form; and

(4) Instructions on obtaining the clinical review criteria used to make the determination;

(5) A statement that the appellant has up to one hundred eighty days to file a request for external review, and that if review is not requested, the internal review decision is final and binding.

[Statutory Authority: RCW 48.02.060. WSR 16-14-106 (Matter No. R 2016-11), § 284-43-3150, filed 7/6/16, effective 8/6/16. WSR 16-01-081, recodified as § 284-43-3150, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.43.525, 48.43.530, 48.43.535, and The Patient Protection and Affordable Care Act, P.L. 111-148, as amended (2010). WSR 12-23-005 (Matter No. R 2011-11), § 284-43-535, filed 11/7/12, effective 11/20/12.]

WAC 284-43-3170 Expedited review. (1) A carrier's internal and external review processes must permit an expedited review of an adverse benefit determination at any time in the review process, if:

(a) The appellant is currently receiving or is prescribed treatment or benefits that would end because of the adverse benefit determination; or

(b) The ordering provider for the appellant, regardless of their affiliation with the carrier or health plan, believes that a delay in treatment based on the standard review time may seriously jeopardize the appellant's life, overall health or ability to regain maximum function, or would subject the appellant to severe and intolerable pain; or

(c) The determination is related to an issue related to admission, availability of care, continued stay, or emergency health care services where the appellant has not been discharged from the emergency room or transport service.

(2) An appellant is not entitled to expedited review if the treatment has already been delivered and the review involves payment for the delivered treatment, if the situation is not urgent, or if the situation does not involve the delivery of services for an existing condition, illness, or disease.

(3) An expedited review may be filed by an appellant, the appellant's authorized representative, or the appellant's provider orally, or in writing.

(4) The carrier must respond as expeditiously as possible to an expedited review request, preferably within twenty-four hours, but in no case longer than seventy-two hours.

(a) The carrier's response to an expedited review request may be delivered orally, and must be reduced to and issued in writing not later than seventy-two hours after the date of the decision. Regardless of who makes the carrier's determination, the time frame for providing a response to an expedited review request begins when the carrier first receives the request.

(b) If the carrier requires additional information to determine whether the service or treatment determination being reviewed is covered under the health plan, or eligible for benefits, they must request such information as soon as possible after receiving the request for expedited review.

(5) If the treating health care provider determines that a delay could jeopardize the covered person's health or ability to regain maximum function, the carrier must presume the need for expedited review, and treat the review request as such, including the need for an expedited determination of an external review under RCW 48.43.535.

(6) A carrier may require exhaustion of the internal appeal process before an appellant may request an external review in urgent care situations that justify expedited review as set forth in this section.

(7) An expedited review must be conducted by an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed. The clinical peer or peers must not have been involved in making the initial adverse determination.

(8) These requirements do not replace the requirements related to utilization review for the initial authorization of coverage for services set forth in WAC 284-43-2000. These requirements apply when the utilization review decision results in an adverse benefit determination. In some circumstances, an urgent care review under WAC 284-43-2000 may apply in an identical manner to an expedited review under this section.

[Statutory Authority: RCW 48.02.060. WSR 16-14-106 (Matter No. R 2016-11), § 284-43-3170, filed 7/6/16, effective 8/6/16. WSR 16-01-081, recodified as § 284-43-3170, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.43.525, 48.43.530, 48.43.535, and The Patient Protection and Affordable Care Act, P.L.

111-148, as amended (2010). WSR 12-23-005 (Matter No. R 2011-11), § 284-43-540, filed 11/7/12, effective 11/20/12.]

WAC 284-43-3190 Concurrent expedited review of adverse benefit determinations. (1) "Concurrent expedited review" means initiation of both the internal and external expedited review simultaneously to:

(a) Review of a decision made under WAC 284-43-2000; or

(b) Review conducted during a patient's stay or course of treatment in a facility, the office of a health care professional or other inpatient or outpatient health care setting so that the final adverse benefit determination is reached as expeditiously as possible.

(2) A carrier must offer the right to request concurrent expedited internal and external review of adverse benefit determinations. When a concurrent expedited review is requested, a carrier may not extend the timelines by making the determinations consecutively. The requisite timelines must be applied concurrently.

(3) A carrier may deny a request for concurrent expedited review only if the conditions for expedited review in WAC 284-43-3170 are not met. A carrier may not require exhaustion of internal review if an appellant requests concurrent expedited review.

[Statutory Authority: RCW 48.02.060. WSR 16-14-106 (Matter No. R 2016-11), § 284-43-3190, filed 7/6/16, effective 8/6/16. WSR 16-01-081, recodified as § 284-43-3190, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.43.525, 48.43.530, 48.43.535, and The Patient Protection and Affordable Care Act, P.L. 111-148, as amended (2010). WSR 12-23-005 (Matter No. R 2011-11), § 284-43-545, filed 11/7/12, effective 11/20/12.]

SUBCHAPTER F
GRANDFATHERED HEALTH PLAN APPEAL PROCEDURES

WAC 284-43-4000 Application of subchapter F. Subchapter F applies to grandfathered health plans. For any grandfathered health plan as defined in RCW 48.43.005, a carrier may comply with RCW 48.43.530 and 48.43.535 by using an appeal process that conforms to the procedures and standards set forth in WAC 284-43-4020 through 284-43-4040 and 284-43A-150.

[Statutory Authority: RCW 48.02.060, 48.43.535, and 48.43.537. WSR 16-23-168 (Matter No. R 2016-17), § 284-43-4000, filed 11/23/16, effective 1/1/17. Statutory Authority: RCW 48.02.060. WSR 16-14-106 (Matter No. R 2016-11), § 284-43-4000, filed 7/6/16, effective 8/6/16. WSR 16-01-081, recodified as § 284-43-4000, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.43.525, 48.43.530, 48.43.535, and The Patient Protection and Affordable Care Act, P.L. 111-148, as amended (2010). WSR 12-23-005 (Matter No. R 2011-11), § 284-43-611, filed 11/7/12, effective 11/20/12.]

WAC 284-43-4020 Grievance and complaint procedures—Generally. (1) Each carrier must adopt and implement a comprehensive process for the resolution of appeals of adverse determinations. This process

shall meet accepted national certification standards such as those used by the National Committee for Quality Assurance except as otherwise required by this chapter.

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

(a) Provide a clear explanation of the appeal process upon request, upon enrollment to new enrollees, and annually to enrollees and subcontractors of the carrier.

(b) Ensure that the appeal process is accessible to enrollees who are limited-English speakers, who have literacy problems, or who have physical or mental disabilities that impede their ability to file an appeal.

(c) Implement procedures for registering and responding to oral and written appeals in a timely and thorough manner including the notification of an enrollee that an appeal has been received.

(d) Assist the enrollee with all appeal processes.

(e) Cooperate with any representative authorized in writing by the enrollee.

(f) Consider all information submitted by the enrollee or representative.

(g) Investigate and resolve all appeals.

(h) Provide information on the enrollee's right to obtain second opinions.

(i) Track each appeal until final resolution; maintain, and make accessible to the commissioner for a period of three years, a written log of all appeals; and identify and evaluate trends in appeals. The written log may be maintained electronically.

[WSR 16-01-081, recodified as § 284-43-4020, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.43.525, 48.43.530, 48.43.535, and The Patient Protection and Affordable Care Act, P.L. 111-148, as amended (2010). WSR 12-23-005 (Matter No. R 2011-11), § 284-43-615, filed 11/7/12, effective 11/20/12. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.100, 48.46.200, 48.43.505, 48.43.510, 48.43.515, 48.43.520, 48.43.525, 48.43.530, 48.43.535. WSR 01-03-033 (Matter No. R 2000-02), § 284-43-615, filed 1/9/01, effective 7/1/01.]

WAC 284-43-4040 Procedures for review and appeal of adverse determinations. (1) An enrollee or the enrollee's representative, including the treating provider (regardless of whether the provider is affiliated with the carrier) acting on behalf of the enrollee may appeal an adverse determination in writing. The carrier must reconsider the adverse determination and notify the enrollee of its decision within fourteen days of receipt of the appeal unless the carrier notifies the enrollee that an extension is necessary to complete the appeal; however, the extension cannot delay the decision beyond thirty days of the request for appeal, without the informed, written consent of the enrollee.

Whenever an adverse determination relates to a protected individual, as defined in RCW 48.43.005, the health carrier must follow RCW 48.43.505.

(2) Whenever a health carrier makes an adverse determination and delay would jeopardize the enrollee's life or materially jeopardize the enrollee's health, the carrier shall expedite and process either a written or an oral appeal and issue a decision no later than seventy-

two hours after receipt of the appeal. If the treating health care provider determines that delay could jeopardize the enrollee's health or ability to regain maximum function, the carrier shall presume the need for expeditious review, including the need for an expeditious determination in any independent review under WAC 284-43-4040 and 284-43A-150.

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

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

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

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

Whenever an adverse determination notification relates to a protected individual, as defined in RCW 48.43.005, the health carrier must follow RCW 48.43.505.

[Statutory Authority: RCW 48.02.060, 48.43.505, and 48.43.5051. WSR 20-24-120, § 284-43-4040, filed 12/2/20, effective 1/2/21. Statutory Authority: RCW 48.02.060, 48.43.535, and 48.43.537. WSR 16-23-168 (Matter No. R 2016-17), § 284-43-4040, filed 11/23/16, effective 1/1/17. Statutory Authority: RCW 48.02.060. WSR 16-14-106 (Matter No. R 2016-11), § 284-43-4040, filed 7/6/16, effective 8/6/16. WSR 16-01-081, recodified as § 284-43-4040, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.43.525, 48.43.530, 48.43.535, and The Patient Protection and Affordable Care Act, P.L. 111-148, as amended (2010). WSR 12-23-005 (Matter No. R 2011-11), § 284-43-620, filed 11/7/12, effective 11/20/12. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.100, 48.46.200, 48.43.505, 48.43.510, 48.43.515, 48.43.520, 48.43.525, 48.43.530, 48.43.535. WSR 01-03-033 (Matter No. R 2000-02), § 284-43-620, filed 1/9/01, effective 7/1/01. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.43.055, 48.44.050, 48.46.100 and 48.46.200. WSR 99-24-075 (Matter No. R 98-17), § 284-43-620, filed 11/29/99, effective 12/30/99.]

SUBCHAPTER G
GRIEVANCES

WAC 284-43-4500 Definition. This definition applies to subchapter G. "Grievant" means a person filing a grievance as defined in WAC 284-43-0160, and who is not an appellant under either subchapter E or F of this chapter.

[Statutory Authority: RCW 48.02.060. WSR 16-14-106 (Matter No. R 2016-11), § 284-43-4500, filed 7/6/16, effective 8/6/16. WSR 16-01-081, recodified as § 284-43-4500, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.43.525, 48.43.530, 48.43.535, and The Patient Protection and Affordable Care Act, P.L. 111-148, as amended (2010). WSR 12-23-005 (Matter No. R 2011-11), § 284-43-711, filed 11/7/12, effective 11/20/12.]

WAC 284-43-4520 Grievance process—Generally. This section applies to a health benefit plan regardless of its status as grandfathered or nongrandfathered.

(1) Each carrier and health plan must offer applicants, covered persons, and providers a way to resolve grievances.

(2) Each carrier must maintain a log or otherwise register grievances, and retain the log or record for three years. It must be available for review by the commissioner upon request. The log must provide sufficient detail to permit the commissioner to determine whether the carrier is administering its grievance process in accordance with the law, and in good faith, and to identify whether and in what manner the carrier adjusted practices or requirements in response to a grievance.

(3) Grievances are not adverse benefit determinations and do not establish the right to internal or external review of a carrier or health plan's resolution of the grievance.

(4) Nothing in this section prohibits a carrier from creating or using its own system to categorize the nature of grievances in order to collect data, if the system permits reporting of the data specified in subsection (2) of this section.

[WSR 16-01-081, recodified as § 284-43-4520, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.43.525, 48.43.530, 48.43.535, and The Patient Protection and Affordable Care Act, P.L. 111-148, as amended (2010). WSR 12-23-005 (Matter No. R 2011-11), § 284-43-721, filed 11/7/12, effective 11/20/12.]

SUBCHAPTER H
HEALTH PLAN BENEFITS

WAC 284-43-5000 Preexisting condition limitations. For health plans offered, issued or renewed on or after January 1, 2014, issuers must not condition or otherwise limit enrollment based on preexisting health conditions.

[WSR 16-01-081, recodified as § 284-43-5000, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.18.120(2), 48.20.450, 48.43.0211, 48.43.720(3), 48.44.050, 48.46.200, 45 C.F.R. §§ 147.104, 147.106, 155.420, and 155.725. WSR 14-01-042 (Matter No. R 2013-02), § 284-170-400, filed 12/11/13, effective 1/1/14.]

WAC 284-43-5020 Recognizing the exercise of conscience by purchasers of basic health plan services and ensuring access for all enrollees to such services. (1) All carriers required pursuant to law

to offer and file with the commissioner a plan providing benefits identical to the basic health plan services (the model plan) shall file for such plan a full description of the process it will use to recognize an organization or individual's exercise of conscience based on a religious belief or conscientious objection to the purchase of coverage for a specific service. This process may not affect a nonobjecting enrollee's access to coverage for those services.

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

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

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

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

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

[WSR 16-01-081, recodified as § 284-43-5020, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. WSR 98-04-005 (Matter No. R 97-3), § 284-43-800, filed 1/22/98, effective 2/22/98.]

WAC 284-43-5060 General prescription drug benefit requirements. A health carrier must not offer, renew, or issue a health benefit plan providing a prescription drug benefit, which the commissioner determines results or can reasonably be expected to result in an unreasonable restriction on the treatment of patients. A carrier may restrict prescription drug coverage based on contract or plan terms and conditions that otherwise limit coverage, such as a preexisting condition waiting period, or medical necessity.

(1) A carrier must ensure that a prescription drug benefit covers Federal Drug Administration approved prescribed drugs, medications or drug therapies that are the sole prescription drug available for a covered medical condition.

(2) A prescription drug benefit that only covers generic drugs constitutes an unreasonable restriction on the treatment of patients.

(3) A prescription drug benefit or formulary must not exclude coverage for a nonformulary drug or medication if the only formulary drug available for an enrollee's covered condition is one that the enrollee cannot tolerate or that is not clinically efficacious for the enrollee.

(4) Nothing in this chapter is intended to limit or deter the use of "Dispense as Written" prescriptions, subject to the terms and conditions of the health plan.

[WSR 16-01-081, recodified as § 284-43-5060, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.02.062, 48.18.140, 48.43.525, 48.44.050, 48.44.440(2), 48.44.460(2), 48.46.200, and 48.46.510. WSR 12-21-019 (Matter No. R 2012-03), § 284-43-816, filed 10/8/12, effective 11/8/12.]

WAC 284-43-5080 Prescription drug benefit design. (1) Except as provided in subsection (2) of this section, a carrier may design its prescription drug benefit to include cost control measures, including requiring preferred drug substitution in a given therapeutic class, if the restriction is for a less expensive, equally therapeutic alternative product available to treat the condition.

(2) Beginning January 1, 2025, a carrier or its health care benefit manager may not require the substitution of a nonpreferred drug with a preferred drug in a given therapeutic class, or increase an enrollee's cost-sharing obligation mid-plan year for the drug, if:

(a) The prescription is for a refill of an antipsychotic, antidepressant, antiepileptic, or other drug prescribed to the enrollee to treat a serious mental illness;

(b) The enrollee is medically stable on the drug; and

(c) A participating provider continues to prescribe the drug.

(3) Nothing in subsection (2) of this section prohibits:

(a) A carrier from requiring generic substitution during the current plan year;

(b) A carrier from adding new drugs to its formulary during the current plan year;

(c) A carrier from removing a drug from its formulary for reasons of patient safety concerns, drug recall or removal from the market, or medical evidence indicating no therapeutic effect of the drug; or

(d) A participating provider from prescribing a different drug that is covered by the plan and medically appropriate for the enrollee.

(4) Except to the extent provided otherwise in subsection (2) of this section, a carrier may include elements in its prescription drug benefit design that, where clinically feasible, create incentives for the use of generic drugs. Examples of permitted incentives include, but are not limited to, refusal to pay for higher cost drugs until it can be shown that a lower cost drug or medication is not effective (also known as step therapy protocols or fail-first policies), establishing a preferred brand and nonpreferred brand formulary, or otherwise limiting the benefit to the use of a generic drug in lieu of brand name drugs, subject to a substitution process as set forth in subsection (5) of this section.

(5) Except to the extent provided otherwise in subsection (2) of this section, a carrier may include a preauthorization requirement for its prescription drug benefit and its substitution process, based on accepted peer reviewed clinical studies, Federal Drug Administration black box warnings, the fact that the drug is available over-the-counter, objective and relevant clinical information about the enrollee's condition, specific medical necessity criteria, patient safety, or other criteria that meet an accepted, medically applicable standard of care.

(6) A carrier may require an enrollee to try an AB-rated generic equivalent or a biological product that is an interchangeable biological product prior to providing coverage for the equivalent branded prescription drug.

(7) A nongrandfathered health plan issued or renewed on or after January 1, 2023, that provides coverage for prescription drugs must comply with RCW 48.43.435.

(a) **For the purposes of this subsection**, any cost sharing amount paid directly by or on behalf of the enrollee by another person for a covered prescription drug, at the time it is rendered, must be applied in full toward the enrollee's applicable cost-sharing as defined in

WAC 284-43-0160 and out-of-pocket maximum as defined in RCW 48.43.005 consistent with RCW 48.43.435.

(b) If an enrollee requests an exception under RCW 48.43.420 or appeals a denial of an exception request, and the request or appeal is still pending, any amount paid by or on behalf of an enrollee for a covered prescription drug must be applied towards the enrollee's contribution to any applicable deductible, copayment, coinsurance, or out-of-pocket maximum until the review is resolved and the status of the request is communicated to the carrier.

(c) The health carrier must disclose to the enrollee information about when third-party payments, including payments made through application of a manufacturer drug coupon or other manufacturer discount, are applied towards the enrollee's annual cost-sharing obligations, including applicable deductibles, copayments, coinsurances, or out-of-pocket maximums. The disclosure shall be included in the certificate of coverage (also commonly referred to as the member booklet or member handbook). Carriers are not required to use verbatim language from either the statute or regulation; however, the information provided to the enrollee about the application of third-party payments must be sufficiently detailed to address the situations set forth in RCW 48.43.435.

[Statutory Authority: RCW 48.02.060, 48.43.0961, 2023 c 325, 48.43.735, 2024 c 215, 48.43.047, 2024 c 314, and 89 F.R. 37522. WSR 24-24-067 (Matter R 2024-05), s 284-43-5080, filed 11/27/24, effective 12/28/24. Statutory Authority: 2022 c 228 § 1(3). WSR 22-23-070 (Matter R 2022-05), § 284-43-5080, filed 11/10/22, effective 12/11/22. Statutory Authority: RCW 48.02.060, 48.43.400, 48.43.410, and 48.43.420. WSR 20-24-105, § 284-43-5080, filed 12/1/20, effective 1/1/21. Statutory Authority: RCW 48.02.060, 48.18.140, and 48.43.510. WSR 17-03-087 (Matter No. R 2016-22), § 284-43-5080, filed 1/12/17, effective 2/12/17. WSR 16-01-081, recodified as § 284-43-5080, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.02.062, 48.18.140, 48.43.525, 48.44.050, 48.44.440(2), 48.44.460(2), 48.46.200, and 48.46.510. WSR 12-21-019 (Matter No. R 2012-03), § 284-43-817, filed 10/8/12, effective 11/8/12.]

WAC 284-43-5100 Formulary changes. An issuer is not required to use a formulary as part of its prescription drug benefit design. If a formulary is used, an issuer must, at a minimum, comply with these requirements when a formulary change occurs.

(1) In addition to the requirements set forth in WAC 284-30-450, an issuer must not exclude or remove a medication from its formulary if the medication is the sole prescription medication option available to treat a disease or condition for which the health benefit plan, policy or agreement otherwise provides coverage, unless the medication or drug is removed because the drug or medication becomes available over-the-counter, is proven to be medically inefficacious, or for documented medical risk to patient health.

(2) If a drug is removed from an issuer's formulary for a reason other than withdrawal of the drug from the market, availability of the drug over-the-counter, or the issue of black box warnings by the Federal Drug Administration, an issuer must continue to cover a drug that is removed from the issuer's formulary for the time period required for an enrollee who is taking the medication at the time of the formulary change to use an issuer's exception request process to request

continuation of coverage for the removed medication, and receive a decision through that process, unless patient safety requires swifter replacement.

(3) Formularies and related preauthorization information must be posted on an issuer or issuer's contracted pharmacy benefit manager website and must be current. Unless the removal is done on an immediate or emergency basis or because a generic equivalent becomes available without prior notice, formulary changes must be posted sixty days before the effective date of the change. In the case of an emergency removal, the change must be posted as soon as practicable, without unreasonable delay.

(4) An issuer must make current formulary information electronically available for loading into e-prescribing applications/electronic health records utilizing the National Council for Prescription Drug Programs (NCPDP) formulary and benefit standard transaction. Issuers must include all required data elements as well as the following information, to the extent supported by the transaction:

(a) Tier level;

(b) Contract exclusions;

(c) Quantity limits;

(d) Preauthorization required;

(e) Preferred/step therapy.

(5) The issuer's exception request process for any aspect of its prescription drug utilization management program must permit requests for off-formulary substitutions, as well as substitution of one drug on the formulary for another.

[Statutory Authority: RCW 48.02.060, 48.43.400, 48.43.410, and 48.43.420. WSR 20-24-105, § 284-43-5100, filed 12/1/20, effective 1/1/21. WSR 16-01-081, recodified as § 284-43-5100, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.165.0301, 48.43.525, 48.43.530, 48.44.020, 48.44.050, 48.46.060(2), and 48.46.200. WSR 15-24-074 (Matter No. R 2014-13), § 284-43-818, filed 11/25/15, effective 7/1/16. Statutory Authority: RCW 48.02.060, 48.02.062, 48.18.140, 48.43.525, 48.44.050, 48.44.440(2), 48.44.460(2), 48.46.200, and 48.46.510. WSR 12-21-019 (Matter No. R 2012-03), § 284-43-818, filed 10/8/12, effective 11/8/12.]

WAC 284-43-5110 Cost-sharing for prescription drugs. (1) A carrier and health plan unreasonably restrict the treatment of patients if an ancillary charge, in addition to the plan's normal copayment or coinsurance requirements, is imposed for a drug that is covered because of one of the circumstances set forth in either WAC 284-43-5080 or 284-43-5100. An ancillary charge means any payment required by a carrier that is in addition to or excess of cost-sharing explained in the policy or contract form as approved by the commissioner. Cost-sharing means amounts paid directly to a provider or pharmacy by an enrollee for services received under the health benefit plan, and includes copayment, coinsurance, or deductible amounts.

(2) Except to the extent provided otherwise WAC 284-43-5080, when an enrollee requests a brand name drug from the formulary in lieu of a therapeutically equivalent generic drug or a drug from a higher tier within a tiered formulary, and there is not a documented clinical basis for the substitution, a carrier may require the enrollee to pay for the difference in price between the drug that the formulary would

have required, and the covered drug, in addition to the copayment. This charge must reflect the actual cost difference.

(3) When a carrier approves a substitution drug, whether or not the drug is in the carrier's formulary, the enrollee's cost-sharing for the substitution drug must be adjusted to reflect any discount agreements or other pricing adjustments for the drug that are available to a carrier. Any charge to the enrollee for a substitution drug must not increase the carrier's underwriting gain for the plan beyond the gain contribution calculated for the original formulary drug that is replaced by the substitution.

(4) Except to the extent provided otherwise in WAC 284-43-5080, if a carrier uses a tiered formulary in its prescription drug benefit design, and a substitute drug that is in the formulary is required based on one of the circumstances in either WAC 284-43-5080 or 284-43-5100, the enrollee's cost sharing may be based on the tier in which the carrier has placed the substitute drug.

(5) If a carrier requires cost-sharing for enrollees receiving an emergency fill as defined in WAC 284-170-470, then issuers must disclose that information to enrollees within their policy forms.

(6) For individual and small group plans, if a substitution is granted, the carrier must treat the drug as an essential health benefit, including by counting any cost-sharing towards the plan's annual limitation on cost-sharing and towards any deductible.

[Statutory Authority: RCW 48.02.060, 48.43.0961, 2023 c 325, 48.43.735, 2024 c 215, 48.43.047, 2024 c 314, and 89 F.R. 37522. WSR 24-24-067 (Matter R 2024-05), s 284-43-5110, filed 11/27/24, effective 12/28/24. Statutory Authority: RCW 48.02.060, 48.18.140, and 48.43.510. WSR 17-03-087 (Matter No. R 2016-22), § 284-43-5110, filed 1/12/17, effective 2/12/17. Statutory Authority: RCW 48.02.060, 48.43.510. WSR 16-19-086 (Matter No. R 2016-08), § 284-43-5110, filed 9/20/16, effective 10/21/16. Statutory Authority: RCW 48.02.060. WSR 16-14-106 (Matter No. R 2016-11), § 284-43-5110, filed 7/6/16, effective 8/6/16. WSR 16-01-081, recodified as § 284-43-5110, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.02.062, 48.18.140, 48.43.525, 48.44.050, 48.44.440(2), 48.44.460(2), 48.46.200, and 48.46.510. WSR 12-21-019 (Matter No. R 2012-03), § 284-43-819, filed 10/8/12, effective 11/8/12.]

WAC 284-43-5130 Health plan disclosure requirements. (1) Health plan disclosure information must comply with and include each requirement listed in RCW 48.43.510.

(2) Health plan disclosures must be current and:

(a) Provided by paper copy upon request;

(b) Provided by electronic communication upon request;

(c) Clearly identified as health plan disclosures; and

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

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

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

[WSR 16-01-081, recodified as § 284-43-5130, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060 and 48.43.510. WSR 10-02-068 (Matter No. R 2008-16), § 284-43-820, filed 1/4/10, effective 2/4/10. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.100, 48.46.200, 48.43.505, 48.43.510, 48.43.515, 48.43.520, 48.43.525, 48.43.530, 48.43.535. WSR 01-03-033 (Matter No. R 2000-02), § 284-43-820, filed 1/9/01, effective 7/1/01.]

WAC 284-43-5150 Unfair practice relating to health coverage. (1) It is an unfair practice for any health carrier to restrict, exclude, or reduce coverage or benefits under any health plan on the basis of sex. By way of example, a health plan providing generally comprehensive coverage of prescription drugs and prescription devices restricts, excludes, or reduces coverage or benefits on the basis of sex if it fails to provide prescription contraceptive coverage that complies with this regulation.

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

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

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

(c) Health plans may not require cost sharing, such as copayments or deductibles, for prescription contraceptives and for services associated with the prescribing, dispensing, delivery, distribution, administration, and removal of the prescription contraceptives.

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

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

[Statutory Authority: RCW 48.02.060, 48.43.072, 48.43.073, and 2019 c 399. WSR 19-24-039, § 284-43-5150, filed 11/26/19, effective 12/27/19. WSR 16-01-081, recodified as § 284-43-5150, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.18.480, 48.20.450, 48.20.460, 48.21.045, 48.30.010, 48.30.300, 48.41.110, 48.41.170, 48.42.010, 48.42.040, 48.42.100, 48.43.012, 48.43.025, 48.43.035,

48.43.041, 48.43.115, 48.43.520, 48.44.020, 48.44.023, 48.44.050, 48.44.220, 48.46.060, 48.46.066, 48.46.110, 48.46.200, 49.60.010, 49.60.030, 49.60.120, 49.60.178, 49.60.220. WSR 01-19-001 (Matter No. R 2001-02), § 284-43-822, filed 9/5/01, effective 10/6/01.]

WAC 284-43-5151 Unfair practice relating to gender affirming treatment and services. When a treatment or service is gender affirming treatment, as defined in RCW 48.43.0128, it is an unfair practice for any health carrier to:

(1) Deny or limit coverage, issue automatic denials of coverage, impose additional cost sharing or other limitations or restrictions on coverage, or deny or limit coverage of a claim, if gender affirming treatment is:

(a) Prescribed to an individual because of, related to, or consistent with a person's gender expression or identity, as defined in RCW 49.60.040;

(b) Medically necessary. A carrier or its designated or contracted representative must make medically necessary determinations in accordance with the carrier's current clinical review criteria based on reasonable medical evidence and use the medical necessity definition stated in the enrollee's plan; and

(c) Prescribed in accordance with accepted standards of care;

(2) Apply blanket exclusions or categorical exclusions to gender affirming treatment; or

(3) When prescribed as medically necessary, exclude facial gender affirming treatment (such as tracheal shaves), hair removal procedures, and other care (such as mastectomies, breast reductions, breast implants, or any combination of gender affirming procedures, including revisions to prior treatment) as cosmetic services.

[Statutory Authority: RCW 48.02.060, 48.49.110, 2024 c 366, 2025 c 25, and 2025 c 171. WSR 26-01-148 (Matter R 2025-12), s 284-43-5151, filed 12/19/25, effective 1/19/26. Statutory Authority: RCW 48.02.060, 48.43.515 and 2021 c 280. WSR 21-24-072 (Matter No. R 2021-14), § 284-43-5151, filed 11/30/21, effective 1/1/22.]

WAC 284-43-5170 Prescription drug benefit disclosures. (1) A carrier must include the following information in the certificate of coverage issued for a health benefit plan, policy or agreement that includes a prescription drug benefit in addition to those required elsewhere in Titles 48 RCW and 284 WAC. The commissioner may disapprove any contract issued on or after January 1, 2018, if the requirements of this subsection are not met.

(a) A clear statement explaining that the health benefit plan uses the following in its coverage of drugs (as applicable):

(i) Exclusion of certain brand name or other medications from its formulary;

(ii) Therapeutic drug substitution;

(iii) Incentives for use of generic drugs (such as step-therapy protocols);

(iv) Prior authorization requirements;

(v) Mid-plan year formulary changes; or

(vi) Other limits of its prescription drug benefit.

(b) For health plans delivered, issued, or renewed on or before January 1, 2021, a clear explanation of the substitution process re-

quired under WAC 284-43-5080 that the enrollee or their provider must use to seek coverage of a prescription drug or medication that is not in the formulary or is not the carrier's preferred drug or medication for the covered medical condition.

(c) For health plans delivered, issued, or renewed on or after January 1, 2021, a clear explanation of the exception and substitution processes required under WAC 284-43-2021, 284-43-2022, and 284-43-5080.

(d) A clear statement explaining that consumers may be eligible to receive an emergency fill for prescription drugs under the circumstances described in WAC 284-170-470. The disclosure must include the process for consumers to obtain an emergency fill, and cost-sharing requirements, if any, for an emergency fill.

(e) The process for developing coverage standards and formularies, including the principal criteria by which drugs are selected for inclusion, exclusion, restriction or limitation.

(f) The process of changing formularies and coverage standards, including changes in the use of substitute drugs. If the plan has provisions for "grandfathering" certain ongoing prescriptions or other coverage exceptions, these practices must be disclosed.

(g) The disclosure must state whether drugs may move between tiers during a plan year and whether this may affect cost-sharing.

(h) Any medication management, disease management, or other pharmacy-related services reimbursed by the plan in addition to those required under state and federal law in connection with dispensing drugs, such as disease management services for migraine, diabetes, smoking cessation, asthma, or lipid management.

(i) The general categories of drugs excluded from coverage must be disclosed. Such categories may include items such as appetite suppressants, dental prescriptions, cosmetic agents or most over-the-counter medications. This subsection does not require that any particular category of coverage for drugs or pharmacy services should be excluded, reduced, or limited by a health plan.

(2) When a carrier eliminates a previously covered drug from its formulary, or establishes new limitations on coverage of the drug or medication, at a minimum a carrier must ensure that prior notice of the change will be provided as soon as is practicable, to enrollees who filled a prescription for the drug within the prior three months.

(a) Provided the enrollee agrees to receive electronic notice and such agreement has not been withdrawn, either electronic mail notice, or written notice by first class mail at the last known address of the enrollee, are acceptable methods of notice.

(b) If neither of these notice methods is available because the carrier lacks contact information for enrollees, a carrier may post notice on its website or at another location that may be appropriate, so long as the posting is done in a manner that is reasonably calculated to reach and be noticed by affected enrollees.

(3) A carrier and health plan may use provider and enrollee education to promote the use of therapeutically equivalent generic drugs. The materials must not mislead an enrollee about the difference between biosimilar or bioequivalent, and therapeutically equivalent, generic medications.

(4) A carrier must include the following statement in the certificate of coverage issued for a health benefit plan, policy, or agreement that includes a prescription drug benefit, and provide current contact information as prompted below:

YOUR PRESCRIPTION DRUG RIGHTS

You have the right to safe and effective pharmacy services. You also have the right to know what drugs are covered by your plan and the limits that apply. If you have a question or concern about your prescription drug benefits, please contact us (the health carrier) at (health carrier's contact phone number) or visit (health carrier's website). If you would like to know more about your rights, or if you have concerns about your plan, you may contact the Washington state office of insurance commissioner at 1-800-562-6900 or www.insurance.wa.gov. If you have a concern about the pharmacists or pharmacies serving you, please contact the Washington state department of health at 360-236-4700, www.doh.wa.gov, or HSQACSC@doh.wa.gov.

[Statutory Authority: RCW 48.02.060, 48.43.400, 48.43.410, and 48.43.420. WSR 20-24-105, § 284-43-5170, filed 12/1/20, effective 1/1/21. Statutory Authority: RCW 48.02.060, 48.43.510. WSR 17-01-166 (Matter No. R 2016-16), § 284-43-5170, filed 12/21/16, effective 1/21/17; WSR 16-19-086 (Matter No. R 2016-08), § 284-43-5170, filed 9/20/16, effective 10/21/16. Statutory Authority: RCW 48.02.060. WSR 16-14-106 (Matter No. R 2016-11), § 284-43-5170, filed 7/6/16, effective 8/6/16. WSR 16-01-081, recodified as § 284-43-5170, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.02.062, 48.18.140, 48.43.525, 48.44.050, 48.44.440(2), 48.44.460(2), 48.46.200, and 48.46.510. WSR 12-21-019 (Matter No. R 2012-03), § 284-43-825, filed 10/8/12, effective 11/8/12.]

WAC 284-43-5200 Anticancer medication. A carrier and health plan must cover prescribed, self-administered anticancer medication that is used to kill or slow the growth of cancerous cells on at least a comparable basis to the plan's coverage for the delivery of cancer chemotherapy medications administered in a clinical or medical setting.

(1) A carrier may not impose dollar limits, copayments, deductibles or coinsurance requirements on coverage for orally administered anticancer drugs or chemotherapy that are less favorable to an insured or enrollee than the dollar limits, copayments, deductibles or coinsurance requirements that apply to coverage for anticancer medication or chemotherapy that is administered intravenously or by injection.

(2) A carrier may not reclassify an anticancer medication or increase an enrollee's out-of-pocket costs as a method of compliance with the requirements of this section.

[WSR 16-01-081, recodified as § 284-43-5200, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.02.062, 48.18.140, 48.43.525, 48.44.050, 48.44.440(2), 48.44.460(2), 48.46.200, and 48.46.510. WSR 12-21-019 (Matter No. R 2012-03), § 284-43-840, filed 10/8/12, effective 11/8/12.]

WAC 284-43-5400 Purpose and scope. For plan years beginning on or after January 1, 2014, each nongrandfathered health benefit plan offered, issued, 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. WAC 284-43-5400 through 284-43-5820 explains the regulatory standards defining this coverage, and establishes supplementa-

tion of the base-benchmark plan consistent with RCW 48.43.715, and the parameters of the state EHB-benchmark plan.

(1) WAC 284-43-5400 through 284-43-5820 do 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), to a health benefit plan that qualifies as a grandfathered health plan as defined in RCW 48.43.005, nor to a health plan excluded from the definition of "health plan" as defined in RCW 48.43.005.

(2) WAC 284-43-5400 through 284-43-5820 do not require provider reimbursement at the same levels negotiated by the base-benchmark plan's issuer for their plan.

(3) WAC 284-43-5400 through 284-43-5820 do not require a health benefit plan to exclude the services or treatments from coverage that are excluded in the base-benchmark plan.

[Statutory Authority: RCW 48.02.060, 48.43.012, 48.43.01211, 48.43.0123, 48.43.0124, 48.43.0126, 48.43.0127, 48.43.0128, and 48.43.715. WSR 20-03-114 (Matter No. R 2019-10), § 284-43-5400, filed 1/16/20, effective 2/16/20. Statutory Authority: RCW 48.02.060. WSR 16-14-106 (Matter No. R 2016-11), § 284-43-5400, filed 7/6/16, effective 8/6/16. WSR 16-01-081, recodified as § 284-43-5400, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.21.241, 48.21.320, 48.44.050, 48.44.341, 48.44.460, 48.46.200, 48.46.291, 48.46.530, 48.43.715, and Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010) (PPACA), as amended by the Health Care and Education Reconciliation Act (HCERA), Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010), in particular § 1302 of PPACA, § 10104 (b)(1) (HCERA). WSR 13-15-025 (Matter No. R 2012-17), § 284-43-849, filed 7/9/13, effective 7/10/13.]

WAC 284-43-5410 Definitions. The following definitions apply to WAC 284-43-5400 through 284-43-5820 unless the context indicates otherwise.

"Base-benchmark plan" means the small group plan with the largest enrollment, as designated in WAC 284-43-5602(1) until December 31, 2025, or the updated essential health benefits benchmark plan described in WAC 284-43-5604(1), prior to any supplementation or 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, or renewed by an admitted issuer in the state of Washington for the individual health benefit plan market, unless the certificate of coverage is issued to an individual pursuant to or issued through an organization meeting the definition established 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, delivery method, or health status based requirements.

"Meaningful health benefit" means a benefit that must be included in an essential health benefit category, without which the coverage for the category does not 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 health benefit 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, 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, and 45 C.F.R. 144.102(c), 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.

[Statutory Authority: RCW 48.02.060, 48.49.110, 2024 c 366, 2025 c 25, and 2025 c 171. WSR 26-01-148 (Matter R 2025-12), s 284-43-5410, filed 12/19/25, effective 1/19/26. Statutory Authority: RCW 48.02.060. WSR 16-14-106 (Matter No. R 2016-11), § 284-43-5410, filed 7/6/16, effective 8/6/16. WSR 16-01-081, recodified as § 284-43-5410, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.21.241, 48.21.320, 48.44.050, 48.44.341, 48.44.460, 48.46.200, 48.46.291, 48.46.530, 48.43.715, and Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010) (PPACA), as amended by the Health Care and Education Reconciliation Act (HCERA), Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010), in particular § 1302 of PPACA, § 10104 (b)(1) (HCERA). WSR 13-15-025 (Matter No. R 2012-17), § 284-43-852, filed 7/9/13, effective 7/10/13.]

WAC 284-43-5420 Clinical trials. A carrier must not restrict coverage of routine patient costs for enrollees who participate in a clinical trial. "Routine costs" means items and services delivered to the enrollee that are consistent with and typically covered by the plan or coverage for an enrollee who is not enrolled in a clinical trial. A carrier may continue to apply its limitations and requirements related to use of network services.

(1) A carrier may require enrollees to meet the eligibility requirements of the clinical trial according to the trial protocol. While not required to impose such a condition, a carrier may refuse coverage under this section if the enrollee does not provide medical and scientific information establishing that the individual's participation in such trial would be appropriate based on the individual

meeting the eligibility requirements for the clinical trial, unless the enrollee is referred to the clinical trial by a health care provider participating in the carrier's network.

(2) This includes the cost of prescription medication used for the direct clinical management of the enrollee, unless the trial is for the investigation of the prescription medication or the medication is typically provided by the research sponsors free of charge for any enrollee in the trial.

(3) The requirement does not apply to:

(a) A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;

(b) For items and services provided solely to satisfy data collection and analysis needs;

(c) Items and services that are not used in the direct clinical management of the enrollee; or

(d) The investigational item, device, or service itself.

(4) Clinical trial means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, funded or approved by:

(a) One of the National Institutes of Health (NIH);

(b) An NIH cooperative group or center which is a formal network of facilities that collaborate on research projects and have an established NIH-approved peer review program operating within the group including, but not limited to, the NCI Clinical Cooperative Group and the NCI Community Clinical Oncology Program;

(c) The federal Departments of Veterans Affairs or Defense;

(d) An institutional review board of an institution in this state that has a multiple project assurance contract approval by the Office of Protection for the Research Risks of the NIH; or

(e) A qualified research entity that meets the criteria for NIH Center Support Grant eligibility.

"Life threatening condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

[WSR 16-01-081, recodified as § 284-43-5420, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060. WSR 13-03-038 (Matter No. R 2012-25), § 284-43-850, filed 1/9/13, effective 2/9/13. Statutory Authority: RCW 48.02.060, 48.02.062, 48.18.140, 48.43.525, 48.44.050, 48.44.440(2), 48.44.460(2), 48.46.200, and 48.46.510. WSR 12-21-019 (Matter No. R 2012-03), § 284-43-850, filed 10/8/12, effective 11/8/12.]

WAC 284-43-5440 Medical necessity determination. (1) An issuer's certificate of coverage and the summary of coverage for the health benefit 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;

(d) Identify the information needed in the decision-making process and incorporate appropriate outcomes within a developmental framework;

(e) 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;

(f) Comply with inclusion of the ten essential health benefits categories;

(g) Not discriminate 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;

(h) 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;

(i) Identify by role who will participate in the issuer's medical necessity decision-making process; and

(j) Ensure that where medically appropriate, and consistent with the health benefit plan's contract terms, an enrollee is not unreasonably 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 one of but not the sole criteria for determining medical necessity.

(4) Within thirty days of receiving a request, an issuer must furnish its medical necessity criteria for medical/surgical benefits and mental health/substance use disorder benefits or for other essential health benefit categories to an enrollee or provider.

[WSR 16-01-081, recodified as § 284-43-5440, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.21.241, 48.21.320, 48.44.050, 48.44.341, 48.44.460, 48.46.200, 48.46.291, 48.46.530, 48.43.715, and Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010) (PPACA), as amended by the Health Care and Education Reconciliation Act (HCERA), Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010), in particular § 1302 of PPACA, § 10104 (b)(1) (HCERA). WSR 13-15-025 (Matter No. R 2012-17), § 284-43-860, filed 7/9/13, effective 7/10/13.]

WAC 284-43-5602 Essential health benefits package benchmark reference plan. A nongrandfathered individual or small group health benefit plan offered, issued, amended, or renewed on or after January 1, 2017, must, at a minimum, include coverage for essential health benefits. "Essential health benefits" means all of the following:

(1) The benefits and services covered by health care service contractor Regence BlueShield as the *Regence Direct Gold* + small group plan, policy form number WW0114CCONMSD and certificate form number

WW0114BPPO1SD, offered during the first quarter of 2014. The SERFF form filing number is RGWA-128968362.

(2) The services and items covered by a health benefit plan that are within the categories defined in RCW 48.43.005 as "essential health benefits" including, but not limited to:

(a) Ambulatory patient services;

(b) Emergency services;

(c) Hospitalization;

(d) Maternity and newborn care;

(e) Mental health and substance use disorder services, including behavioral health treatment;

(f) Prescription drugs;

(g) Rehabilitative and habilitative services and devices;

(h) Laboratory services;

(i) Preventive and wellness services and chronic disease management;

(j) Pediatric services, including oral and vision care; and

(k) Other services as supplemented by the commissioner or required by the secretary of the U.S. Department of Health and Human Services.

(3) Mandated benefits pursuant to Title 48 RCW enacted before December 31, 2011.

(4) This section applies to health plans that have an effective date of January 1, 2017, or later.

(5) This section expires on December 31, 2025.

[Statutory Authority: RCW 48.02.060, 48.49.110, 2024 c 366, 2025 c 25, and 2025 c 171. WSR 26-01-148 (Matter R 2025-12), s 284-43-5602, filed 12/19/25, effective 1/19/26. Statutory Authority: RCW 48.02.060, 48.43.012, 48.43.01211, 48.43.0123, 48.43.0124, 48.43.0126, 48.43.0127, 48.43.0128, and 48.43.715. WSR 20-03-114 (Matter No. R 2019-10), § 284-43-5602, filed 1/16/20, effective 2/16/20. WSR 16-01-081, recodified as § 284-43-5602, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.21.241, 48.21.320, 48.44.460, 48.44.341, 48.46.291, 48.46.530, and 48.43.715. WSR 15-20-042 (Matter No. R 2015-02), § 284-43-8651, filed 9/29/15, effective 9/29/15.]

WAC 284-43-5604 Essential health benefits package benchmark plan. A nongrandfathered individual or small group health benefit plan offered, issued, amended, or renewed on or after January 1, 2026, must, at a minimum, include coverage for essential health benefits. "Essential health benefits" means all of the following:

(1) The benefits and services covered within Appendix B - Washington Essential Health Benefits Benchmark Plan and Appendix C - State EHB Benefits Benchmark Summary of Benefits as approved by the department of health and human services Centers for Medicare and Medicaid Services on October 7, 2024, as posted on the website of the office of the insurance commissioner.

(2) The services and items covered by a health benefit plan that are within the categories defined in RCW 48.43.005 as "essential health benefits" including, but not limited to:

(a) Ambulatory patient services;

(b) Emergency services;

(c) Hospitalization;

(d) Maternity and newborn care;

(e) Mental health and substance use disorder services, including behavioral health treatment;

(f) Prescription drugs;

(g) Rehabilitative and habilitative services and devices;

(h) Laboratory services;

(i) Preventive and wellness services and chronic disease management;

(j) Pediatric services, including oral and vision care; and

(k) Other services as supplemented by the commissioner or required by the secretary of the U.S. Department of Health and Human Services.

(3) Mandated benefits pursuant to Title 48 RCW enacted before December 31, 2011.

[Statutory Authority: RCW 48.02.060, 48.49.110, 2024 c 366, 2025 c 25, and 2025 c 171. WSR 26-01-148 (Matter R 2025-12), s 284-43-5604, filed 12/19/25, effective 1/19/26.]

WAC 284-43-5622 Plan design. (1) A nongrandfathered individual or small group health benefit plan offered, issued, or renewed, on or after January 1, 2017, must provide coverage that is substantially equal to the EHB-benchmark plan, as described in WAC 284-43-5642, 284-43-5702, and 284-43-5782.

(a) For plans offered, issued, or renewed for a plan or policy year beginning on or after January 1, 2017, an issuer must offer the EHB-benchmark plan without substituting benefits for the benefits specifically identified in the EHB-benchmark plan.

(b) "Substantially equal" means that:

(i) The scope and level of benefits offered within each essential health benefit category supports a determination by the commissioner that the benefit is a meaningful health benefit;

(ii) The aggregate actuarial value of the benefits across all essential health benefit categories does not vary more than a de minimis amount from the aggregate actuarial 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 284-43-5642, 284-43-5702, and 284-43-5782 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 benefits not specifically identified as covered or excluded is determined based on medical necessity. An issuer may use this plan design, provided that 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 that are specifically excluded by the base-benchmark plan. If an issuer elects to cover a benefit excluded in the base-benchmark plan, the issuer must

not include the benefit in its essential health benefits package for purposes of determining actuarial value. A health benefit 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 a method of accessing services, and are not a separate benefit for purposes of the essential health benefits package. Issuers must provide essential health benefits consistent with the requirements of RCW 48.43.735.

(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) Benefits under each category set forth in WAC 284-43-5642, 284-43-5702, or 284-43-5782 must be covered for both pediatric and adult populations unless:

(a) A benefit is specifically limited to a particular age group in the base-benchmark plan and such limitation is consistent with state and federal law; or

(b) The category of essential health benefits is specifically stated to be applicable only to the pediatric population, such as pediatric oral services.

(9) A health benefit plan must 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 health 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). The commissioner will approve health benefit plans for offer in Washington state that are, at a minimum, consistent with current state law including, but not limited to, RCW 49.60.040, 49.60.178, 48.30.300, 48.43.0128, 48.43.072, 48.43.073, 48.44.220, and 48.46.370 and with federal rules and guidance implementing 42 U.S.C. 18116, Sec. 1557 including, but not limited to, those specifically found in 81 Fed. Reg. 31375, et seq. (2016), that were in effect on January 1, 2017.

(10) An issuer must not impose annual or lifetime dollar limits on an essential health benefit, other than those permitted under WAC 284-43-5642, 284-43-5702, and 284-43-5782.

(11) This section applies to health plans that have an effective date of January 1, 2017, or later.

(12) This section expires December 31, 2025.

[Statutory Authority: RCW 48.02.060, 48.49.110, 2024 c 366, 2025 c 25, and 2025 c 171. WSR 26-01-148 (Matter R 2025-12), s 284-43-5622, filed 12/19/25, effective 1/19/26. Statutory Authority: RCW 48.02.060, 48.43.012, 48.43.01211, 48.43.0123, 48.43.0124, 48.43.0126, 48.43.0127, 48.43.0128, and 48.43.715. WSR 20-03-114 (Matter No. R 2019-10), § 284-43-5622, filed 1/16/20, effective 2/16/20. Statutory Authority: RCW 48.02.060. WSR 16-14-106 (Matter No. R 2016-11), § 284-43-5622, filed 7/6/16, effective 8/6/16. WSR 16-01-081, recodified as § 284-43-5622, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.21.241, 48.21.320, 48.44.460, 48.44.341, 48.46.291, 48.46.530, and 48.43.715. WSR 15-20-042 (Matter No. R 2015-02), § 284-43-8771, filed 9/29/15, effective 9/29/15.]

WAC 284-43-5624 Plan design. (1) A nongrandfathered individual or small group health benefit plan offered, issued, or renewed, on or after January 1, 2026, must provide coverage that is substantially equal to the EHB-benchmark plan, as described in WAC 284-43-5644, 284-43-5704, and 284-43-5784.

(a) For plans offered, issued, or renewed for a plan or policy year beginning on or after January 1, 2026, an issuer must offer the EHB-benchmark plan without substituting benefits for the benefits specifically identified in the EHB-benchmark plan.

(b) "Substantially equal" means that:

(i) The scope and level of benefits offered within each essential health benefit category supports a determination by the commissioner that the benefit is a meaningful health benefit;

(ii) The aggregate actuarial value of the benefits across all essential health benefit categories does not vary more than a de minimis amount from the aggregate actuarial 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 284-43-5644, 284-43-5704, and 284-43-5784 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 benefits not specifically identified as covered or excluded is determined based on medical necessity. An issuer may use this plan design, provided that 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 that are specifically excluded by the base-benchmark plan. If an issuer elects to cover a benefit excluded in the base-benchmark plan, the issuer must not include the benefit in its essential health benefits package for purposes of determining actuarial value. A health benefit 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 practice as determined by Washington state law 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 a method of accessing services, and are not a separate benefit for purposes of the essential health benefits package. Issuers must provide essential health benefits consistent with the requirements of RCW 48.43.735.

(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) Benefits under each category set forth in WAC 284-43-5644, 284-43-5704, or 284-43-5784 must be covered for both pediatric and adult populations unless:

(a) A benefit is specifically limited to a particular age group in the base-benchmark plan and such limitation is consistent with state and federal law; or

(b) The category of essential health benefits is specifically stated to be applicable only to the pediatric population, such as pediatric oral services.

(9) A health benefit plan must 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 health 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). The commissioner may approve health benefit plans for offer in Washington state that are, at a minimum, consistent with current state laws including, but not limited to, RCW 49.60.040, 49.60.178, 48.30.300, 48.43.0128, 48.43.072, 48.43.073, 48.44.220, and 48.46.370 and with federal rules and guidance implementing 42 U.S.C. 18116, Sec. 1557 including, but not limited to, those specifically found in 81 Fed. Reg. 31375, et seq. (2016), that were in effect on January 1, 2017.

(10) An issuer must not impose annual or lifetime dollar limits on an essential health benefit, other than those permitted under WAC 284-43-5644, 284-43-5704, and 284-43-5784.

[Statutory Authority: RCW 48.02.060, 48.49.110, 2024 c 366, 2025 c 25, and 2025 c 171. WSR 26-01-148 (Matter R 2025-12), s 284-43-5624, filed 12/19/25, effective 1/19/26.]

WAC 284-43-5642 Essential health benefit categories. (1) A health benefit plan must cover "ambulatory patient services" in a man-

ner substantially equal to the base-benchmark plan. For purposes of determining a plan's actuarial value, an issuer must classify as "ambulatory patient services" those 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.

(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 outpatient 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, professional surgical services, surgical supplies and facility costs;

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

(vii) Provider contraceptive services and supplies including, but not limited to, vasectomy, tubal ligation and insertion 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. The base-benchmark plan specifically excludes these services. If an issuer includes these benefits in a health plan, the issuer should not include the following benefits in establishing actuarial value for the ambulatory 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. However, health plans must cover oral surgery related to trauma and injury. Therefore, a plan may not exclude services or appliances necessary for or resulting from medical treatment if the service is either emergency in nature or requires extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease;

(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. However, plans must cover cochlear implants and hearing screening tests that are 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; and

(viii) Obesity or weight reduction or control other than:

(A) Covered nutritional counseling; and

(B) Obesity-related services for which the U.S. Preventive Services Task Force for prevention and chronic care has issued A and B recommendations on or before the applicable plan year, which issuers must cover under subsection (9) of this section.

(c) The base-benchmark plan's visit limitations on services in the ambulatory patient services 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; and

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

(d) State benefit requirements classified to the ambulatory patient services category are:

(i) Chiropractic care (RCW 48.44.310);

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

(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" in a manner substantially equal to the base-benchmark plan. For purposes of determining a plan's actuarial value, an issuer must classify as emergency medical services the care and services related to an emergency medical condition.

(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 and department 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 specifically exclude services classified to the emergency medical services category.

(c) The base-benchmark plan does not establish visit limitations on services in the emergency medical services category.

(d) State benefit requirements classified to the emergency medical services category include services necessary to screen and stabilize a covered person (RCW 48.43.093).

(3) A health benefit plan must cover "hospitalization" in a manner substantially equal to the base-benchmark plan. For purposes of determining a plan's actuarial value, an issuer must classify as hospitalization services the medically necessary 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.

(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 or donor 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 recommendations;

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

(vii) Inpatient hospitalization where mental illness is the primary diagnosis.

(b) A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. The base-benchmark plan specifically excludes these services. If an issuer includes these benefits in a health plan, the issuer should not include the following benefits in establishing actuarial value for the hospitalization category:

(i) 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;

(ii) 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.

(iii) Reversal of sterilizations; and

(iv) 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, 2017. Health plans may not include the base-benchmark plan limitations listed below and must cover all services consistent with federal rules and guidance implementing 42 U.S.C. 18116, Sec. 1557, including those codified at 81 Fed. Reg. 31375 et seq. (2016), that were in effect on January 1, 2017, RCW 48.30.300, 48.43.0128, 48.43.072, 48.43.073, 49.60.040 and 49.60.178:

(i) The base-benchmark plan allows a waiting period for transplant services;

(ii) The base-benchmark plan excludes coverage for sexual reassignment treatment, surgery, or counseling services; and

(iii) The base-benchmark plan excludes coverage for hospitalization where mental illness or a substance use disorder is the primary diagnosis.

(d) The base-benchmark plan's visit limitations on services in the hospitalization 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. For purposes of determining actuarial value, this benefit may be classified to the hospitalization category or to the rehabilitation services category, but not to both.

(e) State benefit requirements classified to the hospitalization 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); and

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

(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 coverage that is substantially equivalent to coverage for maternal care or services, as provided in RCW 48.43.073.

(b) A health benefit plan may, but is not required to, include genetic testing of the child's father as part of the EHB-benchmark package. The base-benchmark plan specifically excludes this service. If an issuer covers this benefit, the issuer may not include this benefit in establishing actuarial value for the maternity and newborn category.

(c) The base-benchmark plan's limitations on services in the maternity and newborn services category include coverage of home birth by a midwife or nurse midwife only for low risk pregnancy.

(d) State benefit requirements classified to the maternity and newborn services 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 postnatal coverage for the mother, for no less than three weeks (RCW 48.43.115); and

(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" in a manner substantially equal to the base-benchmark plan. For purposes of determining a plan's actuarial value, an issuer must classify as men-

tal health and substance use disorder services, including behavioral health treatment, the 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)* published by the American Psychiatric Association, including behavioral health treatment for those conditions.

(a) A health benefit plan must include the following services, 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 diagnosis, 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 including medications 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, but is not required to, include court-ordered mental health treatment that is not medically necessary as part of the EHB-benchmark package. The base-benchmark plan specifically excludes this service. If an issuer includes this benefit in a health plan, the issuer may not include this benefit in establishing actuarial value for the category of mental health and substance use disorder services including behavioral 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, 2017. The state EHB-benchmark plan requirements for these services are: The base-benchmark plan does not provide coverage for mental health services and substance use disorder treatment delivered in a home health setting in parity with medical surgical benefits consistent with state and federal law. Health plans must cover mental health services and substance use disorder treatment that is delivered in parity with medical surgical benefits, consistent with state and federal law.

(d) The base-benchmark plan's visit limitations on services in this category include court-ordered treatment only when medically necessary.

(e) State benefit requirements classified to 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); and

(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) including where state law is silent, or where federal law preempts state law.

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

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

(i) Drugs and medications both generic and brand name, including self-administrable prescription medications, consistent with the requirements of (b) through (e) 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;

(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; and

(v) Medical foods to treat inborn errors of metabolism in accordance with RCW 48.44.440, 48.46.510, 48.20.520, 48.21.300, and 48.43.176.

(b) A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. The base-benchmark plan specifically excludes these services for the prescription drug services category. If an issuer includes these services, the issuer may not include the following benefits in establishing actuarial value for the prescription drug services category:

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

(ii) Weight loss drugs.

(c) The base-benchmark plan's visit limitations on services in the prescription drug services category include:

(i) Prescriptions for self-administrable injectable medication are limited to 30 day supplies at a time, other than insulin, which may be offered with more than a 30 day supply. This limitation is a floor, and an issuer may permit supplies greater than 30 days as part of its health benefit plan;

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

(d) State benefit requirements classified to the prescription drug services category include:

(i) Medical foods to treat inborn errors of metabolism (RCW 48.44.440, 48.46.510, 48.20.520, 48.21.300, and 48.43.176);

(ii) Diabetes supplies ordered by the physician (RCW 48.44.315, 48.46.272, 48.20.391, and 48.21.143). Inclusion of this benefit requirement 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);

(iv) Reproductive health-related over-the-counter drugs, devices, and products approved by the federal Food and Drug Administration.

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

(iii) An issuer may include over-the-counter medications in its formulary for purposes of establishing quantitative limits and administering the benefit.

(7) A health benefit plan must cover "rehabilitative and habilitative services" in a manner substantially equal to the base-benchmark plan.

(a) For purposes of determining a plan's actuarial value, an issuer must classify as rehabilitative services the 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.

(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) Inpatient rehabilitation facilities 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 apparatus used to support, align or correct deformities or to improve the function of moving parts; and

(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. The base-benchmark plan specifically excludes these services. If an issuer includes the following benefits in a health plan, the issuer may not include these benefits in establishing actuarial value for the rehabilitative and habilitative services category:

(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) For purposes of determining a plan's actuarial value, an issuer must classify as habilitative services the range of medically necessary health care services and health care devices designed to assist a person to keep, learn or improve skills and functioning for daily living. Examples include services for a child who isn't walking or talking at the expected age, or services to assist with keeping or learning skills and functioning within an individual's environment, or

to compensate for a person's progressive physical, cognitive, and emotional illness. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient or outpatient settings.

(i) As a minimum level of coverage, an issuer must establish limitations on habilitative services on parity with those for rehabilitative services. A health benefit plan may include such 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 supersede any rehabilitative services parity limitations permitted by this subsection.

(ii) 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.

(iii) 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.

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

(v) 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.

(vi) 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 and included in an individual educational plan (IEP).

(e) The base-benchmark plan's visit limitations on services in the rehabilitative and habilitative services category include:

(i) Inpatient rehabilitation facilities and professional services delivered in those facilities are limited to 30 service days per calendar year; and

(ii) Outpatient physical therapy, occupational therapy and speech therapy are limited to 25 outpatient visits per calendar year, on a combined basis, for rehabilitative purposes.

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

(i) State sales tax for durable medical equipment; and

(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" in a manner substantially equal to the base-benchmark plan. For purposes of determining actuarial value, an issuer must classify as laboratory services the 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.

(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; and

(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. The base-benchmark plan specifically excludes procurement and storage of personal blood supplies provided by a member of the enrollee's family when this service is not medically indicated. If an issuer includes this benefit in a health plan, the issuer may not include this benefit in establishing the health plan's actuarial value.

(9) A health plan must cover "preventive and wellness services, including chronic disease management" in a manner substantially equal to the base-benchmark plan. For purposes of determining a plan's actuarial value, an issuer must classify as preventive and wellness services, including chronic disease management, the 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; and services of particular preventative or early identification of disease or illness of value to specific populations, such as women, children and seniors.

(a) If a plan does not have in its network a provider who can perform the particular service, then the plan must cover the item or service when performed by an out-of-network provider and must not impose cost-sharing with respect to the item or service. In addition, a health plan must not limit sex-specific recommended preventive services based on an individual's sex assigned at birth, gender identity or recorded gender. If a provider determines that a sex-specific recommended preventive service is medically appropriate for an individual, and the individual otherwise satisfies the coverage requirements, the plan must provide coverage without cost-sharing.

(b) A health benefit plan must include the following services as preventive and wellness services, including chronic disease management:

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

(ii)(A) Screening and tests for which the U.S. Preventive Services Task Force has issued A and B recommendations on or before the applicable plan year.

(B) To the extent not specified in the relevant recommendation or guideline, federal rules and guidance related to preventive services in effect on January 8, 2024, and in chapter 284-43 WAC, a plan may use reasonable medical management techniques to determine the frequency, method, treatment, or setting for the provision of an item or service described in RCW 48.43.047;

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

(iv) Services, tests, screening and supplies recommended in the HRSA women's preventive and wellness services guidelines:

(A) If the plan covers children under the age of 19, or covers dependent children age 19 or over who are on the plan pursuant to RCW 48.44.200, 48.44.210, or 48.46.320, the plan must provide the child with the full range of recommended preventive services suggested under HRSA guidelines for the child's age group without cost-sharing. Services provided in this regard may be combined in one visit as medically appropriate or may be spread over more than one visit, without incurring cost-sharing, as medically appropriate; and

(B) A plan may use reasonable medical management techniques to determine the frequency, method, treatment or setting for an item or service described in RCW 48.43.047, including providing multiple prevention and screening services at a single visit or across multiple visits. Medical management techniques may not be used that limit enrollee choice in accessing the full range of contraceptive drugs, devices, or other products approved by the federal Food and Drug Administration.

(v) Chronic disease management services, which typically include, but are not limited to, a treatment plan with regular monitoring, coordination of care between multiple providers and settings, medication management, evidence-based care, measuring care quality and outcomes, and support for patient self-management through education or tools; and

(vi) Wellness services.

(c) The base-benchmark plan establishes specific limitations on services classified to the preventive services category that conflict with state or federal law as of January 1, 2017, and should not be included in essential health benefit plans. Specifically, the base-benchmark plan excludes coverage for obesity or weight control other than covered nutritional counseling. Health plans must cover certain obesity-related services that are listed as A or B recommendations by the U.S. Preventive Services Task Force, consistent with RCW 48.43.047 and 45 C.F.R. 147.130 (a)(1)(i).

(d) The base-benchmark plan does not establish visit limitations on services in this category. In accordance with Sec. 2713 of the Public Health Service Act (PHS Act) and its implementing regulations relating to coverage of preventive services, the base-benchmark plan does not impose cost-sharing requirements with respect to the preventive services listed under (b)(i) through (iv) of this subsection that are provided in-network.

(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); and

(iii) Prostate cancer screening (RCW 48.20.392, 48.21.227, 48.44.327, and 48.46.277).

(10) Some state benefit requirements are limited to those receiving pediatric services, but are classified to other categories for purposes of determining actuarial value.

(a) These benefits include:

(i) Neurodevelopmental therapy, 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). This state benefit requirement may be classified to ambulatory patient services or mental health and substance abuse disorder including behavioral health categories; and

(ii) Treatment of congenital anomalies in newborn and dependent children (RCW 48.20.430, 48.21.155, 48.44.212, and 48.46.250). This state benefit requirement may be classified to hospitalization, ambulatory patient services or maternity and newborn categories.

(b) The base-benchmark plan contains limitations or scope restrictions that conflict with state or federal law as of January 1, 2017. Specifically, the plan covers outpatient neurodevelopmental therapy services only for persons age six and under. Health plans must cover medically necessary neurodevelopmental therapy for any DSM diagnosis without blanket exclusions.

(11) Issuers must know and apply relevant guidance, clarifications and expectations issued by federal governmental agencies regarding essential health benefits. Such clarifications may include, but are not limited to, Affordable Care Act implementation and frequently asked questions jointly issued by the U.S. Department of Health and Human Services, the U.S. Department of Labor and the U.S. Department of the Treasury.

(12) Each category of essential health benefits must at a minimum cover services required by current state law and be consistent with federal rules and guidance implementing 42 U.S.C. 18116, Sec. 1557, including those codified at 81 Fed. Reg. 31375 et seq. (2016), that were in effect on January 1, 2017.

(13) This section applies to health plans that have an effective date of January 1, 2020, or later.

(14) This section expires on December 31, 2025.

[Statutory Authority: RCW 48.02.060, 48.49.110, 2024 c 366, 2025 c 25, and 2025 c 171. WSR 26-01-148 (Matter R 2025-12), s 284-43-5642, filed 12/19/25, effective 1/19/26. Statutory Authority: RCW 48.02.060, 48.43.0961, 2023 c 325, 48.43.735, 2024 c 215, 48.43.047, 2024 c 314, and 89 F.R. 37522. WSR 24-24-067 (Matter R 2024-05), s 284-43-5642, filed 11/27/24, effective 12/28/24. Statutory Authority: RCW 48.02.060, 48.20.460, 48.43.0128, 48.44.050, and 48.46.200. WSR 20-24-040, § 284-43-5642, filed 11/23/20, effective 12/24/20. Statutory Authority: RCW 48.02.060, 48.43.012, 48.43.01211, 48.43.0123, 48.43.0124, 48.43.0126, 48.43.0127, 48.43.0128, and 48.43.715. WSR 20-03-114 (Matter No. R 2019-10), § 284-43-5642, filed 1/16/20, effective 2/16/20. Statutory Authority: RCW 48.02.060 and 48.43.715. WSR 20-01-071 (Matter No. R 2019-09), § 284-43-5642, filed 12/11/19, effective 1/11/20; WSR 16-19-085 (Matter No. R 2015-18), § 284-43-5642, filed 9/20/16, effective 10/21/16. WSR 16-01-081, recodified as § 284-43-5642, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.21.241, 48.21.320, 48.44.460, 48.44.341, 48.46.291, 48.46.530, and 48.43.715. WSR 15-20-042 (Matter No. R 2015-02), § 284-43-8781, filed 9/29/15, effective 9/29/15.]

WAC 284-43-5644 Essential health benefit categories. (1) A health benefit plan must cover "ambulatory patient services" in a manner substantially equal to the base-benchmark plan. For purposes of determining a plan's actuarial value, an issuer must classify as "ambulatory patient services" those 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.

(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 outpatient 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, professional surgical services, surgical supplies and facility costs;

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

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

(viii) Medically necessary routine foot care;

(ix) Acupuncture as medically necessary; and

(x) Preliminary evaluations and diagnosis to determine if and why a covered member is infertile and artificial insemination procedures.

(b) A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. The base-benchmark plan specifically excludes these services. If an issuer includes these benefits in a health plan, the issuer should not include the following benefits in establishing actuarial value for the ambulatory category:

(i) Infertility treatment,other than preliminary evaluations and diagnosis to determine if and why a covered member is infertile and artificial insemination;

(ii) Reversal of voluntary sterilization and those services referenced in (a)(vii) of this subsection;

(iii) Coverage of dental services following injury to sound natural teeth. However, health plans must cover oral surgery related to trauma and injury. Therefore, a plan may not exclude services or appliances necessary for or resulting from medical treatment if the service is either emergency in nature or requires extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease;

(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) Obesity or weight reduction or control other than:

(A) Covered nutritional counseling; and

(B) Obesity-related services for which the U.S. Preventive Services Task Force for prevention and chronic care has issued A and B recommendations on or before the applicable plan year, which issuers must cover under subsection (9) of this section.

(c) The base-benchmark plan's visit limitations on services in the ambulatory patient services category include:

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

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

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

(d) State benefit requirements classified to the ambulatory patient services category are:

(i) Chiropractic care (RCW 48.44.310);

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

(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" in a manner substantially equal to the base-benchmark plan. For purposes of determining a plan's actuarial value, an issuer must classify as "emergency medical services" the care and services related to an emergency medical condition.

(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 or behavioral health emergency services provider and treatment provided as part of the ambulance service;

(ii) Emergency room and department based services, supplies and treatment and behavioral health emergency services provider 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. Detoxification services are an emergency service;

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

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

(c) The base-benchmark plan does not establish visit limitations on services in the emergency medical services category.

(d) State benefit requirements classified to the emergency medical services category include services necessary to screen and stabilize a covered person (RCW 48.43.093).

(3) A health benefit plan must cover "hospitalization" in a manner substantially equal to the base-benchmark plan. For purposes of determining a plan's actuarial value, an issuer must classify as "hospitalization services" the medically necessary 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.

(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 or donor 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 recommendations;

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

(vii) Inpatient hospitalization where mental illness is the primary diagnosis.

(b) A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. The base-benchmark plan specifically excludes these services. If an issuer includes these benefits in a health plan, the issuer should not include the following benefits in establishing actuarial value for the hospitalization category:

(i) 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;

(ii) 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;

(iii) Reversal of sterilizations; and

(iv) 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, 2017. Health plans may not include the base-benchmark plan limitations listed below and must cover all services consistent with federal rules and guidance implementing 42 U.S.C. 18116, Sec. 1557, including those codified at 81 Fed. Reg. 31375 et seq. (2016), that were in effect on January 1, 2017, RCW 48.30.300, 48.43.0128, 48.43.072, 48.43.073, 49.60.040 and 49.60.178.

(d) The base-benchmark plan's visit limitations on services in the hospitalization 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. For purposes of determining actuarial value, this benefit may be classified to the hospitalization category or to the rehabilitation services category, but not to both.

(e) State benefit requirements classified to the hospitalization 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); and

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

(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) Donor human milk for inpatient use when ordered by a licensed health care provider with prescriptive authority or an international board certified lactation consultant certified by the international board of lactation consultant examiners for an infant who is medically or physically unable to receive maternal human milk or participate in chest feeding or whose parent is medically or physically unable to produce maternal human milk in sufficient quantities or caloric density or participate in chest feeding, if the infant meets at least one of the criteria outlined in RCW 48.43.815;

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

(viii) Termination of pregnancy coverage that is substantially equivalent to coverage for maternal care or services, as provided in RCW 48.43.073.

(b) A health benefit plan may, but is not required to, include genetic testing of the child's father as part of the EHB-benchmark package. The base-benchmark plan specifically excludes this service. If an issuer covers this benefit, the issuer may not include this benefit in establishing actuarial value for the maternity and newborn category.

(c) The base-benchmark plan's limitations on services in the maternity and newborn services category include coverage of home birth by a midwife or nurse midwife only for low risk pregnancy.

(d) State benefit requirements classified to the maternity and newborn services 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 postnatal coverage for the mother, for no less than three weeks (RCW 48.43.115); and

(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" in a manner substantially equal to the base-benchmark plan. 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," the 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)* published by the American Psychiatric Association, including behavioral health treatment for those conditions.

(a) A health benefit plan must include the following services, 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 diagnosis, 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 including medications prescribed during an inpatient and residential course of treatment; and

(vi) Acupuncture treatment visits as medically necessary.

(b) A health benefit plan may, but is not required to, include court-ordered mental health treatment that is not medically necessary as part of the EHB-benchmark package. The base-benchmark plan specifically excludes this service. If an issuer includes this benefit in a health plan, the issuer may not include this benefit in establishing actuarial value for the category of mental health and substance use disorder services including behavioral 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, 2026. Health plans must cover mental health services and substance use disorder treatment that is delivered in parity with medical surgical benefits, consistent with state and federal law.

(d) The base-benchmark plan's visit limitations on services in this category include court-ordered treatment only when medically necessary.

(e) State benefit requirements classified to 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); and

(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) including where state law is silent, or where federal law preempts state law.

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

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

(i) Drugs and medications both generic and brand name, including self-administrable prescription medications, consistent with the requirements of (b) through (e) 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, and insulin and insulin syringes;

(iii) All FDA-approved contraceptive methods, and prescription-based sterilization procedures;

(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; and

(v) Medical foods to treat inborn errors of metabolism in accordance with RCW 48.44.440, 48.46.510, 48.20.520, 48.21.300, and 48.43.176.

(b) A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. The base-benchmark plan specifically excludes these services for the prescription drug services category. If an issuer includes these services, the issuer may not include the following benefits in establishing actuarial value for the prescription drug services category:

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

(ii) Weight loss drugs.

(c) The base-benchmark plan's visit limitations on services in the prescription drug services category include:

(i) Prescriptions for self-administrable injectable medication are limited to 30 day supplies at a time, other than insulin, which may be offered with more than a 30 day supply. This limitation is a floor, and an issuer may permit supplies greater than 30 days as part of its health benefit plan;

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

(d) State benefit requirements classified to the prescription drug services category include:

(i) Medical foods to treat inborn errors of metabolism (RCW 48.44.440, 48.46.510, 48.20.520, 48.21.300, and 48.43.176);

(ii) Diabetes supplies ordered by the physician (RCW 48.44.315, 48.46.272, 48.20.391, and 48.21.143). Inclusion of this benefit requirement 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);

(iv) Reproductive health-related over-the-counter drugs, devices, and products approved by the federal Food and Drug Administration.

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

(iii) An issuer may include over-the-counter medications in its formulary for purposes of establishing quantitative limits and administering the benefit.

(7) A health benefit plan must cover "rehabilitative and habilitative services" in a manner substantially equal to the base-benchmark plan.

(a) For purposes of determining a plan's actuarial value, an issuer must classify as "rehabilitative services" the 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.

(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) Inpatient rehabilitation facilities 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 apparatus used to support, align, or correct deformities or to improve the function of moving parts; and

(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. The base-benchmark plan specifically excludes these services. If an issuer includes the following benefits in a health plan, the issuer may not include these benefits in establishing actuarial value for the rehabilitative and habilitative services category:

(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

(d) For purposes of determining a plan's actuarial value, an issuer must classify as "habilitative services" the range of medically necessary health care services and health care devices designed to assist a person to keep, learn, or improve skills and functioning for daily living. Examples include services for a child who is not walking or talking at the expected age, or services to assist with keeping or learning skills and functioning within an individual's environment, or to compensate for a person's progressive physical, cognitive, and emo-

tional illness. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient or outpatient settings.

(i) As a minimum level of coverage, an issuer must establish limitations on habilitative services in parity with those for rehabilitative services. A health benefit plan may include such 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 supersede any rehabilitative services parity limitations permitted by this subsection.

(ii) 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.

(iii) 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.

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

(v) 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.

(vi) 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 and included in an individual educational plan (IEP).

(e) The base-benchmark plan's visit limitations on services in the rehabilitative and habilitative services category include:

(i) Inpatient rehabilitation facilities and professional services delivered in those facilities are limited to 30 service days per calendar year; and

(ii) Outpatient physical therapy, occupational therapy, and speech therapy are limited to 25 outpatient visits per calendar year, on a combined basis, for rehabilitative purposes.

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

(i) State sales tax for durable medical equipment; and

(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" in a manner substantially equal to the base-benchmark plan. For purposes of determining actuarial value, an issuer must classify as "laboratory services" the 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 scan.

(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; and

(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. The base-benchmark plan specifically excludes procurement and storage of personal blood supplies provided by a member of the enrollee's family when this service is not medically indicated. If an issuer includes this benefit in a health plan, the issuer may not include this benefit in establishing the health plan's actuarial value.

(9) A health plan must cover "preventive and wellness services, including chronic disease management" in a manner substantially equal to the base-benchmark plan. For purposes of determining a plan's actuarial value, an issuer must classify as "preventive and wellness services, including chronic disease management," the 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; and services of particular preventative or early identification of disease or illness of value to specific populations, such as women, children and seniors.

(a) If a plan does not have in its network a provider who can perform the particular service, then the plan must cover the item or service when performed by an out-of-network provider and must not impose cost-sharing with respect to the item or service. In addition, a health plan must not limit sex-specific recommended preventive services based on an individual's sex assigned at birth, gender identity, or recorded gender. If a provider determines that a sex-specific recommended preventive service is medically appropriate for an individual, and the individual otherwise satisfies the coverage requirements, the plan must provide coverage without cost-sharing.

(b) A health benefit plan must include the following services as preventive and wellness services, including chronic disease management:

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

(ii) Screening and tests for which the U.S. Preventive Services Task Force has issued A and B recommendations on or before the applicable plan year.

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

(iv) Services, tests, screening, and supplies recommended in the HRSA women's preventive and wellness services guidelines:

(A) If the plan covers children under the age of 19, or covers dependent children age 19 or over who are on the plan pursuant to RCW 48.44.200, 48.44.210, or 48.46.320, the plan must provide the child with the full range of recommended preventive services suggested under HRSA guidelines for the child's age group without cost-sharing. Services provided in this regard may be combined in one visit as medically appropriate or may be spread over more than one visit, without incurring cost-sharing, as medically appropriate; and

(B) A plan may use reasonable medical management techniques to determine the frequency, method, treatment, or setting for an item or service described in RCW 48.43.047, including providing multiple prevention and screening services at a single visit or across multiple visits. Medical management techniques may not be used that limit enrollee choice in accessing the full range of contraceptive drugs, devices, or other products approved by the federal Food and Drug Administration.

(v) To the extent not specified in the relevant recommendation or guideline, federal rules and guidance related to preventive services and in chapter 284-43 WAC, a plan may use reasonable medical management techniques to determine the frequency, method, treatment, or setting for the provision of an item or service described in RCW 48.43.047;

(vi) Chronic disease management services, which typically include, but are not limited to, a treatment plan with regular monitoring, coordination of care between multiple providers and settings, medication management, evidence-based care, measuring care quality and outcomes, and support for patient self-management through education or tools; and

(vii) Wellness services.

(c) The base-benchmark plan establishes specific limitations on services classified to the preventive services category that conflict with state or federal law as of January 1, 2017, and should not be included in essential health benefit plans. Specifically, the base-benchmark plan excludes coverage for obesity or weight control other than covered nutritional counseling and certain obesity-related services that are listed as A or B recommendations by the U.S. Preventive Services Task Force, consistent with RCW 48.43.047 and 45 C.F.R. 147.130 (a)(1)(i).

(d) The base-benchmark plan does not establish visit limitations on services in this category. In accordance with Sec. 2713 of the Public Health Service Act (PHS Act) and its implementing regulations relating to coverage of preventive services, the base-benchmark plan does not impose cost-sharing requirements with respect to the preventive services listed under (b)(i) through (iv) of this subsection that are provided in-network.

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

(i) Colorectal cancer screening (RCW 48.43.047);

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

(iii) Prostate cancer screening (RCW 48.20.392, 48.21.227, 48.44.327, and 48.46.277).

(10) Some state benefit requirements are limited to those receiving pediatric services, but are classified to other categories for purposes of determining actuarial value.

(a) These benefits include:

(i) Neurodevelopmental therapy, 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). This state benefit requirement may be classified to ambulatory patient services or mental health and substance abuse disorder including behavioral health categories; and

(ii) Treatment of congenital anomalies in newborn and dependent children (RCW 48.20.430, 48.21.155, 48.44.212, and 48.46.250). This state benefit requirement may be classified to hospitalization, ambulatory patient services, or maternity and newborn categories.

(11) Issuers must know and apply relevant guidance, clarifications, and expectations issued by federal governmental agencies regarding essential health benefits. Such clarifications may include, but are not limited to, Affordable Care Act implementation and frequently asked questions jointly issued by the U.S. Department of Health and Human Services, the U.S. Department of Labor, and the U.S. Department of the Treasury.

(12) Each category of essential health benefits must, at a minimum, cover services required by current state law and be consistent with federal rules and guidance implementing 42 U.S.C. 18116, Sec. 1557, including those codified at 81 Fed. Reg. 31375 et seq. (2016), that were in effect on January 1, 2017.

(13) This section applies to health plans that have an effective date of January 1, 2026, or later.

[Statutory Authority: RCW 48.02.060, 48.49.110, 2024 c 366, 2025 c 25, and 2025 c 171. WSR 26-01-148 (Matter R 2025-12), s 284-43-5644, filed 12/19/25, effective 1/19/26.]

WAC 284-43-5702 Essential health benefit category—Pediatric oral services. A health benefit plan must include "pediatric dental benefits" in its essential health benefits package. Pediatric dental benefits means coverage for the oral services listed in subsection (3) of this section, delivered to those under age 19. Plans must provide this coverage for enrollees until at least the end of the month in which the enrollee turns age 19.

(1) For benefit years beginning January 1, 2017, a health benefit plan must include pediatric dental benefits as an embedded set of benefits, or through a combination of a health benefit plan and a stand-alone dental plan that includes pediatric dental benefits certified as a qualified dental plan. For a health benefit plan certified by the health benefit exchange as a qualified health plan, this requirement is met if a stand-alone dental plan meeting the requirements of subsection (4) of this section is offered in the health benefit exchange for that benefit year.

(2) The requirements of WAC 284-43-5642 and 284-43-5782 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 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 284-43-5642 and covers pediatric oral services. The designated base-benchmark plan for pediatric dental benefits consists of the benefits and services covered by health care service contractor Regence BlueShield as the *Regence Direct Gold* small group plan policy form, policy form number WW0114CCONMSD, and certificate form number WW0114BPPO1SD, offered during the first quarter of 2014 (SERFF filing number RGWA-128968362). A health plan issuer must offer coverage for and classify the following pediatric oral services as pediatric dental benefits in a manner substantially equal to the base-benchmark plan:

(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, not including indirect pulp capping;

(f) Periodontics;

(g) Crown and fixed bridge;

(h) Removable prosthetics; and

(i) Medically necessary orthodontia.

(5) The 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, plus limited oral evaluations when necessary to evaluate for a specific dental problem or oral health complaint, dental emergency or referral for other treatment;

(b) Limited visual oral assessments or screenings, limited to two per member per calendar year, not performed in conjunction with other clinical oral evaluation services;

(c) Two sets of bitewing X-rays once a year for a total of four bitewing X-rays per year;

(d) Cephalometric films, limited to once in a two-year period;

(e) Panoramic X-rays once every three years;

(f) Occlusal intraoral X-rays, limited to once in a two-year period;

(g) Periapical X-rays not included in a complete series for diagnosis in conjunction with definitive treatment;

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

(i) Fluoride three times in a 12-month period for ages six and under; two times in a 12-month period for ages seven and older; and three times in a 12-month period during orthodontic treatment;

(j) Sealant once every three years for permanent bicuspids and molars only;

(k) Oral hygiene instruction two times in 12 months for ages eight and under if not billed on the same day as a prophylaxis treatment;

(l) Restorations (fillings) on the same tooth every two years;

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

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

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

(p) Periodontal scaling and root planing once per quadrant in a two-year period for ages 13 and older;

(q) Periodontal maintenance once per quadrant in a 12-month period for ages 13 and older;

(r) Stainless steel crowns for primary anterior teeth once every three years, if age 13 and older;

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

(t) Installation of space maintainers (fixed unilateral or fixed bilateral) for members 12 years of age or under, including:

(i) Recementation of space maintainers;

(ii) Removal of space maintainers; and

(iii) Replacement space maintainers when dentally appropriate.

(u) One resin-based partial denture, if provided at least three years after the seat date;

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

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

(6) Issuers must know and apply relevant guidance, clarifications and expectations issued by federal governmental agencies regarding essential health benefits. Such clarifications may include, but are not limited to, Affordable Care Act implementation and frequently asked questions jointly issued by the U.S. Department of Health and Human Services, the U.S. Department of Labor and the U.S. Department of the Treasury.

(7) This section applies to health plans that have an effective date of January 1, 2017, or later.

(8) This section expires December 31, 2025.

[Statutory Authority: RCW 48.02.060, 48.49.110, 2024 c 366, 2025 c 25, and 2025 c 171. WSR 26-01-148 (Matter R 2025-12), s 284-43-5702, filed 12/19/25, effective 1/19/26. Statutory Authority: RCW 48.02.060. WSR 16-14-106 (Matter No. R 2016-11), § 284-43-5702, filed 7/6/16, effective 8/6/16. WSR 16-01-081, recodified as § 284-43-5702, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.21.241, 48.21.320, 48.44.460, 48.44.341, 48.46.291, 48.46.530, and 48.43.715. WSR 15-20-042 (Matter No. R 2015-02), § 284-43-8791, filed 9/29/15, effective 9/29/15.]

WAC 284-43-5704 Essential health benefit category—Pediatric oral services. A health benefit plan must include "pediatric dental benefits" in its essential health benefits package. Pediatric dental benefits means coverage for the oral services listed in subsection (3) of this section, delivered to those under age 19. Plans must provide this coverage for enrollees until at least the end of the month in which the enrollee turns age 19.

(1) For benefit years beginning January 1, 2026, a health benefit plan must include pediatric dental benefits as an embedded set of benefits, or through a combination of a health benefit plan and a stand-alone dental plan that includes pediatric dental benefits certified as a qualified dental plan. For a health benefit plan certified by the health benefit exchange as a qualified health plan, this requirement is met if a stand-alone dental plan meeting the requirements of subsection (4) of this section is offered in the health benefit exchange for that benefit year.

(2) The requirements of WAC 284-43-5644 and 284-43-5784 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 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 284-43-5644 and covers pediatric oral services. The designated base-benchmark plan for pediatric dental benefits consists of the benefits and services covered within Appendix B - Washington Essential Health Benefits Benchmark Plan and Appendix C - State EHB Benchmark Summary of Benefits as approved by the department of health and human services Centers for Medicare and Medicaid Services on October 7, 2024, as available on the commissioner's website.

(a) Pediatric preventive and diagnostic dental services.

(i) Bitewing x-rays;

(ii) Cephalometric films;

(iii) Complete intra-oral mouth x-rays;

(iv) Diagnostic casts when dentally appropriate;

(v) Limited oral evaluations to evaluate the member for a specific dental problem or oral health complaint, dental emergency, or referral for other treatment;

(vi) Limited visual oral assessments or screenings not performed in conjunction with other clinical oral evaluation services;

(vii) Occlusal intraoral x-rays;

(viii) Oral hygiene instruction if not billed on the same day as a cleaning;

(ix) Periapical x-rays that are not included in a completed series for diagnosis in conjunction with definitive treatment;

(x) Photographic images (oral and facial) when dentally appropriate;

(xi) Periodic and comprehensive oral examinations, limited to two per member per calendar year, beginning before one year of age;

(xii) Problem focused oral examinations;

(xiii) Panoramic mouth x-rays;

(xiv) Cleanings, limited to two per member per calendar year;

(xv) Sealants;

(xvi) Space maintainers (fixed unilateral or fixed bilateral), subject to the following limits:

(A) Recementation of space maintainers;

(B) Removal of space maintainers; and

(C) Replacement space maintainers are covered when dentally appropriate.

(xvii) Topical fluoride application when dentally appropriate.

(b) Basic dental services.

(i) Complex oral surgery procedures including:

(A) Surgical extractions of teeth;

(B) Impactions;

(C) Alveoloplasty;

(D) Vestibuloplasty;

(E) Residual root removal;

(F) Frenulectomy;

(G) Frenuloplasty.

(ii) Emergency treatment for pain relief.

(iii) Endodontic services consisting of:

(A) Apexification for apical closures of anterior permanent teeth;
(B) Apicoectomy;
(C) Debridement;
(D) Direct pulp capping;
(E) Pulpal therapy;
(F) Pulp vitality tests;
(G) Pulpotomy; and
(H) Root canal treatment.
(iv) Endodontic benefits will not be provided for indirect pulp capping.
(v) Fillings consisting of composite and amalgam restorations, limited to the following:
(A) A maximum of five surfaces per tooth for permanent posterior teeth, except for upper molars;
(B) A maximum of six surfaces per tooth for teeth one, two, three, 14, 15, and 16;
(C) A maximum of six surfaces per tooth for permanent anterior teeth;
(D) Restorations on the same tooth are limited to once in a two-year period; and
(E) Two occlusal restorations for the upper molars on teeth one, two, three, 14, 15, and 16.
(vi) General dental anesthesia or intravenous sedation administered in connection with the extractions of partially or completely bony impacted teeth. Other services related to general anesthesia or intravenous sedations are covered as follows:
(A) Drugs and/or medications only when used with parenteral conscious sedation, deep sedation, or general anesthesia;
(B) Inhalation of nitrous oxide, once per day; and
(C) Local anesthesia and regional blocks, including office-based oral or parenteral conscious sedation, deep sedation, or general anesthesia.
(vii) Periodontal services consisting of:
(A) Complex periodontal procedures (osseous surgery including flap entry and closure, mucogingivoplastic surgery);
(B) Debridement limited to once per member in a three-year period;
(C) Gingivectomy and gingivoplasty limited to once per member per quadrant in a three-year period;
(D) Periodontal maintenance limited to once per quadrant in a calendar year; and
(E) Scaling and root planning limited to once per member per quadrant in a two-year period.
(viii) Uncomplicated oral surgery procedures including removal of teeth, incision, and drainage.
(c) Major dental services.
(i) Adjustments and repair of dentures and bridges, except that benefits will not be provided for adjustments or repairs done within one year of insertion;
(ii) Behavior management;
(iii) Bridges (fixed partial dentures), except that benefits will not be provided for replacement made fewer than seven years after placement;
(iv) Crowns and crown build-ups, limited to the following:

(A) An indirect crown in a five-year period, per tooth, for permanent anterior teeth for members with fully erupted permanent anterior teeth;

(B) Cast post and core or prefabricated post and core, on permanent teeth when performed in conjunction with a crown;

(C) Core build-ups, including pins, only on permanent teeth when performed in conjunction with a crown;

(D) Recommendations of permanent indirect crowns for members with fully erupted permanent anterior teeth;

(E) Stainless steel crowns for primary posterior teeth once in a three-year period; and

(F) Stainless steel crowns for permanent posterior teeth (excluding teeth one, 16, 17, and 32) once in a three-year period.

(v) Dental implant crown and abutment related procedures, limited to one per member per tooth in a seven-year period;

(vi) Dentures, full and partial, including:

(A) Denture rebase, limited to one per member per arch in a three-year period, if performed at least six months from the seating date;

(B) Denture relines, limited to one per member per arch in a three-year period, if performed at least six months from the seating date;

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

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

(vii) Home visits, including extended care facility calls, limited to two calls per facility per provider;

(viii) Medically necessary orthodontic services for members with malocclusions associated with:

(A) Cleft lip and palate, cleft palate, and cleft lip with alveolar process involvement; and

(B) Craniofacial anomalies for hemifacial microsomia, cranosynostosis syndromes, anthrogryposis, or Marfan syndrome.

(ix) Occlusal guards;

(x) Post-surgical complications;

(xi) Repair of crowns is limited to one per tooth;

(xii) Repair of implant supported prosthesis or abutment, limited to one per tooth.

(5) An issuer must supply pediatric dental exclusions in a manner substantially equal to the base-benchmark plan.

(6) Pediatric dental plans must categorize covered dental services in a manner consistent with the essential health benefit benchmark plan (i.e., preventative and diagnostic services, basic services, major services, etc.).

(7) Issuers must know and apply relevant guidance, clarifications, and expectations issued by federal governmental agencies regarding essential health benefits. Such clarifications may include, but are not limited to, Affordable Care Act implementation and frequently asked questions jointly issued by the U.S. Department of Health and Human Services, the U.S. Department of Labor, and the U.S. Department of the Treasury.

(8) This section applies to health plans that have an effective date of January 1, 2026, or later.

[Statutory Authority: RCW 48.02.060, 48.49.110, 2024 c 366, 2025 c 25, and 2025 c 171. WSR 26-01-148 (Matter R 2025-12), s 284-43-5704, filed 12/19/25, effective 1/19/26.]

WAC 284-43-5720 Purpose and scope—Pediatric dental benefits for health benefit plans sold outside of the health benefit exchange. For plan years beginning on or after January 1, 2015, each nongrandfathered health benefit plan offered, issued or renewed to small employers or individuals, outside the Washington health benefit exchange, must include pediatric dental benefits as an essential health benefit (EHB). This design requirement must be met by one of the methods set forth in WAC 284-43-5760. Pediatric dental benefits must meet cost sharing requirements including deductible and out-of-pocket maximums as required by the ACA. All pediatric dental benefits are subject to premium tax.

[Statutory Authority: RCW 48.02.060. WSR 16-14-106 (Matter No. R 2016-11), § 284-43-5720, filed 7/6/16, effective 8/6/16. WSR 16-01-081, recodified as § 284-43-5720, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060 and 48.43.715. WSR 14-09-080 (Matter No. R 2013-19), § 284-170-800, filed 4/18/14, effective 5/19/14.]

WAC 284-43-5740 Definitions. "PPACA" or "ACA" 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), collectively known as the Affordable Care Act, and any rules, regulations, or guidance issued, thereunder.

"Stand-alone dental plan" means coverage for a set of benefits limited to oral care including, but not necessarily limited to, the pediatric oral services listed in WAC 284-43-5700(3) or 284-43-5702(3).

[Statutory Authority: RCW 48.02.060. WSR 16-14-106 (Matter No. R 2016-11), § 284-43-5740, filed 7/6/16, effective 8/6/16. WSR 16-01-081, recodified as § 284-43-5740, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060 and 48.43.715. WSR 14-09-080 (Matter No. R 2013-19), § 284-170-805, filed 4/18/14, effective 5/19/14.]

WAC 284-43-5760 Pediatric dental benefits design—Methods of satisfying requirements. (1) An issuer of a health benefit plan may satisfy the requirement of WAC 284-43-5720 in any one of the following ways.

(a) A health benefit plan includes pediatric dental benefits as an embedded benefit; or

(b) A separate health benefit plan is offered without pediatric dental benefits, if and only if, the issuer receives reasonable assurance that the applicant has obtained or will obtain pediatric dental benefits through a stand-alone dental plan certified as a qualified dental plan. This reasonable assurance must be received by the issuer within sixty days.

(i) "Reasonable assurance" means receipt of proof of coverage from the stand-alone dental plan and a signed attestation of coverage from the applicant. In cases where the enrollment process is for a health plan and a dental plan that are being jointly purchased (bundled), verification by the dental carrier of enrollment in the dental plan and transmission of the enrollment confirmation to the health carrier will be considered reasonable assurance.

(ii) The health benefit plan issuer has the responsibility to obtain any required documents establishing reasonable assurance at the initial application and every renewal.

(iii) The stand-alone dental plan issuer has the responsibility for providing the proof of coverage upon request of the health benefit plan issuer or applicant. If a health benefit plan issuer requests proof of coverage for an applicant, the stand-alone dental issuer must provide proof of coverage or inform the health benefit plan issuer that no coverage exists. The stand-alone dental issuer must respond within thirty days of a request for proof of coverage.

(iv) The health benefit plan issuer may issue coverage prior to receiving reasonable assurance. If the health benefit plan issuer receives the reasonable assurance within sixty days of the effective date of the health benefit plan, the enrollee's stand-alone dental coverage will be considered to satisfy the requirement of WAC 284-43-5700 or 284-43-5702, as appropriate. If the health benefit plan issuer does not receive reasonable assurance within the sixty days provided in (iii) of this subsection, the health benefit plan issuer must discontinue the health benefit plan for that applicant unless and until the health benefit plan issuer receives reasonable assurance that the applicant has obtained pediatric dental benefits as required under the ACA.

(2) Nothing in this section precludes issuing ACA compliant pediatric dental benefits as part of a family dental plan sold as group or individual coverage.

[Statutory Authority: RCW 48.02.060. WSR 16-14-106 (Matter No. R 2016-11), § 284-43-5760, filed 7/6/16, effective 8/6/16. WSR 16-01-081, recodified as § 284-43-5760, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060 and 48.43.715. WSR 14-09-080 (Matter No. R 2013-19), § 284-170-810, filed 4/18/14, effective 5/19/14.]

WAC 284-43-5782 Pediatric vision services. A health benefit plan must include "pediatric vision services" in its essential health benefits package. The designated base-benchmark plan for pediatric vision benefits consists of the benefits and services covered by health care service contractor Regence BlueShield as the *Regence Direct Gold* small group plan policy form, policy form number WW0114CCONMSD, and certificate form number WW0114BPPO1SD, offered during the first quarter of 2014 (SERFF filing number RGWA-128968362).

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

(2) For the purpose of determining a plan's actuarial value, an issuer must classify as pediatric vision services the following vision services delivered to enrollees until at least the end of the month in which enrollees turn age 19:

(a) Routine vision screening;

(b) A comprehensive eye exam for children, including dilation as professionally indicated and with refraction every calendar year;

(c) 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 lenses;

(d) 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;

(e) Contact lenses covered once every calendar year in lieu of the lenses and frame benefits. Issuers must apply this limitation based on the manner in which the lenses must be dispensed. If disposable lenses are prescribed, a sufficient number and amount for one calendar year's equivalent must be covered. 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, and irregular astigmatism;

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

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

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

(iii) Follow-up care of four visits in any five-year period, with prior approval.

(3) The base-benchmark plan specifically excludes the following benefits. If an issuer includes the following benefits in a health plan, the issuer may not include these benefits in establishing the plan's actuarial value for the pediatric vision services category:

(a) Visual therapy, which is otherwise covered under the medical/surgical benefits of the plan; and

(b) Ordering two pairs of glasses in lieu of bifocals.

(4) Issuers must know and apply relevant guidance, clarifications and expectations issued by federal governmental agencies regarding essential health benefits. Such clarifications may include, but are not limited to, Affordable Care Act implementation and frequently asked questions jointly issued by the U.S. Department of Health and Human Services, the U.S. Department of Labor and the U.S. Department of the Treasury.

(5) This section applies to health plans that have an effective date of January 1, 2017, or later.

(6) This section expires December 31, 2025.

[Statutory Authority: RCW 48.02.060, 48.49.110, 2024 c 366, 2025 c 25, and 2025 c 171. WSR 26-01-148 (Matter R 2025-12), s 284-43-5782, filed 12/19/25, effective 1/19/26. WSR 16-01-081, recodified as § 284-43-5782, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.21.241, 48.21.320, 48.44.460, 48.44.341, 48.46.291, 48.46.530, and 48.43.715. WSR 15-20-042 (Matter No. R 2015-02), § 284-43-8801, filed 9/29/15, effective 9/29/15.]

WAC 284-43-5784 Pediatric vision services. A health benefit plan must include "pediatric vision services" in its essential health benefits package. The designated base-benchmark plan for pediatric vision benefits consists of the benefits and services covered within Appendix B - Washington Essential Health Benefits Benchmark Plan and Appendix C - State EHB Benchmark Summary of Benefits as approved by the department of health and human services Centers for Medicare and Medicaid Services on October 7, 2024, as available on the commissioner's website.

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

(2) For the purpose of determining a plan's actuarial value, an issuer must classify as "pediatric vision services" the following vision services delivered to enrollees until at least the end of the month in which enrollees turn age 19:

(a) Routine vision screening;

(b) A comprehensive eye exam for children, including dilation as professionally indicated and with refraction every calendar year;

(c) 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 lenses;

(d) 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;

(e) Contact lenses covered once every calendar year in lieu of the lenses and frame benefits. Issuers must apply this limitation based on the manner in which the lenses must be dispensed. If disposable lenses are prescribed, a sufficient number and amount for one calendar year's equivalent must be covered. 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, and irregular astigmatism;

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

(i) One comprehensive low vision evaluation;

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

(iii) Follow-up care of four visits.

(3) The base-benchmark plan specifically excludes the following benefits. If an issuer includes the following benefits in a health plan, the issuer may not include these benefits in establishing the plan's actuarial value for the pediatric vision services category:

(a) Visual therapy, which is otherwise covered under the medical/surgical benefits of the plan; and

(b) Ordering two pairs of glasses in lieu of bifocals.

(4) Issuers must know and apply relevant guidance, clarifications, and expectations issued by federal governmental agencies regarding essential health benefits. Such clarifications may include, but are not limited to, Affordable Care Act implementation and frequently asked questions jointly issued by the U.S. Department of

Health and Human Services, the U.S. Department of Labor, and the U.S. Department of the Treasury.

(5) This section applies to health plans that have an effective date of January 1, 2026, or later.

[Statutory Authority: RCW 48.02.060, 48.49.110, 2024 c 366, 2025 c 25, and 2025 c 171. WSR 26-01-148 (Matter R 2025-12), s 284-43-5784, filed 12/19/25, effective 1/19/26.]

WAC 284-43-5800 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 300 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 a 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. An issuer may still apply applicable in-network requirements.

(4)(a) An issuer may not require cost-sharing for preventive services as defined in RCW 48.43.047, delivered by network providers. If a health plan offered by an issuer does not have in its network a provider who can provide an item or service described in RCW 48.43.047, the plan must cover the item or service when performed by an out-of-network provider and may not impose cost sharing with respect to the item or service.

(b) An issuer must post on its website a list of the specific preventive and wellness services mandated by PPACA or RCW 48.43.047 that it covers.

(5) If an issuer establishes cost-sharing levels, structures or tiers for specific essential health benefit categories, the cost-sharing levels, structures or tiers must not be discriminatory. "Cost-sharing" has the same meaning as set forth in RCW 48.43.005 and WAC 284-43-0160.

(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.

(6) For health plans that include prescription drug coverage issued or renewed on or after January 1, 2025, a health carrier or its health benefit manager may not increase an enrollee's cost-sharing obligation mid-plan year for a prescription drug refill of an antipsychotic, antidepressant, antiepileptic, or other drug prescribed to the enrollee to treat a serious mental illness, if the enrollee is medically stable on the drug, and a participating provider continues to prescribe the drug.

[Statutory Authority: RCW 48.02.060, 48.43.0961, 2023 c 325, 48.43.735, 2024 c 215, 48.43.047, 2024 c 314, and 89 F.R. 37522. WSR 24-24-067 (Matter R 2024-05), s 284-43-5800, filed 11/27/24, effective 12/28/24. Statutory Authority: RCW 48.02.060. WSR 16-14-106 (Matter No. R 2016-11), § 284-43-5800, filed 7/6/16, effective 8/6/16. WSR 16-01-081, recodified as § 284-43-5800, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.21.241, 48.21.320, 48.44.050, 48.44.341, 48.44.460, 48.46.200, 48.46.291, 48.46.530, 48.43.715, and Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010) (PPACA), as amended by the Health Care and Education Reconciliation Act (HCERA), Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010), in particular § 1302 of PPACA, § 10104 (b)(1) (HCERA). WSR 13-15-025 (Matter No. R 2012-17), § 284-43-882, filed 7/9/13, effective 7/10/13.]

WAC 284-43-5820 Representations regarding coverage. A health benefit 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 WAC 284-43-5400 through 284-43-5800. This requirement applies to any health benefit plan offered on or off the Washington health benefit exchange.

[Statutory Authority: RCW 48.02.060. WSR 16-14-106 (Matter No. R 2016-11), § 284-43-5820, filed 7/6/16, effective 8/6/16. WSR 16-01-081, recodified as § 284-43-5820, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.21.241, 48.21.320, 48.44.050, 48.44.341, 48.44.460, 48.46.200, 48.46.291, 48.46.530, 48.43.715, and Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010) (PPACA), as amended by the Health Care and Education Reconciliation Act (HCERA), Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010), in particular § 1302 of PPACA, § 10104 (b)(1) (HCERA). WSR 13-15-025 (Matter No. R 2012-17), § 284-43-885, filed 7/9/13, effective 7/10/13.]

WAC 284-43-5900 Effective date. The effective date of WAC 284-43-0160, 284-170-200, 284-170-360, 284-43-2000, 284-43-4020, 284-43-4040, 284-43-5130, and 284-43A-150 is July 1, 2001.

[Statutory Authority: RCW 48.02.060, 48.43.535, and 48.43.537. WSR 16-23-168 (Matter No. R 2016-17), § 284-43-5900, filed 11/23/16, effective 1/1/17. Statutory Authority: RCW 48.02.060. WSR 16-14-106 (Matter No. R 2016-11), § 284-43-5900, filed 7/6/16, effective 8/6/16. WSR 16-01-081, recodified as § 284-43-5900, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.100, 48.46.200, 48.43.505,

48.43.510, 48.43.515, 48.43.520, 48.43.525, 48.43.530, 48.43.535. WSR 01-03-033 (Matter No. R 2000-02), § 284-43-899, filed 1/9/01, effective 2/9/01.]

WAC 284-43-5910 Prohibition on organ transplant waiting periods. An issuer offering an individual, small group or large group health plan may not impose waiting periods for organ transplant services in any health plan.

[Statutory Authority: RCW 48.02.060, 48.43.012, 48.43.01211, 48.43.0123, 48.43.0124, 48.43.0126, 48.43.0127, 48.43.0128, and 48.43.715. WSR 20-03-114 (Matter No. R 2019-10), § 284-43-5910, filed 1/16/20, effective 2/16/20.]

WAC 284-43-5920 Health plan rescission. A health plan cannot be rescinded by an issuer during the coverage period, except for an enrollee who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan or coverage. If the plan is rescinded, the issuer must refund to the enrollee all payments made by or on behalf of the enrollee for the health plan coverage.

[Statutory Authority: RCW 48.02.060, 48.43.012, 48.43.01211, 48.43.0123, 48.43.0124, 48.43.0126, 48.43.0127, 48.43.0128, and 48.43.715. WSR 20-03-114 (Matter No. R 2019-10), § 284-43-5920, filed 1/16/20, effective 2/16/20.]

WAC 284-43-5930 Qualified health plan marketing and benefit design. (1) An issuer offering qualified health plans as defined in 42 U.S.C. 18021, and its officials, employees, agents, and representatives must not employ marketing practices or benefit designs with respect to these plans that the commissioner determines will have the effect of discouraging the enrollment of individuals with significant health needs. An example of such a prohibited design may occur when there are multiple nonspecialty drugs for persons with a specific condition or disorder, and a health plan places a majority of the drugs in the highest cost tier of the formulary.

(2) The commissioner will determine whether an issuer's actions to comply with this section are consistent with current state law, the legislative intent underlying RCW 48.43.0128 to maintain enrollee protections of the Affordable Care Act, and the federal regulations and guidance in effect as of January 1, 2017, including those issued by the U.S. Department of Health and Human Services Office of Civil Rights.

[Statutory Authority: RCW 48.02.060, 48.43.012, 48.43.01211, 48.43.0123, 48.43.0124, 48.43.0126, 48.43.0127, 48.43.0128, and 48.43.715. WSR 20-03-114 (Matter No. R 2019-10), § 284-43-5930, filed 1/16/20, effective 2/16/20.]

WAC 284-43-5935 Definitions. As used in WAC 284-43-5940 through 284-43-5980, the following terms have the following meaning:

(1) Auxiliary aids and services include:

(a) Qualified interpreters on-site or through video remote interpreting (VRI) services, as defined in 28 C.F.R. 35.104 and 36.303(b); note takers; real-time computer-aided transcription services; written materials; exchange of written notes; telephone handset amplifiers; assistive listening devices; assistive listening systems; telephones compatible with hearing aids; closed caption decoders; open and closed captioning, including real-time captioning; voice, text, and video-based telecommunication products and systems, text telephones (TTYs), videophones, and captioned telephones, or equally effective telecommunications devices; videotext displays; accessible electronic and information technology; or other effective methods of making aurally delivered information available to individuals who are deaf or hard of hearing;

(b) Qualified readers; taped texts; audio recordings; Braille materials and displays; screen reader software; magnification software; optical readers; secondary auditory programs; large print materials; accessible electronic and information technology; or other effective methods of making visually delivered materials available to individuals who are blind or have low vision;

(c) Acquisition or modification of equipment and devices; and

(d) Other similar services and actions.

(2) Individual with limited-English proficiency means an individual whose primary language for communication is not English and who has a limited ability to read, write, speak, or understand English.

(3) Language assistance services may include, but are not limited to:

(a) Oral language assistance, including interpretation in non-English languages provided in-person or remotely by a qualified interpreter for an individual with limited-English proficiency, and the use of qualified bilingual or multilingual staff to communicate directly with individuals with limited-English proficiency;

(b) Written translation, performed by a qualified translator, of written content in paper or electronic form into languages other than English; and

(c) Taglines.

(4) National origin includes, but is not limited to, an individual's, or his or her ancestor's, place of origin (such as country or world region) or an individual's manifestation of the physical, cultural, or linguistic characteristics of a national origin group.

(5) Plan means a nongrandfathered health plan as defined in RCW 48.43.005, a plan deemed by the commissioner to have a short-term limited purpose or duration, or a plan deemed by the commissioner to be a student-only plan that is guaranteed renewable while the covered person is enrolled as a regular, full-time undergraduate student at an accredited higher education institution.

(6) Qualified bilingual/multilingual staff means a member of an issuer's workforce who is designated by the issuer to provide oral language assistance as part of the individual's current, assigned job responsibilities and who has demonstrated to the issuer that he or she:

(a) Is proficient in speaking and understanding both spoken English and at least one other spoken language, including any necessary specialized vocabulary, terminology and phraseology; and

(b) Is able to effectively, accurately, and impartially communicate directly with individuals with limited-English proficiency in their primary languages.

(7) Qualified interpreter for an individual with a disability means an interpreter who via a remote interpreting service or an on-site appearance:

(a) Adheres to generally accepted interpreter ethics principles, including client confidentiality; and

(b) Is able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary, terminology and phraseology.

For an individual with a disability, qualified interpreters can include, for example, sign language interpreters, oral transliterators (individuals who represent or spell in the characters of another alphabet), and cued language transliterators (individuals who represent or spell by using a small number of handshapes).

(8) Qualified interpreter for an individual with limited-English proficiency means an interpreter who via a remote interpreting service or an on-site appearance:

(a) Adheres to generally accepted interpreter ethics principles, including client confidentiality;

(b) Has demonstrated proficiency in speaking and understanding both spoken English and at least one other spoken language; and

(c) Is able to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using any necessary specialized vocabulary, terminology and phraseology.

(9) Qualified translator means a translator who:

(a) Adheres to generally accepted translator ethics principles, including client confidentiality;

(b) Has demonstrated proficiency in writing and understanding both written English and at least one other written non-English language; and

(c) Is able to translate effectively, accurately, and impartially to and from such language(s) and English, using any necessary specialized vocabulary, terminology and phraseology.

(10) Taglines mean short statements written in non-English languages that indicate the availability of language assistance services free of charge and how to obtain them.

[Statutory Authority: RCW 48.02.060, 48.20.460, 48.43.0128, 48.44.050, and 48.46.200. WSR 20-24-040, § 284-43-5935, filed 11/23/20, effective 12/24/20.]

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.

(7) This section expires December 31, 2025.

[Statutory Authority: RCW 48.02.060, 48.49.110, 2024 c 366, 2025 c 25, and 2025 c 171. WSR 26-01-148 (Matter R 2025-12), s 284-43-5937, filed 12/19/25, effective 1/19/26. Statutory Authority: RCW 48.02.060, 48.43.735, 48.44.050, 48.46.200, 48.200.040, and 48.200.900. WSR 23-24-034 (Matter R 2023-07), § 284-43-5937, filed 11/30/23, effective 1/1/24.]

WAC 284-43-5939 Hearing instrument coverage. (1) For purposes of compliance with RCW 48.43.135 and WAC 284-43-5644, which require health plans issued or renewed on or after January 1, 2026, to cover hearing instruments and related services:

(a) "Hearing instrument" has the same meaning as defined in RCW 48.43.135;

(b) "Initial assessment" means the same as "hearing screening" per the American Speech-Language-Hearing Association and basic hearing evaluation tests conducted as found in the current procedural terminology;

(c) "Over-the-counter hearing instrument" has the same meaning as defined in RCW 48.43.135; and

(d) "Annual hearing exam" means the same as hearing evaluation per the American Speech-Language-Hearing Association and comprehensive hearing evaluation tests conducted as found in the current procedural terminology.

(2) A health carrier shall provide in-network coverage for hearing instruments every 36 months per ear with hearing loss and may not establish any lifetime or annual limit on the dollar amount of coverage for services for any individual, whether provided in-network or out-of-network.

(3) In addition to coverage of hearing instruments, health carriers shall provide coverage of an initial assessment, annual hearing exams, fitting, adjustment, auditory training, and ear molds as necessary to ensure optimal fit. Coverage of over-the-counter hearing instruments is not required.

(4) The 36-month time period referenced in subsection (2) of this section and RCW 48.43.135 is specific to the enrollee's current health carrier.

(5) The services and hearing instruments covered under this section are not subject to the enrollee's deductible unless the health plan is offered as a qualifying health plan for a health savings account. For such a qualifying health plan, the carrier may apply a deductible to coverage of the services covered under this section only 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.

[Statutory Authority: RCW 48.02.060, 48.49.110, 2024 c 366, 2025 c 25, and 2025 c 171. WSR 26-01-148 (Matter R 2025-12), s 284-43-5939, filed 12/19/25, effective 1/19/26.]

WAC 284-43-5940 Nondiscrimination in health plans, short-term limited duration medical plans and student-only health plans. (1) An issuer offering a plan, and the issuer's officials, employees, agents, or representatives may not:

(a) Design plan benefits, or implement its plan benefits, in a manner that results in discrimination against individuals because of their age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions; and

(b) With respect to the plan including, but not limited to, administration, member communication, medical protocols or criteria for medical necessity or other aspects of plan operations:

(i) Discriminate on the basis of race, color, national origin, sex, gender identity, sexual orientation, age, or disability;

(ii) Deny, cancel, limit, or refuse to issue or renew a plan, or deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, on the basis of race, color, national origin, sex, gender identity, sexual orientation, age, or disability;

(iii) Have or implement marketing practices or benefit designs that discriminate on the basis of race, color, national origin, sex, gender identity, sexual orientation, age, or disability. In reviewing plan design, plan features that attempt to circumvent coverage of medically necessary benefits such as by labeling a benefit as a pediatric service, and thereby excluding adults, or by placing all or most drugs for a specific condition in the highest cost-sharing tier, absent an appropriate reason for the exclusion, are potentially discriminatory. In these or other instances, the commissioner may request a justification for the practice. If requested, issuers must identify an appropriate nondiscriminatory reason that supports their benefit design;

(iv) Deny or limit coverage, deny or limit coverage of a claim, issue automatic denials of coverage or impose additional cost sharing or other limitations or restrictions on coverage, for:

(A) Any health services that are ordinarily or exclusively available to individuals of one sex, based on the fact that an individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily or exclusively available. For example, a denial of coverage for medically necessary hormone prescriptions for transgender, gender nonconforming, or intersex individuals because the dosages exceed those typically prescribed for cisgender people would be discriminatory against transgender, nonbinary, gender nonconforming, or intersex individuals; or

(B) Gender affirming treatment, as defined in RCW 48.43.0128, when that treatment is:

(I) Prescribed to an individual because of, related to, or consistent with a person's gender expression or identity, as defined in RCW 49.60.040;

(II) Medically necessary; and

(III) Prescribed in accordance with accepted standards of care;

(v) Have or implement a categorical coverage exclusion or limitation for all medical, surgical, or behavioral health services related to a person's gender identity or sexual orientation, including gender affirming treatment; or

(vi) When prescribed as medically necessary, exclude facial gender affirming treatment (such as tracheal shaves), hair removal procedures, and other care (such as mastectomies, breast reductions, breast

implants, or any combination of gender affirming procedures, including revisions to prior treatment) as cosmetic services; or

(vii) Otherwise deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for specific medical, surgical, or behavioral health services related to a person's gender identity or sexual orientation if such denial, limitation, or restriction results in discrimination against a transgender, nonbinary, gender nonconforming or intersex individual.

(2) The enumeration of specific forms of discrimination in subsection (1)(b)(ii) through (vii) of this section does not limit the general applicability of the prohibition in subsection (1)(b)(i) of this section.

(3) Nothing in this section may be construed to prevent an issuer from appropriately utilizing fair and reasonable medical management techniques. Appropriate use of medical management techniques includes use of evidence based criteria for determining whether a service or benefit is medically necessary and clinically appropriate.

(4) An issuer's obligation to comply with these requirements is nondelegable; an issuer is obligated to ensure compliance with WAC 284-43-5935 through 284-43-5980, even if they use a third-party vendor or subcontracting arrangement. An issuer is not exempt from any of these requirements because it relied upon a third-party vendor or subcontracting arrangement for administration of any aspect of its benefits or services.

(5) The commissioner may determine whether an issuer's actions to comply with this section are consistent with current state law, the legislative intent underlying RCW 48.43.0128 to maintain the enrollee protections of the Affordable Care Act, and the federal regulations and guidance in effect as of January 1, 2017, including, but not limited to, those issued by the U.S. Department of Health and Human Services Office of Civil Rights and federal regulations implementing 42 U.S.C. Sec. 18116 (Sec. 1557 of the Affordable Care Act) as set forth in 81 Fed. Reg. 31375 et seq. (2016).

[Statutory Authority: RCW 48.02.060, 48.43.515 and 2021 c 280. WSR 21-24-072 (Matter No. R 2021-14), § 284-43-5940, filed 11/30/21, effective 1/1/22. Statutory Authority: RCW 48.02.060, 48.20.460, 48.43.0128, 48.44.050, and 48.46.200. WSR 20-24-040, § 284-43-5940, filed 11/23/20, effective 12/24/20. Statutory Authority: RCW 48.02.060, 48.43.012, 48.43.01211, 48.43.0123, 48.43.0124, 48.43.0126, 48.43.0127, 48.43.0128, and 48.43.715. WSR 20-03-114 (Matter No. R 2019-10), § 284-43-5940, filed 1/16/20, effective 2/16/20.]

WAC 284-43-5950 Access for individuals with limited-English proficiency and individuals with disabilities. Each issuer offering a plan, and the issuer's officials, employees, agents or representatives must take fair and reasonable steps to provide meaningful access to each enrollee or individual likely to be encountered who has limited-English proficiency or a disability consistent with federal rules and guidance in effect on January 1, 2017, including those implementing 42 U.S.C. Sec. 18116 (Sec. 1557 of the Affordable Care Act) as set forth in 81 Fed. Reg. 31375 et seq. (2016).

[Statutory Authority: RCW 48.02.060, 48.20.460, 48.43.0128, 48.44.050, and 48.46.200. WSR 20-24-040, § 284-43-5950, filed 11/23/20, effective

12/24/20. Statutory Authority: RCW 48.02.060, 48.43.012, 48.43.01211, 48.43.0123, 48.43.0124, 48.43.0126, 48.43.0127, 48.43.0128, and 48.43.715. WSR 20-03-114 (Matter No. R 2019-10), § 284-43-5950, filed 1/16/20, effective 2/16/20.]

WAC 284-43-5960 Meaningful access for individuals with limited-English proficiency. (1) **General requirement.** An issuer offering a plan shall take reasonable steps to provide meaningful access to each enrollee or individual likely to be encountered with limited-English proficiency.

(2) **Evaluation of compliance.** In evaluating whether an issuer has met its obligation under subsection (1) of this section, the commissioner will:

(a) Evaluate, and give substantial weight to, the nature and importance of access to the health services involved and the particular communication at issue, to the individual with limited-English proficiency; and

(b) Take into account other relevant factors, including whether an issuer has developed and implemented an effective written language access plan, that is appropriate to its particular circumstances, to be prepared to meet its obligations under this section.

(3) **Language assistance services requirements.** Language assistance services required under subsection (1) of this section must be provided free of charge, be accurate and timely, and protect the privacy and independence of the individual with limited-English proficiency, regardless of whether an associated health service is provided in person or through telehealth.

(4) **Specific requirements for interpreter and translation services.** Subject to subsection (1) of this section:

(a) An issuer shall offer a qualified interpreter to an individual with limited-English proficiency when oral interpretation is a reasonable step to provide meaningful access for that individual with limited-English proficiency; and

(b) An issuer shall use a qualified translator when translating written content in paper or electronic form.

(5) **Restricted use of certain persons to interpret or facilitate communication.** An issuer shall not:

(a) Require an individual with limited-English proficiency to provide their own interpreter;

(b) Rely on an adult accompanying an individual with limited-English proficiency to interpret or facilitate communication, except:

(i) In an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with limited-English proficiency immediately available; or

(ii) Where the individual with limited-English proficiency specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide such assistance, and reliance on that adult for such assistance is appropriate under the circumstances.

(c) Rely on a minor child to interpret or facilitate communication, except in an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with limited-English proficiency immediately available; or

(d) Rely on staff other than qualified bilingual/multilingual staff to communicate directly with individuals with limited-English proficiency.

(6) **Video remote interpreting services.** An issuer that provides a qualified interpreter for an individual with limited-English proficiency through video remote interpreting services shall provide:

(a) Real-time, full-motion video and audio over a dedicated high-speed, wide-bandwidth video connection or wireless connection that delivers high-quality video images that do not produce lags, choppy, blurry, or grainy images, or irregular pauses in communication;

(b) A sharply delineated image that is large enough to display the interpreter's face and the participating individual's face regardless of the individual's body position;

(c) A clear, audible transmission of voices; and

(d) Adequate training to users of the technology and other involved individuals so that they may quickly and efficiently set up and operate the video remote interpreting.

(7) **Acceptance of language assistance services is not required.** Nothing in this section shall be construed to require an individual with limited-English proficiency to accept language assistance services.

[Statutory Authority: RCW 48.02.060, 48.20.460, 48.43.0128, 48.44.050, and 48.46.200. WSR 20-24-040, § 284-43-5960, filed 11/23/20, effective 12/24/20.]

WAC 284-43-5965 Effective communication for people with disabilities. An issuer offering a plan shall:

(1) Take appropriate steps to ensure that communications with individuals with disabilities are as effective as communications with others with respect to benefits and services, in accordance with the standards found at 28 C.F.R. 35.160 through 35.164. Where the regulatory provisions referenced in this section use the term "public entity," the term "issuer" shall apply in its place.

(2) Provide appropriate auxiliary aids and services to persons with impaired sensory, manual, or speaking skills, where necessary to afford such persons an equal opportunity to benefit from the service in question.

(3) Ensure that their benefits and services provided through electronic and information technology, including telehealth, are accessible to individuals with disabilities, unless doing so would result in undue financial and administrative burdens or a fundamental alteration in the nature of the health programs or activities. When undue financial and administrative burdens or a fundamental alteration exist, the issuer shall provide information in a format other than an electronic format that would not result in such undue financial and administrative burdens or a fundamental alteration but would ensure, to the maximum extent possible, that individuals with disabilities receive the benefits or services of the plan that are provided through electronic and information technology.

(4) Ensure that their health programs and activities provided through websites comply with the requirements of Title II of the ADA.

(5) Make reasonable modifications to policies, practices, or procedures when such modifications are necessary to avoid discrimination on the basis of disability, unless the issuer can demonstrate that making the modifications would fundamentally alter the nature of the

health program or activity. Reasonable modifications must be interpreted consistent with the term as set forth in the ADA Title II regulation at 28 C.F.R. Sec. 35.230(b)(7).

[Statutory Authority: RCW 48.02.060, 48.20.460, 48.43.0128, 48.44.050, and 48.46.200. WSR 20-24-040, § 284-43-5965, filed 11/23/20, effective 12/24/20.]

WAC 284-43-5970 Equal program access on the basis of sex. An issuer offering a plan, and the issuer's officials, employees, agents, or representatives shall:

(1) Provide individuals equal access with respect to the plan including, but not limited to, plan administration, member communication, medical protocols or criteria for medical necessity or other aspects of plan operations without discrimination on the basis of sex; and

(2) Treat individuals consistent with their gender identity and sexual orientation, except that an issuer may not deny or limit health services that are ordinarily or exclusively available to individuals of one sex, to a transgender, nonbinary, intersex or gender nonconforming individual based on the fact that the individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily or exclusively available.

[Statutory Authority: RCW 48.02.060, 48.20.460, 48.43.0128, 48.44.050, and 48.46.200. WSR 20-24-040, § 284-43-5970, filed 11/23/20, effective 12/24/20.]

WAC 284-43-5975 Designation of responsible employee and adoption of grievance procedures. (1) Each issuer shall designate at least one employee to coordinate its efforts to comply with and carry out its responsibilities under RCW 48.43.0128 and WAC 284-43-5935 through 284-43-5980, including the investigation of any grievance communicated to it alleging noncompliance with RCW 48.43.0128 or WAC 284-43-5935 through 284-43-5980 or alleging any action that would be prohibited by RCW 48.43.0128 or WAC 284-43-5935 through 284-43-5980.

(2) Each issuer shall adopt grievance procedures that incorporate appropriate due process standards and that provide for the prompt and equitable resolution of grievances alleging any action that would be prohibited by RCW 48.43.0128 or WAC 284-43-5935 through 284-43-5980. An issuer whose grievance procedures comply with 45 C.F.R. 92.7 as in effect on January 1, 2017, will be deemed compliant with this subsection.

[Statutory Authority: RCW 48.02.060, 48.20.460, 48.43.0128, 48.44.050, and 48.46.200. WSR 20-24-040, § 284-43-5975, filed 11/23/20, effective 12/24/20.]

WAC 284-43-5980 Notice requirement. (1) An issuer offering a plan shall take appropriate initial and continuing steps to notify enrollees, applicants, and members of the public of the following:

(a) The issuer does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation in its benefits and services;

(b) The issuer provides appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate formats, free of charge and in a timely manner, when such aids and services are necessary to ensure an equal opportunity to participate to individuals with disabilities;

(c) The issuer provides language assistance services, including translated documents and oral interpretation, free of charge and in a timely manner, when such services are necessary to provide meaningful access to individuals with limited-English proficiency;

(d) How to obtain the aids and services in (b) and (c) of this subsection;

(e) An identification of, and contact information for, the employee responsible for compliance with RCW 48.43.0128 and WAC 284-43-5935 through 284-43-5980;

(f) How to file a grievance with the issuer related to the issuer's compliance with RCW 48.43.0128 and WAC 284-43-5935 through 284-43-5980; and

(g) How to file a complaint with the commissioner related to the issuer's compliance with RCW 48.43.0128 and WAC 284-43-5935 through this section or with the federal Department of Health and Human Services, Office of Civil Rights related to the issuer's compliance with 42 U.S.C. Sec. 18119 (Sec. 1557 of the Affordable Care Act).

(2) An issuer offering a plan shall:

(a) As described in subsection (7) of this section, post a notice that conveys the information in subsection (1)(a) through (g) of this section; and

(b) As described in subsection (8) of this section, if applicable, post a nondiscrimination statement that conveys the information in subsection (1)(a) of this section.

(3) To aid in compliance with the requirements of this section, issuers may use the sample notices published at https://www.hhs.gov/civil-rights/for-providers/resources-covered-entities/index.html. For use beginning January 1, 2022, the notice referenced in this subsection must be modified to identify the office of the insurance commissioner as the designated entity to file a complaint regarding compliance with RCW 48.43.0128 and WAC 284-43-5935 through 284-43-5980 and the federal Department of Health and Human Services, Office of Civil Rights as the designated entity to file a complaint regarding compliance related to the issuer's compliance with 42 U.S.C. Sec. 18119 (Sec. 1557 of the Affordable Care Act).

(4) Except to the extent provided otherwise in subsection (5) of this section, each issuer shall:

(a) As described in subsection (7)(a) of this section, post taglines in at least the top 15 languages spoken by individuals with limited-English proficiency in Washington state; and

(b) As described in subsection (8)(b) of this section, if applicable, post taglines in at least the top two languages spoken by individuals with limited-English proficiency in Washington state.

(5) Plans deemed by the commissioner to have a short-term limited purpose or duration that are offered in Washington state must come into compliance with the language assistance notice and tagline requirements in this section on or before April 1, 2021.

(6) To satisfy the requirements of this section, issuers may use taglines provided by the federal Department of Health and Human Services pursuant to 45 C.F.R. 92.8, as in effect on January 1, 2017.

(7)(a) Each issuer shall post the notice required by subsection (1) of this section and the taglines required by subsection (4)(a) of this section in a conspicuously visible font size:

(i) In significant publications and significant communications targeted to enrollees, applicants, and members of the public, except for significant publications and significant communications that are small-sized, such as postcards and tri-fold brochures;

(ii) In conspicuous physical locations where the issuer interacts with the public; and

(iii) In a conspicuous location on the issuer's website accessible from the home page of the issuer's website.

(b) An issuer may also post the notice and taglines in additional publications and communications.

(8) Each issuer shall post, in a conspicuously visible font size, in significant publications and significant communications that are small-sized, such as postcards and tri-fold brochures:

(a) The nondiscrimination statement required by subsection (1)(a) of this section; and

(b) The taglines required by subsection (4)(b) of this section.

(9) An issuer may combine the content of the notice required in subsection (1) of this section with the content of other notices if the combined notice clearly informs individuals of their rights under RCW 48.43.0128 and WAC 284-43-5935 through 284-43-5980 and 42 U.S.C. Sec. 18119 (Sec. 1557 of the Affordable Care Act).

[Statutory Authority: RCW 48.02.060, 48.43.0961, 2023 c 325, 48.43.735, 2024 c 215, 48.43.047, 2024 c 314, and 89 F.R. 37522. WSR 24-24-067 (Matter R 2024-05), s 284-43-5980, filed 11/27/24, effective 12/28/24. Statutory Authority: RCW 48.02.060, 48.20.460, 48.43.0128, 48.44.050, and 48.46.200. WSR 20-24-040, § 284-43-5980, filed 11/23/20, effective 12/24/20.]

SUBCHAPTER I
HEALTH PLAN RATES

WAC 284-43-6000 Authority and purpose. This subchapter is adopted under the general authority of RCW 48.02.060, 48.44.017, 48.44.020, 48.44.050, 48.46.060, 48.46.062, 48.46.200, and 48.43.733. Its purpose is to provide guidelines for the implementation of RCW 48.44.017(2), 48.44.020(3), 48.44.022, 48.44.023, 48.44.040, 48.46.060 (4) and (6), 48.46.062(2), 48.46.064, 48.46.066, 48.18.110, 48.18.480, and 48.43.733 as to the filing of grandfathered individual and small group health plans applicable under RCW 48.44.017, 48.44.022, and 48.44.023 by health care service contractors, grandfathered individual and small group health plans applicable under RCW 48.46.062, 48.46.064, and 48.46.066 by health maintenance organizations, stand-alone dental plans and stand-alone vision plans offered by health care service contractors, health maintenance organizations, and disability carriers to individuals and small groups, and the calculations and evaluations of premium rates for these contracts.

[Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, and 2016 c 156. WSR 16-23-019 (Matter No. R 2016-06), § 284-43-6000, filed 11/4/16, effective 12/5/16. WSR 16-01-081, recodified as § 284-43-6000, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.18.110, 48.44.020, 48.44.050, 48.46.060, 48.46.200. WSR 08-20-071 (Matter No. R 2008-08), § 284-43-901, filed 9/25/08, effective 10/26/08.]

WAC 284-43-6010 Applicability and scope. This subchapter applies to grandfathered individual and small group health benefit plans offered by health care service contractors and health maintenance organizations transacting business in this state under chapter 48.44 or 48.46 RCW, stand-alone dental plans and stand-alone vision plans. This subchapter applies to such plans purchased directly by individuals and small employers.

[Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, and 2016 c 156. WSR 16-23-019 (Matter No. R 2016-06), § 284-43-6010, filed 11/4/16, effective 12/5/16. WSR 16-01-081, recodified as § 284-43-6010, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. WSR 05-07-006 (Matter No. R 2004-05), § 284-43-905, filed 3/3/05, effective 4/3/05. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066. WSR 98-04-011 (Matter No. R 97-2), § 284-43-905, filed 1/23/98, effective 3/1/98.]

WAC 284-43-6020 Definitions. For the purpose of this subchapter:

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

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

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

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

(5) "Capitation expenses" means the amount paid to a provider or facility on a per "covered person" basis, or as part of risk-sharing provisions, for the coverage of specified health care services.

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

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

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

(9) "Claims" means the cost to the "carrier" of health care services provided to a "covered person" or paid to or on behalf of the "covered person" in accordance with the terms of a "plan." This in-

cludes "capitation payments" or other similar payments made to providers or facilities for the purpose of paying for health care services for a "covered person."

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

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

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

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

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

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

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

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

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

(a) Claim adjudication costs;

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

(c) Home office and field overhead;

(d) Acquisition and selling costs;

(e) Taxes; and

(f) All other costs except "claims."

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

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

(21) "Grandfathered" has the same meaning as that contained in RCW 48.43.005.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(42) "Stand-alone dental plan" means coverage for a set of benefits limited to oral care including, but not necessarily limited to, pediatric oral care.

(43) "Stand-alone vision plan" means coverage for a set of benefits limited to vision care including, but not necessarily limited to, materials.

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

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

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

[Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, and 2016 c 156. WSR 16-23-019 (Matter No. R 2016-06), § 284-43-6020, filed 11/4/16, effective 12/5/16. WSR 16-01-081, recodified as § 284-43-6020, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.18.110, 48.44.020, 48.44.050, 48.46.060, 48.46.200. WSR 08-20-071 (Matter No. R 2008-08), § 284-43-910, filed 9/25/08, effective 10/26/08. Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. WSR 05-07-006 (Matter No. R 2004-05), § 284-43-910, filed 3/3/05, effective 4/3/05. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066. WSR 98-04-011 (Matter No. R 97-2), § 284-43-910, filed 1/23/98, effective 3/1/98.]

WAC 284-43-6040 Demonstration that benefits provided are not reasonable in relation to the amount charged for a contract per RCW 48.44.020 and 48.46.060. (1) The provisions of this section are in addition to the requirements set forth in RCW 48.44.022, 48.44.023, 48.46.064, and 48.46.066.

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

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

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

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

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

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

[WSR 16-01-081, recodified as § 284-43-6040, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. WSR 05-07-006 (Matter No. R 2004-05), § 284-43-915, filed 3/3/05, effective 4/3/05. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066. WSR 98-04-011 (Matter No. R 97-2), § 284-43-915, filed 1/23/98, effective 3/1/98.]

WAC 284-43-6100 Contents of individual and small group filings. Under RCW 48.44.022 and 48.46.064 the experience of all individual

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[WSR 16-01-081, recodified as § 284-43-6100, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.18.110, 48.44.020, 48.44.050, 48.46.060, 48.46.200. WSR 08-20-071 (Matter No. R 2008-08), § 284-43-930, filed 9/25/08, effective 10/26/08. Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. WSR 05-07-006 (Matter No. R 2004-05), § 284-43-930, filed 3/3/05, effective 4/3/05. Statutory Authority: RCW 48.02.060 and 48.92.140. WSR 98-11-089 (Matter No. R 98-8), § 284-43-930, filed 5/20/98, effective 6/20/98. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066. WSR 98-04-011 (Matter No. R 97-2), § 284-43-930, filed 1/23/98, effective 3/1/98.]

SUBCHAPTER J
HEALTH PLANS, STAND-ALONE DENTAL PLANS AND STAND-ALONE VISION PLANS—FILING REQUIREMENTS

WAC 284-43-6500 Applicability and scope. This subchapter is adopted under the general authority of RCW 48.02.060. This subchapter applies to health benefit plans as defined in RCW 48.43.005, contracts for limited health care services as defined in RCW 48.44.035, stand-alone dental plans and stand-alone vision plans. This subchapter also

applies to plans offered by carriers under the requirements of RCW 48.43.733.

[Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, and 2016 c 156. WSR 16-23-019 (Matter No. R 2016-06), § 284-43-6500, filed 11/4/16, effective 12/5/16. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064, 48.46.066, and 2015 c 19. WSR 16-03-018 (Matter No. R 2015-04), § 284-43-6500, filed 1/8/16, effective 1/8/16.]

WAC 284-43-6520 Definitions. For the purpose of this subchapter:

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

(2) "Contract form" means the prototype of a "contract" and any associated riders and endorsements filed with the commissioner by a carrier.

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

(4) "Dependent" has the same meaning as that contained in RCW 48.43.005.

(5) "Health carrier" or "carrier" has the same meaning as that contained in RCW 48.43.005.

(6) "Individual market" has the same meaning as that contained in RCW 48.43.005.

(7) "Individual health plan" means a health plan issued in the individual market.

(8) "Large group contracts" or "large group plans" include group health benefit plans and stand-alone dental plans or stand-alone vision plans that are not small group plans and are not individual plans.

(9) "Limited health care service contractor" means a health care service contractor that offers one and only one limited health care service.

(10) "Negotiated contract" form means a health benefit plan or stand-alone dental plan or stand-alone vision plan where benefits and other terms and conditions, including the applicable rate schedules, are negotiated and agreed to by the carrier or limited health care service contractor and the policy or contract holder. The only plans that carriers can negotiate are large group plans. The negotiated policy form and associated rate schedule must otherwise comply with state and federal laws governing the content and schedule of rates for the negotiated plans.

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

(12) "Rate" or "rates" means all classification manuals, rate manuals, rating schedules, class rates, and rating rules.

(13) "Rate schedule" means the schedule of rates that includes the description of methodology used to obtain the premium rate for a

specific individual or group, if given the necessary information such as the demographic data and plan design of the individual or group. For a single negotiated contract form, the rate schedule also includes the premium for the employer.

(14) "Small employer" has the same meaning as defined in 42 U.S.C. 18024.

(15) "Small group plans" means the class of "group contracts" issued to "small employers." For the purposes of this section, "small group contracts" and "small group plans" also apply to stand-alone dental plans or stand-alone vision plans.

(16) "Stand-alone dental plan" means coverage for a set of benefits limited to oral care including, but not necessarily limited to, pediatric oral care.

(17) "Stand-alone vision plan" means coverage for a set of benefits limited to vision care including, but not necessarily limited to, materials.

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

[Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, and 48.43.733. WSR 26-09-083 (Matter R 2025-02), s 284-43-6520, filed 4/15/26, effective 5/16/26. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064, 48.46.066, and 2015 c 19. WSR 16-03-018 (Matter No. R 2015-04), § 284-43-6520, filed 1/8/16, effective 1/8/16.]

WAC 284-43-6540 Summary for group contract filings other than small group contract filings.

Groups Other Than Small Groups Filing Summary

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

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

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

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

Rate Summary

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

Summary of Contract Experience

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

Attach comments or additional information.

Preparer's Information

Name: _____

Title: _____

Telephone Number: _____

[Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064, 48.46.066, and 2015 c 19. WSR 16-03-018 (Matter No. R 2015-04), § 284-43-6540, filed 1/8/16, effective 1/8/16.]

WAC 284-43-6560 When a carrier is required to file. (1) All rates and forms of group health benefit plans other than small group plans and all stand-alone dental and stand-alone vision plans offered by a health carrier or limited health care service contractor as defined in RCW 48.44.035 and modification of a contract form or rate must be filed before the contract form is offered for sale to the public and before the rate schedule is used.

(2) Filings of negotiated contract forms for groups other than small groups, and applicable rate schedules, that are placed into effect at time of negotiation or that have a retroactive effective date are not required to be filed in accordance with subsection (1) of this

section, but must be filed within thirty working days after the earlier of:

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

(b) The date renewal premiums are implemented.

(3) When a carrier submits a late filing, the carrier must include an explanation on the filing document describing why the carrier submitted the filing late.

(4) The negotiated policy form and associated rate schedule must otherwise comply with state and federal laws governing the content and schedule of rates for the negotiated plans.

(5) Stand-alone dental plans and stand-alone vision plans offered by a disability insurer to out-of-state groups specified by RCW 48.21.010(2) may be negotiated, but may not be offered in this state before the commissioner finds that the stand-alone dental plan or stand-alone vision plan otherwise meets the standards set forth in RCW 48.21.010 (2)(a) and (b).

[Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064, 48.46.066, and 2015 c 19. WSR 16-03-018 (Matter No. R 2015-04), § 284-43-6560, filed 1/8/16, effective 1/8/16.]

WAC 284-43-6580 General contents of all filings. Each filing required by WAC 284-43-6560 must be submitted with the filing transmittal form prescribed by and available from the commissioner. The form must include the name of the filing entity, its address, identification number, the type of filing being submitted, the form name or group name and number, and other relevant information. Filings also must include the information required on the filing summary set forth in WAC 284-43-6660 for individual and small group plans and rate schedules or as set forth in WAC 284-43-6540 for group plans and rate schedules other than those for small groups.

[Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, and 2016 c 156. WSR 16-23-019 (Matter No. R 2016-06), amended and recodified as § 284-43-6580, filed 11/4/16, effective 12/5/16. WSR 16-01-081, recodified as § 284-43-6060, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.18.110, 48.44.020, 48.44.050, 48.46.060, 48.46.200. WSR 08-20-071 (Matter No. R 2008-08), § 284-43-925, filed 9/25/08, effective 10/26/08. Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. WSR 05-07-006 (Matter No. R 2004-05), § 284-43-925, filed 3/3/05, effective 4/3/05. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066. WSR 98-04-011 (Matter No. R 97-2), § 284-43-925, filed 1/23/98, effective 3/1/98.]

WAC 284-43-6590 Requirements for mitigating inequity in the health insurance market. For the purposes of mitigating inequity in the health insurance market, unless waived by the commissioner pursuant to RCW 48.43.725 and subsection (3) of this section, the commissioner must assess a fee on any health carrier offering a health plan or student health plan that excludes, under state or federal law, any benefit mandated or required by Title 48 RCW or rules adopted by the commissioner. Such health carrier must:

(1) Notify each enrollee in writing of the following:

(a) Which benefits the health plan or student health plan does not cover; and

(b) Alternate ways in which the enrollees may access excluded benefits in a timely manner.

(2) As part of its form filing:

(a) Provide a sample notification to enrollees as required in subsection (1) of this section;

(b) Include in the benefit description alternate ways enrollees may access excluded benefits in a timely manner; and

(c) Describe how enrollees have prompt access to the information required under subsection (1) of this section.

(3) As part of its rate filing:

(a) Include a cover letter and as a separate supporting document, a description of excluded benefits and the specific state or federal law permitting the benefit exclusion;

(b) Submit the health carrier's supporting documentation for calculating the amount of estimated fee, per member per month and in total. The estimated fee in total must be the actuarial equivalent of costs attributed to the provision and administration of the excluded benefit for members in the rating group or rating pool. The carrier must include a certification by a member of the American Academy of Actuaries that the estimated fee in total is the actuarial equivalent of costs attributed to the provision and administration of the excluded benefit; and

(c) If a health carrier intends to request the commissioner's approval to waive the fee calculated in this subsection, the health carrier must submit:

(i) A separate document requesting a fee waiver;

(ii) A description of any excluded mandated or required benefit and the specific state or federal law permitting the benefit exclusion; and

(iii) A detailed description of alternative access provided by the carrier to any excluded mandated or required benefit. The description should include sufficient information for the commissioner to determine whether a carrier excluding a mandated or required benefit has provided enrollees alternative access to such benefit. In making a fee-waiver determination, the commissioner may take into account timely access, cost, ease of use, and provider access.

The commissioner may request from the carrier additional information or documents necessary to evaluate the fee-waiver request.

(4) The commissioner's determination whether to grant the fee waiver requested by the carrier will be part of the rate filing records.

(5) If a fee waiver is not requested or granted based upon a request in the rate filing, fees calculated and assessed by the commissioner under RCW 48.43.725(2) and subsection (3) of this section, must be paid by the health carrier to the OIC within sixty days after the rate filing is approved.

[Statutory Authority: 2020 c 283, RCW 48.02.060, 48.43.072, and 48.43.073. WSR 21-01-163, § 284-43-6590, filed 12/18/20, effective 1/18/21.]

WAC 284-43-6600 Issuer filing of attestation form, transparency tools. Every issuer offering or renewing a health benefit plan on or

after January 1, 2016, must attest to the insurance commissioner that the transparency tools available to their members meet the requirements of RCW 48.43.007.

(1) Annually, each health plan issuer must file an attestation form with the insurance commissioner for each line of business written by the issuer. For purposes of this section, line of business is defined as individual, small group and large group health plans.

(2) The form must be signed by an officer of the issuer that is responsible for ensuring compliance with RCW 48.43.007.

(3) The form must be submitted to the insurance commissioner no later than February 1st of each calendar year. Instructions for filing of the form will be available on the insurance commissioner's website no later than sixty days prior to the filing deadline.

[Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, and 2016 c 156. WSR 16-23-019 (Matter No. R 2016-06), recodified as § 284-43-6600, filed 11/4/16, effective 12/5/16. WSR 16-01-081, recodified as § 284-43-6080, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.43.340, and 48.44.050. WSR 15-21-095 (Matter No. R 2015-03), § 284-43-927, filed 10/21/15, effective 1/1/16.]

WAC 284-43-6620 Experience records. (1) For each plan, carriers must maintain the following records for five years:

(a) Incurred claims;

(b) Earned premiums; and

(c) Expenses.

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

[Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, and 2016 c 156. WSR 16-23-019 (Matter No. R 2016-06), recodified as § 284-43-6620, filed 11/4/16, effective 12/5/16. WSR 16-01-081, recodified as § 284-43-6120, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. WSR 05-07-006 (Matter No. R 2004-05), § 284-43-935, filed 3/3/05, effective 4/3/05. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066. WSR 98-04-011 (Matter No. R 97-2), § 284-43-935, filed 1/23/98, effective 3/1/98.]

WAC 284-43-6640 Evaluating experience data. In determining the credibility and appropriateness of experience data, consideration will be given to all relevant factors, including:

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

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

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

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

[Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, and 2016 c 156. WSR 16-23-019 (Matter No. R 2016-06), recodified as § 284-43-6640, filed 11/4/16, effective 12/5/16. WSR 16-01-081, recodified as § 284-43-6140, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. WSR 05-07-006 (Matter No. R 2004-05), § 284-43-940, filed 3/3/05, effective 4/3/05. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066. WSR 98-04-011 (Matter No. R 97-2), § 284-43-940, filed 1/23/98, effective 3/1/98.]

WAC 284-43-6660 Summary for individual and small group contract filings.

INDIVIDUAL AND SMALL GROUP FILING SUMMARY

Carrier Name	
Address	
Carrier Identification Number	

Rate Renewal Period:	From		To
Date Submitted:			

Proposed Rate Summary

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

Components of Proposed Community Rate

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

Summary of Pooled Experience

	Experience Period From To	First Prior Period From To	Second Prior Period From To
Member Months			
Earned Premium			

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

General Information

1. Trend Factor Summary

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

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

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

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

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

4. Attach a table showing the base rate for each plan affected by this filing.

5. Attach comments or additional information.

6. Preparer's Information

Name: _____

Title: _____

Telephone Number: _____

[Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, and 2016 c 156. WSR 16-23-019 (Matter No. R 2016-06), recodified as § 284-43-6660, filed 11/4/16, effective 12/5/16. WSR 16-01-081, recodified as § 284-43-6160, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.18.110, 48.44.020, 48.44.050, 48.46.060, 48.46.200. WSR 08-20-071 (Matter No. R 2008-08), § 284-43-945, filed 9/25/08, effective 10/26/08. Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. WSR 05-07-006 (Matter No. R 2004-05), § 284-43-945, filed 3/3/05, effective 4/3/05. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066. WSR 98-04-011 (Matter No. R 97-2), § 284-43-945, filed 1/23/98, effective 3/1/98.]

WAC 284-43-6680 Geographic rating area factor development. (1) For nongrandfathered individual or small group health plans offered, issued or renewed on or after January 1, 2014, and on or before December 31, 2018, if an issuer elects to adjust its premium rates based on geographic area, the issuer must use the geographic rating areas designated in WAC 284-43-6700.

(2) The premium ratio for the highest cost geographic rating area, when compared to the lowest cost geographic rating area, must not be more than 1.15.

(a) King County is the index geographic rating area for purposes of calculating the premium ratio. The geographic rating area factor for the index area must be set at 1.00.

(b) A health-status related factor may not be used to establish a rating factor for a geographic rating area. Health factor means any of the following:

(i) Health status of enrollees or the population in an area;

(ii) Medical condition of enrollees or the population in an area, including both physical and mental illnesses;

(iii) Claims experience;

(iv) Health services utilization in the area;

(v) Medical history of enrollees or the population in an area;

(vi) Genetic information of enrollees or the population in an area;

(vii) Disability status of enrollees or the population in an area;

(viii) Other evidence of insurability applicable in the area.

(3) Assignment of a factor to a geographic rating area must be actuarially sound and based on provider reimbursement differences. An issuer must fully document the basis for the assigned rating factors in the actuarial memo submitted with a rate filing.

(4) The geographic rating area factors must be applied uniformly to individuals or small groups applying for or receiving coverage from the issuer.

(5) For out-of-state enrollees covered under a health benefit plan issued to a Washington resident, an issuer must apply the geographic rating area factor based on the primary subscriber's Washington residence. For out-of-state enrollees who are covered under a health benefit plan issued through an employer whose primary place of business is Washington, an issuer must apply the geographic rating area factor based on the employer's primary place of business.

(6) This section does not apply to stand alone dental plans offered on the Washington health benefit exchange.

[Statutory Authority: RCW 48.02.060, 48.43.733, and 45 C.F.R. 147.102. WSR 18-07-053, § 284-43-6680, filed 3/14/18, effective 4/14/18. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, and 2016 c 156. WSR 16-23-019 (Matter No. R 2016-06), amended and recodified as § 284-43-6680, filed 11/4/16, effective 12/5/16. WSR 16-01-081, recodified as § 284-43-6200, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, and 45 C.F.R. 147.102. WSR 13-11-003 (Matter No. R 2013-01), § 284-170-250, filed 5/1/13, effective 6/1/13.]

WAC 284-43-6681 Geographic rating area factor development on or after January 1, 2019. (1) For nongrandfathered individual or small group health plans offered, issued or renewed on or after January 1,

2019, if an issuer elects to adjust its premium rates based on geographic area, the issuer must use the geographic rating areas designated in WAC 284-43-6701.

(2)(a) Except as provided in (b) and (c) of this subsection the premium ratio for the highest cost geographic rating area, when compared to the lowest cost geographic rating area, must not be more than 1.15.

(b) An issuer that offers qualified health plans as described in RCW 43.71.065 in every county in six or more rating areas designated in WAC 284-43-6701 may utilize a premium ratio for the highest cost geographic rating area, when compared to the lowest cost geographic area of up to 1.22, if the development of rating factors is actuarially justified and meets all applicable requirements.

(c) An issuer that offers qualified health plans as described in RCW 43.71.065 in every county in every rating area designated in WAC 284-43-6701 may utilize a premium ratio for the highest cost geographic rating area, when compared to the lowest cost geographic area of up to 1.40, if the development of rating factors is actuarially justified and meets all applicable requirements.

(d)(i) The area factor for the index geographic rating area must be set at 1.00. Except to the extent provided otherwise in (d) of this subsection, King County is the index geographic rating area for purposes of calculating the premium ratio.

(ii) If King County (area 1) is not in an issuer's service area, the geographic rating area of the county with the largest enrollment in the issuer's service area must be set at 1.00.

(iii) If the issuer offers both individual and small group health plans and either the individual or small group health plans are not offered in King County (area 1), the index geographic rating area may be different for individual and small group health plans. The index geographic rating area for each market must be established consistent with (d)(i) or (ii) of this subsection as applicable.

(iv) If the issuer is new to the Washington state market, the geographic rating area within the issuer's service area that has the greatest number of counties must be set at 1.00.

(3) A health-status related factor may not be used to establish a rating factor for a geographic rating area. Health factor means any of the following:

(a) Health status of enrollees or the population in an area;

(b) Medical condition of enrollees or the population in an area, including physical, mental, or behavioral health illnesses;

(c) Claims experience;

(d) Health services utilization in the area;

(e) Medical history of enrollees or the population in an area;

(f) Genetic information of enrollees or the population in an area;

(g) Disability status of enrollees or the population in an area; or

(h) Other evidence of insurability to the area.

(4) Assignment of a factor to a geographic rating area must be actuarially sound and based on provider costs and practice pattern differences. An issuer must fully document the basis for the assigned rating factors in the actuarial memorandum submitted with a rate filing.

(5) The geographic rating area factors used in health plans filed with the commissioner must be applied uniformly to those individuals or small groups applying for or receiving coverage from the issuer.

(6) For out-of-state enrollees under a health benefit plan issued to a Washington resident, an issuer must apply the geographic rating area factor based on the primary subscriber's Washington residence. For out-of-state enrollees who are covered under a health benefit plan issued through an employer whose primary place of business is Washington, an issuer must apply the geographic rating area factor based on the employer's primary place of business.

[Statutory Authority: RCW 48.02.060, 48.43.733, and 45 C.F.R. 147.102. WSR 18-07-053, § 284-43-6681, filed 3/14/18, effective 4/14/18.]

WAC 284-43-6700 Geographic rating area designation. (1) The following geographic rating areas are designated for Washington state for nongrandfathered individual and small group plans offered, issued, or renewed on or after January 1, 2014, and on or before December 31, 2018:

Area 1: Index geographic rating area: King County.

Area 2: Clallam, Cowlitz, Grays Harbor, Island, Jefferson, Mason, Lewis, Kitsap, Pacific, Pierce, San Juan, Skagit, Snohomish, Thurston, Wahkiakum, and Whatcom counties.

Area 3: Clark, Klickitat, and Skamania counties.

Area 4: Ferry, Lincoln, Pend Oreille, Spokane, and Stevens counties.

Area 5: Adams, Asotin, Benton, Chelan, Columbia, Douglas, Franklin, Garfield, Grant, Kittitas, Okanogan, Walla Walla, Whitman, and Yakima counties.

(2) The commissioner will review the geographic rating area designation in this section not more frequently than every three years, beginning January 31, 2016. The commissioner will publish changes in the geographic rating area designation within sixty days of the review date.

[Statutory Authority: RCW 48.02.060, 48.43.733, and 45 C.F.R. 147.102. WSR 18-07-053, § 284-43-6700, filed 3/14/18, effective 4/14/18. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, and 2016 c 156. WSR 16-23-019 (Matter No. R 2016-06), recodified as § 284-43-6700, filed 11/4/16, effective 12/5/16. WSR 16-01-081, recodified as § 284-43-6220, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, and 45 C.F.R. 147.102. WSR 13-11-003 (Matter No. R 2013-01), § 284-170-252, filed 5/1/13, effective 6/1/13.]

WAC 284-43-6701 Geographic rating area designation on or after January 1, 2019. (1) The following geographic rating areas are designated for Washington state for nongrandfathered individual and small group plans issued or renewed on or after January 1, 2019:

Area 1: King County.

Area 2/West: Clallam, Cowlitz, Grays Harbor, Jefferson, Kitsap, Lewis, Pacific, and Wahkiakum counties.

Area 3/South: Clark, Klickitat, and Skamania counties.

Area 4/Northeast: Ferry, Lincoln, Pend Oreille, Spokane, and Stevens counties.

Area 5/South Sound: Mason, Pierce, and Thurston counties.

Area 6/South Central: Benton, Franklin, Kittitas, and Yakima counties.

Area 7/North Central: Adams, Chelan, Douglas, Grant, and Okanogan counties.

Area 8/Northwest: Island, San Juan, Skagit, Snohomish, and Whatcom counties.

Area 9/Southeast: Asotin, Columbia, Garfield, Walla Walla, and Whitman counties.

(2) The commissioner will review the geographic rating area designation in this section not more frequently than every three years, beginning January 31, 2021.

[Statutory Authority: RCW 48.02.060, 48.43.733, and 45 C.F.R. 147.102. WSR 18-07-053, § 284-43-6701, filed 3/14/18, effective 4/14/18.]

WAC 284-43-6800 Definitions. For the purpose of WAC 284-43-6810 and 284-43-6820:

(1) "Actuarial value metal value" or "AV metal value" means the actuarial value that results from use of the federal Actuarial Value Calculator, or a permissible alternative method prescribed in 45 C.F.R. § 156.135(b).

(2) "Actuarial value and cost-sharing design of the plan" has the same meaning as defined in 45 C.F.R. § 156.80(d) and as used in rate development for individual and small group health plans in the Unified Rate Review Template published by the United States Centers for Medicare and Medicaid Services.

(3) "Actuarial value pricing value" or "AV pricing value" means the rate development component of the "actuarial value and cost-sharing design of the plan" adjustment that estimates the expected paid-to-allowed claims ratio for essential health benefits of the plan but does not consider the morbidity or health status of members.

(4) "Cost sharing" has the same meaning as defined in 45 C.F.R. § 155.20.

(5) "Cost-sharing reductions" has the same meaning as defined in 45 C.F.R. § 155.20.

(6) "Cost-sharing reduction silver load" or "CSR silver load" means the rate development component of the "actuarial value and cost-sharing design of the plan" adjustment that accounts for the cost and risk from unfunded cost-sharing reduction amounts provided to eligible enrollees as authorized by 45 C.F.R. § 156.80.

(7) "Cost-sharing reduction variants" or "CSR variants" are silver plan variations defined in 45 C.F.R. § 156.420 that have different actuarial values.

(8) "Essential health benefits" has the same meaning as defined in 45 C.F.R. § 156.110(a).

(9) "Grandfathered health plan" has the same meaning as defined in RCW 48.43.005.

(10) "Percentage of the total allowed costs of benefits" has the same meaning as defined in 45 C.F.R. § 156.20.

(11) "Level of coverage" means one of four standardized actuarial value levels as defined in 42 U.S.C. 18022.

(12) "Induced demand factor" means the rate development component of the "actuarial value and cost-sharing design of the plan" adjustment that reflects the anticipated induced demand associated with the plan's cost-sharing level but does not reflect differences in the plan members' morbidity or health status, as referenced in the federal risk adjustment transfer formula for the individual and small group markets

and Unified Rate Review Template instructions published by the United States Centers for Medicare and Medicaid Services.

(13) "Qualified health plan" has the same meaning as defined in 45 C.F.R. § 155.20.

(14) "Unified Rate Review Template (URRT)" means a spreadsheet that comprises Part I of the rate filing justification, as described in 45 C.F.R. § 154.215, concerning submission of rate filing justification.

[Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, and 48.43.733. WSR 26-09-083 (Matter R 2025-02), s 284-43-6800, filed 4/15/26, effective 5/16/26.]

WAC 284-43-6810 Standardized induced demand factors and AV pricing value guardrails. This section applies to all nongrandfathered individual and small group health plans for plan years beginning on or after January 1, 2027.

(1) The allowed underlying rate development components of the "actuarial value and cost-sharing design of the plan" adjustment are:

(a) AV pricing value;

(b) Induced demand factor;

(c) Cost-sharing reduction silver load (if applicable); and

(d) Exclusion of funds for abortion services per 45 C.F.R. § 156.280(e) (if applicable).

(2) To ensure consistency in rate development, align rating methodology with the federal risk adjustment model and development of cost-sharing reduction silver load, and promote fair competition, the induced demand factors used in the individual and small group health plan rate filings may vary by plan design but must be consistent with the federal risk transfer formula published by the United States Centers for Medicare and Medicaid Services.

(3) Except to the extent provided otherwise in this subsection, to promote fair competition and ensure consumers can compare plans based on consistent metal level categories and pricing methodologies, the AV pricing value must be within ±2% of a plan's designated AV metal value. The allowable range of AV pricing value may be increased or decreased by 1% and must not result in a total adjustment exceeding ±3%, if the plan has significant features that are not considered in the AV metal value calculation. Applicable plan features may include, but are not limited to, an embedded pediatric dental benefit, an aggregate family deductible, or significant out-of-network utilization. The actuarial memorandum in the rate filing must include each plan's AV metal value, AV pricing value, and the method used to develop AV pricing values.

(4) The methodology used to develop the AV pricing value must be based on a standardized population. The carrier must identify all material changes in the AV pricing value development from the prior year's rate filing and quantify their impacts.

[Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, and 48.43.733. WSR 26-09-083 (Matter R 2025-02), s 284-43-6810, filed 4/15/26, effective 5/16/26.]

WAC 284-43-6820 Uniform cost-sharing reduction silver load adjustment factor. (1) This section applies to all individual silver

level plans offered on the health benefit exchange for plan years beginning on or after January 1, 2027.

(2) The following assumptions will be used by the commissioner in the cost-sharing reduction (CSR) silver load calculation:

(a) Actuarial values are based on federal risk transfer formula factors published by the United States Centers for Medicare and Medicaid Services.

(b) The actuarial value for limited cost-share silver variant is 70 percent based on qualified health plan application instructions.

(c) Induced demand factors are based on federal risk transfer formula factors published by the United States Centers for Medicare and Medicaid Services.

(d) Membership distribution and enrollment assumptions are based on the prior year experience provided by the health benefit exchange and include appropriate adjustments for health benefit exchange plan mapping procedures.

(3) The methodology and formula used by the commissioner to calculate the CSR silver loading factor is as follows:

(a) For each exchange silver plan variant, compute the enrollment-weighted product of the plan's actuarial value and the induced demand factor.

(b) Sum the results of step (a) of this subsection.

(c) Divide the result of step (b) of this subsection by the product of the actuarial value and induced demand factor for the base silver plan (values for the 70 percent AV metal level plan).

(d) The result in step (c) of this subsection is the final CSR silver load factor for the plan, which applies only to exchange silver plans. The result must be incorporated into premium rate development as a component of the "actuarial value and cost-sharing design of the plan" adjustment, provided the issuer does not otherwise receive reimbursement for cost-sharing reduction amounts.

(4) Based on the calculation in subsection (3) of this section and the assumptions in subsection (2) of this section, the commissioner may update the final cost-sharing reduction silver loading factor annually, as the commissioner determines appropriate.

(5) The commissioner will provide the final cost-sharing reduction silver loading factor and plan-mapping assumptions used in the commissioner's calculation to issuers by March 31st of each year.

(6) For any plan year during which all issuers receive reimbursement for cost-sharing reduction expenses from the federal government, the commissioner will forego calculating a silver loading factor.

[Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, and 48.43.733. WSR 26-09-083 (Matter R 2025-02), s 284-43-6820, filed 4/15/26, effective 5/16/26.]

SUBCHAPTER K
MENTAL HEALTH AND SUBSTANCE USE DISORDER

WAC 284-43-7000 Scope and intent—Parity in mental health and substance use disorder benefits. This subchapter applies to:

(1) Health plans;

(2) Plans deemed by the commissioner to have a short-term limited purpose or duration;

(3) Plans deemed by the commissioner to be student-only health plans that are guaranteed renewable while the covered person is enrolled as a regular, full-time undergraduate student at an accredited higher education institution; and

(4) Issuers.

The purpose of this subchapter is to consolidate existing state mental health and substance use disorder regulation with federal mental health and substance use disorder parity requirements into state regulation. This rule also provides health plans, plans deemed by the commissioner to have a short-term limited purpose or duration, or to be student-only health plans that are guaranteed renewable while the covered person is enrolled as a regular, full-time undergraduate student at an accredited higher education institution and issuers with the method of demonstrating compliance with these requirements. A plan or issuer's obligation to comply with these requirements is nondelegable; a plan or issuer is obligated to ensure compliance with WAC 284-43-7000 through 284-43-7120, even if they use a third-party vendor or subcontracting arrangement. A plan or issuer is not exempt from any of these requirements because it relied upon a third-party vendor or subcontracting arrangement for administration of any aspect of its mental health or substance use disorder benefits or services.

[Statutory Authority: RCW 48.02.060, 48.20.460, 48.43.0128, 48.44.050, and 48.46.200. WSR 20-24-040, § 284-43-7000, filed 11/23/20, effective 12/24/20. WSR 16-01-081, recodified as § 284-43-7000, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.43.715, 48.44.050, 48.46.200 and Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. 110-343. WSR 14-23-057 (Matter No. R 2012-29), § 284-43-990, filed 11/17/14, effective 12/18/14.]

WAC 284-43-7010 Definitions. Aggregate lifetime limit means a dollar limitation on the total amount of specified benefits that may be paid under a plan (or health insurance coverage offered in connection with a plan) for any coverage unit.

Annual dollar limit means a dollar limitation on the total amount of specified benefits that may be paid in a 12-month period under a plan (or health insurance coverage offered in connection with a plan) for any coverage unit.

Approved treatment program means a discrete program of substance use disorder treatment provided by a treatment program certified by the department of health as meeting standards adopted under chapter 71.24 RCW.

Classification of benefits means a group into which all medical/surgical benefits and mental health or substance use disorder benefits offered by a plan must fall. For the purposes of this rule, the only classifications that may be used are: Inpatient, in-network; inpatient, out-of-network; outpatient, in-network; outpatient, out-of-network; emergency care; and prescription drugs.

Coverage unit means the way in which a plan or issuer groups individuals for purposes of determining benefits, or premiums or contributions. For example, different coverage units include self-only, family, and employee-plus-spouse.

Cumulative financial requirements means financial requirements that determine whether or to what extent benefits are provided based on accumulated amounts and include deductibles and out-of-pocket maxi-

mums. Financial requirements do not include aggregate lifetime or annual dollar limits.

Cumulative quantitative treatment limitations means treatment limitations that determine whether or to what extent benefits are provided based on accumulated amounts, such as annual or lifetime day or visit limits.

Emergency condition, for the purpose of this subchapter, means a medical, mental health or substance use disorder condition manifesting itself by acute symptoms of sufficient severity, including severe emotional or physical distress or a combination of severe emotional and physical distress, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical, mental health or substance use disorder treatment attention to result in a condition placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

Essential health benefits (EHBs). EHBs have the same definition as found in WAC 284-43-5602 or 284-43-5604, as appropriate. The definition of EHBs includes mental health and substance use disorder services, including behavioral health treatment. For EHBs, including mental health and substance use disorder benefits, federal and state law prohibit limitations on age, condition, lifetime and annual dollar amounts.

Financial requirements means cost sharing measures such as deductibles, copayments, coinsurance, and out-of-pocket maximums. Financial requirements do not include aggregate lifetime or annual dollar limits.

Health carrier or issuer has the same meaning as RCW 48.43.005.

Health plan has the same meaning as RCW 48.43.005.

Medical/surgical benefits means benefits with respect to items or services for medical conditions or surgical procedures, as defined under the terms of the plan or health insurance coverage and in accordance with applicable federal and state law, but does not include mental health or substance use disorder benefits. Any condition defined by the plan or coverage as being a medical/surgical condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the *International Classification of Diseases* (ICD) or state guidelines).

Medically necessary or medical necessity:

(a) With regard to substance use disorder is defined by the most recent version of *The ASAM Criteria, Treatment Criteria for Addictive, Substance Related, and Co-Occurring Conditions* as published by the American Society of Addiction Medicine (ASAM).

(b) With regard to mental health services, pharmacy services, and any substance use disorder benefits not governed by ASAM, 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.

Mental health benefits means benefits with respect to items or services for mental health and substance use disorder conditions, as defined under the terms of the plan or health insurance coverage and in accordance with applicable federal and state law. Any condition defined by the plan or coverage as being a mental health condition must be defined to be consistent with the most current version of the *Diagnostic and Statistical Manual of Mental Disorders*, as published by the American Psychiatric Association.

Nonquantitative treatment limitations (NQTL) means processes, strategies, or evidentiary standards, or other factors that are not expressed numerically, but otherwise limit the scope or duration of benefits for treatment. NQTLs include, but are not limited to:

(a) Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;

(b) Formulary design for prescription drugs;

(c) For plans with multiple network tiers (such as preferred providers and participating providers), network tier design;

(d) Standards for provider admission to participate in a network, including reimbursement rates;

(e) Plan methods for determining usual, customary, and reasonable charges;

(f) Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols);

(g) Exclusions based on failure to complete a course of treatment; and

(h) Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage.

Plan means a health plan, a short-term limited duration medical plan or a student-only health plan.

Predominant level: If a type of financial requirement or quantitative treatment limitation applies to substantially all medical surgical benefits in a classification, the predominant level is the level that applies to more than one-half of the medical/surgical benefits in that classification subject to the financial requirement or quantitative treatment limitation.

Quantitative parity analysis means a mathematical test by which plans and issuers determine what level of a financial requirement or quantitative treatment limitation, if any, is the most restrictive level that could be imposed on mental health or substance use disorder benefits within a classification.

Quantitative treatment limitations means types of objectively quantifiable treatment limitations such as frequency of treatments, number of visits, days of coverage, days in a waiting period or other similar limits on the scope or duration of treatment.

Short-term limited duration medical plan means a plan deemed by the commissioner to have a short-term limited purpose or duration.

Student-only health plan means a health plan that is guaranteed renewable while the covered person is enrolled as a regular, full-time undergraduate student at an accredited higher education institution.

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.

Substance use disorder benefits means benefits with respect to items or services for substance use disorders, as defined under the terms of the plan or health insurance coverage and in accordance with applicable federal and state law. Substance use disorder benefits must include payment for reasonable charges for medically necessary treatment and supporting service rendered to an enrollee either within an approved treatment program or by a health care professional that meets the requirements as part of the approved treatment plan.

Substantially all: A type of financial requirement or quantitative treatment limitation considered to apply to substantially all medical/surgical benefits in a classification of benefits if it applies to at least two-thirds of all medical/surgical benefits in that classification as determined by WAC 284-43-7040 (2)(a).

Treatment limitations means limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. Treatment limitations include both quantitative treatment limitations, which are expressed numerically (such as 50 outpatient visits per year), and nonquantitative treatment limitations, which otherwise limit the scope or duration of benefits for treatment under a plan or coverage. A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation for purposes of this section.

[Statutory Authority: RCW 48.02.060, 48.49.110, 2024 c 366, 2025 c 25, and 2025 c 171. WSR 26-01-148 (Matter R 2025-12), s 284-43-7010, filed 12/19/25, effective 1/19/26. Statutory Authority: RCW 48.02.060, 48.20.460, 48.43.0128, 48.44.050, and 48.46.200. WSR 20-24-040, § 284-43-7010, filed 11/23/20, effective 12/24/20. Statutory Authority: RCW 48.02.060. WSR 16-14-106 (Matter No. R 2016-11), § 284-43-7010, filed 7/6/16, effective 8/6/16. WSR 16-01-081, recodified as § 284-43-7010, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.43.715, 48.44.050, 48.46.200 and Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. 110-343. WSR 14-23-057 (Matter No. R 2012-29), § 284-43-991, filed 11/17/14, effective 12/18/14.]

WAC 284-43-7020 Classification of benefits. (1) A plan providing mental health or substance use disorder benefits, must provide mental health or substance use disorder benefits in every classification in which medical/surgical benefits are provided.

(2) Parity requirements must be applied to the following six classifications of benefits: Inpatient, in-network; inpatient, out-of-network; outpatient, in-network; outpatient, out-of-network; emergency care; and prescription drugs. These are the only classifications of benefits that can be used.

(a) **Inpatient, in-network.** Benefits furnished on an inpatient basis and within a network of providers established or recognized under a plan or health insurance coverage.

(b) **Inpatient, out-of-network.** Benefits furnished on an inpatient basis and outside any network of providers established or recognized under a plan or health insurance coverage. This classification includes inpatient benefits under a plan (or health insurance coverage) that has no network of providers.

(c) **Outpatient, in-network.** Benefits furnished on an outpatient basis and within a network of providers established or recognized under a plan or health insurance coverage.

(d) **Outpatient, out-of-network.** Benefits furnished on an outpatient basis and outside any network of providers established or recognized under a plan or health insurance coverage. This classification includes outpatient benefits under a plan (or health insurance coverage) that has no network of providers.

(e) **Emergency care.** Benefits for treatment of an emergency condition related to a mental health or substance use disorder. Such bene-

fits must comply with the requirements for emergency medical services in RCW 48.43.093. Medically necessary detoxification must be covered as an emergency medical condition according to RCW 48.43.093, and may be provided in hospitals licensed under chapter 70.41 RCW. Medically necessary detoxification services must not require prenotification.

(f) **Prescription drugs.** Benefits for prescription drugs.

(3) In determining the classification in which a particular benefit belongs, a plan must apply the same standards to medical/surgical benefits as applied to mental health or substance use disorder benefits.

An issuer or plan must assign covered intermediate mental health/substance use disorder benefits such as residential treatment, partial hospitalization, and intensive outpatient treatment, to the existing six classifications in the same way that they assign comparable intermediate medical/surgical benefits to these classifications. For example, if a plan classifies medical care in skilled nursing facilities as inpatient benefits, then it must also treat covered mental health care in residential treatment facilities as inpatient benefits. If a plan or issuer treats home health care as an outpatient benefit, then any covered intensive outpatient mental health or substance use disorder services and partial hospitalization must be considered outpatient benefits as well.

(4) A plan or issuer may not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits that is more restrictive than the predominant financial requirement or treatment limitation applied to medical/surgical benefits. This parity analysis must be calculated for each type of financial requirement or treatment limitation within a coverage unit for each classification of services.

(5) Medical/surgical benefits and mental health or substance use disorder benefits cannot be categorized as being offered outside of these six classifications and therefore not subject to the parity analysis.

(a) A plan or issuer must treat the least restrictive level of the financial requirement or quantitative treatment limitation that applies to at least two-thirds of medical/surgical benefits across all provider tiers in a classification as the predominant level that it may apply to mental health or substance use disorder benefits in the same classification.

(b) If a plan or issuer classifies providers into tiers, and varies cost-sharing based on the different tiers, the criteria for classification must be applied to generalists and specialists providing mental health or substance use disorder services no more restrictively than such criteria are applied to medical/surgical benefit providers.

(6) **Permitted subclassifications:**

(a) A plan or issuer is permitted to divide benefits furnished on an outpatient basis into two subclassifications:

(i) Office visits; and

(ii) All other outpatient items and services.

(b) A plan or issuer may divide its benefits furnished on an in-network basis into subclassifications that reflect network tiers, if the tiering is based on reasonable factors and without regard to whether a provider is a mental health or substance use disorder provider or a medical/surgical provider.

(c) After network tiers are established, the plan or issuer may not impose any financial requirement or treatment limitation on mental health or substance use disorder benefits in any tier that is more re-

strictive than the predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in that tier.

(d) If a plan applies different levels of financial requirements to different tiers of prescription drug benefits based on reasonable factors and without regard to whether a drug is generally prescribed with respect to medical/surgical benefits or with respect to mental health/substance use disorder benefits, the plan satisfies the parity requirements with respect to prescription drug benefits. Reasonable factors include: Cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up.

(e) A parity analysis applying the financial requirement and treatment rules found in WAC 284-43-7040 and 284-43-7060 must be performed for each type of financial requirement or quantitative treatment limitation within a coverage unit for each subclassification of services.

(7) **Prohibited subclassifications:** All subclassifications other than the permitted subclassification listed in subsection (6) of this section are specifically prohibited. For example, a plan is prohibited from basing a subclassification on generalists and specialists.

[Statutory Authority: RCW 48.02.060, 48.20.460, 48.43.0128, 48.44.050, and 48.46.200. WSR 20-24-040, § 284-43-7020, filed 11/23/20, effective 12/24/20. Statutory Authority: RCW 48.02.060. WSR 16-14-106 (Matter No. R 2016-11), § 284-43-7020, filed 7/6/16, effective 8/6/16. WSR 16-01-081, recodified as § 284-43-7020, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.43.715, 48.44.050, 48.46.200 and Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. 110-343. WSR 14-23-057 (Matter No. R 2012-29), § 284-43-992, filed 11/17/14, effective 12/18/14.]

WAC 284-43-7040 Measuring plan benefits—Financial requirements and quantitative treatment limitations. (1) Classification of benefits must be measured as follows:

(a) By type and level of financial requirement or treatment limitation.

(i) A financial requirement or treatment limitation type includes deductibles, copayments, coinsurance, and out-of-pocket maximums. Types of quantitative treatment limitations include annual, episode, and lifetime day and visit limits.

(ii) A financial requirement or treatment limitation level includes the amount of the financial requirement or treatment limitation type. For example, different levels of coinsurance include twenty percent and thirty percent; different levels of a copayment include fifteen dollars and twenty dollars; different levels of a deductible include two hundred fifty dollars and five hundred dollars; and different levels of an episode limit include twenty-one inpatient days per episode and thirty inpatient days per episode.

(b) A plan or issuer may not apply any financial requirement or quantitative treatment limitation to mental health/substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or quantitative treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification. Whether a financial requirement or treatment limitation is a predominant financial requirement or treatment limita-

tion that applies to substantially all medical/surgical benefits in a classification is determined separately for each type of financial requirement or treatment limitation.

(c) The determination of the portion of medical/surgical benefits in a classification of benefits subject to a financial requirement or quantitative treatment limitation (or subject to any level of a financial requirement or quantitative treatment limitation) is based on the dollar amount of all plan payments for medical/surgical benefits in the classification expected to be paid under the plan for the plan year.

(i) The dollar amount of plan payments is based on the amount the plan allows (before enrollee cost sharing) rather than the amount the plan pays (after enrollee cost sharing) because payment based on the allowed amount covers the full scope of the benefits being provided.

(ii) A reasonable actuarial method must be used to determine the dollar amount expected to be paid under a plan for medical/surgical benefits subject to a financial requirement or quantitative treatment limitation.

(d) Clarifications for certain threshold requirements when performing "substantially all" and "predominant" tests.

(i) For any deductible, the dollar amount of plan payments includes all plan payments with respect to claims that would be subject to the deductible if it had not been satisfied.

(ii) For any out-of-pocket maximum, the dollar amount of plan payments includes all plan payments associated with out-of-pocket payments that are taken into account towards the out-of-pocket maximum as well as all plan payments associated with out-of-pocket payments that would have been made towards the out-of-pocket maximum if it had not been satisfied.

(iii) Similar rules apply for any other thresholds at which the rate of plan payment changes.

(2) Application to different coverage units. If a plan or insurer applies different levels of a financial requirement or quantitative treatment limitation to different coverage units in a classification of medical/surgical benefits, the "predominant" level that applies to "substantially all" medical/surgical benefits in the classification is determined separately for each coverage unit.

(a) Determining "substantially all": A type of financial requirement or quantitative treatment limitation is considered to apply to substantially all medical/surgical benefits in a classification of benefits if it applies to at least two-thirds of all medical/surgical benefits in that classification.

(i) Benefits subject to a zero level for a type of financial requirement are treated as benefits not subject to that type of financial requirement. Benefits with no quantitative treatment limitations are treated as benefits not subject to that type of quantitative treatment limitation.

(ii) If a type of financial requirement or quantitative treatment limitation does not apply to at least two-thirds of all medical/surgical benefits in a classification, the financial requirement or quantitative treatment limitation of that type cannot be applied to mental health or substance use disorder benefits in that classification.

(b) Determining "predominant":

(i) If a type of financial requirement or quantitative treatment limitation applies to at least two-thirds of all medical/surgical benefits in a classification as determined under (a) of this subsection, the level of the financial requirement or quantitative treatment limi-

tation that applies to more than one-half of medical/surgical benefits in that classification subject to the financial requirement or quantitative treatment limitation is the predominant level of that type in a classification of benefits.

(ii) If a type of financial requirement or quantitative treatment limitation applies to at least two-thirds of all medical/surgical benefits in a classification and there is no single level that applies to more than one-half of medical/surgical benefits in the classification subject to the financial requirement or quantitative treatment limitation, the plan or issuer must combine levels until the combination of levels applies to more than one-half of medical/surgical benefits subject to the financial requirement or quantitative treatment limitation in the classification.

(iii) The least restrictive level within the combination is considered the predominant level of that type in the classification. (For this purpose, a plan must combine the most restrictive levels first, with each less restrictive level added to the combination until the combination applies to more than one-half of the benefits subject to the financial requirement or treatment limitation.)

(3) Cumulative financial requirements and cumulative quantitative treatment limitations.

(a) A plan or issuer may not apply cumulative financial requirements (such as deductibles and out-of-pocket maximums) or cumulative quantitative treatment limitations (such as annual or lifetime day or visit limits) for mental health or substance use disorder benefits in a classification that accumulate separately from any cumulative requirement or limitation established for medical/surgical benefits in the same classification.

(b) Cumulative requirements and limitation must also satisfy the quantitative parity analysis.

[Statutory Authority: RCW 48.02.060, 48.20.460, 48.43.0128, 48.44.050, and 48.46.200. WSR 20-24-040, § 284-43-7040, filed 11/23/20, effective 12/24/20. WSR 16-01-081, recodified as § 284-43-7040, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.43.715, 48.44.050, 48.46.200 and Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. 110-343. WSR 14-23-057 (Matter No. R 2012-29), § 284-43-993, filed 11/17/14, effective 12/18/14.]

WAC 284-43-7060 Measuring plan benefits—Nonquantitative treatment limitations. (1) A plan or issuer may not impose an NQTL with respect to mental health or substance use disorder in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards or other factors used in applying the NQTL to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the same classification.

(2) All plan standards, such as in-and-out-of-network geographic limitations, limitations on inpatient services for situations where the enrollee is a threat to self or others, exclusions for court-ordered and involuntary holds, experimental treatment limitations, service coding, exclusions for services provided by clinical social work-

ers, and network adequacy, while not specifically enumerated in the illustrative list of NQTLs must be applied in a manner that complies with this subsection.

[Statutory Authority: RCW 48.02.060, 48.20.460, 48.43.0128, 48.44.050, and 48.46.200. WSR 20-24-040, § 284-43-7060, filed 11/23/20, effective 12/24/20. WSR 16-01-081, recodified as § 284-43-7060, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.43.715, 48.44.050, 48.46.200 and Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. 110-343. WSR 14-23-057 (Matter No. R 2012-29), § 284-43-994, filed 11/17/14, effective 12/18/14.]

WAC 284-43-7080 Prohibited exclusions. (1) Benefits for actual treatment and services rendered may not be denied solely because a course of treatment was interrupted or was not completed.

(2) If a service is prescribed for a mental health condition and is medically necessary, it may not be denied solely on the basis that it is part of a category of services or benefits that is excluded by the terms of the contract.

(3) Benefits for mental health services and substance use disorder may not be limited or denied based solely on age or condition.

(4) When a treatment or service is gender affirming treatment, as defined in RCW 48.43.0128, a health carrier may not:

(a) Deny or limit coverage, deny or limit coverage of a claim, issue automatic denials of coverage or impose additional cost sharing or other limitations or restrictions on coverage if that treatment is:

(i) Prescribed to an individual because of, related to, or consistent with a person's gender expression or identity, as defined in RCW 49.60.040;

(ii) Medically necessary; and

(iii) Prescribed in accordance with accepted standards of care; or

(b) Apply blanket exclusions; or

(c) When prescribed as medically necessary, exclude facial gender affirming treatment (such as tracheal shaves), hair removal procedures, and other care (such as mastectomies, breast reductions, breast implants, or any combination of gender affirming procedures, including revisions to prior treatment) as cosmetic services.

(5) Nothing in this section relieves a plan or an issuer from its obligations to pay for a court ordered substance use disorder benefit or mental health benefit when it is medically necessary.

[Statutory Authority: RCW 48.02.060, 48.43.515 and 2021 c 280. WSR 21-24-072 (Matter No. R 2021-14), § 284-43-7080, filed 11/30/21, effective 1/1/22. Statutory Authority: RCW 48.02.060, 48.20.460, 48.43.0128, 48.44.050, and 48.46.200. WSR 20-24-040, § 284-43-7080, filed 11/23/20, effective 12/24/20. WSR 16-01-081, recodified as § 284-43-7080, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.43.715, 48.44.050, 48.46.200 and Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. 110-343. WSR 14-23-057 (Matter No. R 2012-29), § 284-43-995, filed 11/17/14, effective 12/18/14.]

WAC 284-43-7100 Required disclosures. (1) Plans and issuers must provide reasonable access to and copies of all documents, records, and other information relevant to an individual's claim.

(a) Plans and issuers must provide disclosures consistent with WAC 284-43-4040, 284-43-3170, 284-43-3110, and 284-43-2000. For any other disclosures related to an individual's claim, the plan or issuer must provide disclosures within thirty days.

(b) When a claim relates to a protected individual, as defined in RCW 48.43.005, the health carrier must comply with RCW 48.43.505.

(2) Plans and issuers must provide the criteria, processes, strategies, evidentiary standards and other factors used to make medical necessity determinations of mental health or substance use disorder benefits. These must be made available free of charge by the plan issuer to any current or potential enrollee, beneficiary, or contracting provider upon request, within a reasonable time in compliance with WAC 284-43-2000, and in a manner that provides reasonable access to the requestor. This requirement includes information on the processes, strategies, evidentiary standards, and other factors used to apply an NQTL with respect to medical/surgical and mental health or substance use disorder benefits under the plan.

(3) The reason for any adverse benefit decision for mental health or substance use disorder benefits must be provided with the notification of the adverse benefit decision. When an adverse benefit decision relates to a protected individual, as defined in RCW 48.43.005, the health carrier must comply with RCW 48.43.505.

(4) Compliance with these disclosure requirements is not determinative of compliance with any other provisions of applicable federal or state law.

(5) If a plan is subject to ERISA, it must provide the reason for the claim denial in a form and manner consistent with the requirements of 29 C.F.R. 2560.503-1.

[Statutory Authority: RCW 48.02.060, 48.20.460, 48.43.0128, 48.44.050, and 48.46.200. WSR 20-24-040, § 284-43-7100, filed 11/23/20, effective 12/24/20. Statutory Authority: RCW 48.02.060. WSR 16-14-106 (Matter No. R 2016-11), § 284-43-7100, filed 7/6/16, effective 8/6/16. WSR 16-01-081, recodified as § 284-43-7100, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.43.715, 48.44.050, 48.46.200 and Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. 110-343. WSR 14-23-057 (Matter No. R 2012-29), § 284-43-996, filed 11/17/14, effective 12/18/14.]

WAC 284-43-7120 Compliance and reporting of quantitative parity analysis. (1) Plans and issuers must file a justification demonstrating the analysis of each plan's financial requirements and quantitative treatment limitations as required under WAC 284-43-7040.

(2) Filing of this justification is subject to the requirements of chapters 284-44A, 284-46A, and 284-58 WAC and may be rejected and closed if it does not comply.

[Statutory Authority: RCW 48.02.060, 48.20.460, 48.43.0128, 48.44.050, 48.46.200. WSR 20-24-040, § 284-43-7120, filed 11/23/20, effective 12/24/20. Statutory Authority: RCW 48.02.060. WSR 16-14-106 (Matter No. R 2016-11), § 284-43-7120, filed 7/6/16, effective 8/6/16. WSR 16-01-081, recodified as § 284-43-7120, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.43.715, 48.44.050,

48.46.200 and Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. 110-343. WSR 14-23-057 (Matter No. R 2012-29), § 284-43-997, filed 11/17/14, effective 12/18/14.]

SUBCHAPTER L
REPRODUCTIVE HEALTH CARE AND CONTRACEPTION

WAC 284-43-7200 Purpose and scope. (1) The purpose of this subchapter is to establish uniform regulatory standards for required coverage of contraceptive services and other reproductive health services and supplies, voluntary sterilization, and abortion under RCW 48.43.072 and 48.43.073.

(2) This subchapter applies to all health plans, except as otherwise expressly provided in this subchapter. Health carriers are responsible for compliance with the provisions of this subchapter and are responsible for the compliance of any person or organization acting on behalf of or at the direction of the carrier, or acting pursuant to carrier standards or requirements concerning the coverage of, payment for, or provision of contraceptive services and supplies, voluntary sterilization, and abortion. A carrier may not offer as a defense to a violation of any provision of this subchapter that the violation arose from the act or omission of a participating provider or facility, network administrator, claims administrator, or other person acting on behalf of or at the direction of the carrier, or acting pursuant to carrier standards or requirements under a contract with the carrier rather than from the direct act or omission of the carrier.

(3) Effective January 1, 2021, except as otherwise provided, this subchapter applies to all student health plans deemed by the insurance commissioner to have a short-term limited purpose or duration, including short-term limited purpose student health plans and guaranteed renewable plans while the covered person is an enrolled student as a regular full-time undergraduate or graduate student at an accredited higher education institution.

[Statutory Authority: RCW 48.02.060, 48.43.072, 48.43.073, and 2019 c 399. WSR 19-24-039, § 284-43-7200, filed 11/26/19, effective 12/27/19.]

WAC 284-43-7210 Definitions. (1) "Contraceptive services" means consultations, examinations, procedures, and other health care services to obtain contraceptive supplies or voluntary sterilization. This includes prescribing, dispensing, inserting, delivering, distributing, administering, or removing contraceptive supplies and voluntary sterilization procedures.

(2) "Contraceptive supplies" means all contraceptive drugs, devices, and other products approved by the Federal Food and Drug Administration. This includes over-the-counter contraceptive drugs, devices, and products approved by the Federal Food and Drug Administration.

(3) "Cost-sharing" means any expenditure required of a covered person for covered services or supplies, including applicable taxes. Cost-sharing includes deductibles, coinsurance, copayments, or similar charges. Cost-sharing does not include premiums, balance billing amounts for nonnetwork providers, or spending for noncovered services or supplies.

(4) "Covered person" or "enrollee" has the same meaning as defined in RCW 48.43.005.

(5) "Gender expression" has the same meaning as defined in RCW 48.43.072.

(6) "Gender identity" has the same meaning as defined in RCW 48.43.072.

(7) "Medical management" or "medical management techniques" has the same meaning as defined in RCW 48.165.010.

(8) "Reproductive health care services" has the same meaning as defined in RCW 48.43.072.

(9) "Reproductive system" has the same meaning as defined in RCW 48.43.072.

(10) "Well-person preventative visits" has the same meaning as defined in RCW 48.43.072.

(11) "Prescription hormone therapy" has the same meaning as defined in RCW 48.43.845.

[Statutory Authority: RCW 48.02.060, 48.49.110, 2024 c 366, 2025 c 25, and 2025 c 171. WSR 26-01-148 (Matter R 2025-12), s 284-43-7210, filed 12/19/25, effective 1/19/26. Statutory Authority: RCW 48.02.060 and 2021 c 53. WSR 21-24-032 (Matter No. R 2021-13), § 284-43-7210, filed 11/22/21, effective 12/23/21. Statutory Authority: RCW 48.02.060, 48.43.072, 48.43.073 and 2019 c 399. WSR 19-24-039, § 284-43-7210, filed 11/26/19, effective 12/27/19.]

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 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.

(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.

[Statutory Authority: RCW 48.02.060, 48.43.735, 48.44.050, 48.46.200, 48.200.040, and 48.200.900. WSR 23-24-034 (Matter R 2023-07), § 284-43-7220, filed 11/30/23, effective 1/1/24. Statutory Authority: RCW 48.02.060 and 2021 c 53. WSR 21-24-032 (Matter No. R 2021-13), § 284-43-7220, filed 11/22/21, effective 12/23/21. Statutory Authority: RCW 48.02.060, 48.43.072, 48.43.073, and 2019 c 399. WSR 19-24-039, § 284-43-7220, filed 11/26/19, effective 12/27/19.]

WAC 284-43-7230 Services provided without discrimination, prohibited limitations, and confidentiality. (1) All services and supplies required under RCW 48.43.072 must be covered without discrimination on the basis of race, color, national origin, sex, sexual orientation, gender expression or identity, marital status, age, citizenship, immigration status, or disability. Health plans and student health plans must ensure that all enrollees have access to these services and supplies regardless of gender or gender identity. This includes, but is not limited to, coverage of any method of over-the-counter contraception without regard to the sex, or gender identity or expression, of the covered person.

(2) Reproductive health care, voluntary sterilization, abortion or contraceptive services or contraceptive supplies provided under a health plan or a student health plan are health care services related to reproductive health and protected by the confidentiality requirements of RCW 48.43.505, WAC 284-04-510, and other relevant statutes and regulations providing for enrollee confidentiality.

[Statutory Authority: RCW 48.02.060, 48.43.072, 48.43.073, and 2019 c 399. WSR 19-24-039, § 284-43-7230, filed 11/26/19, effective 12/27/19.]

WAC 284-43-7240 Access to contraceptive services and supplies. (1) Health plans and student health plans must provide covered persons access to sufficient numbers and types of providers and facilities to assure that covered persons are able to access all covered contraceptive services and all Federal Food and Drug Administration approved contraceptive supplies without unreasonable delay or burden.

(2) If a health plan or student health plan limits coverage of contraceptive services and supplies to in-network providers, the carrier must demonstrate that its network for these services and supplies

meets the access and adequacy standards set forth in chapter 284-170 WAC.

(3) In any case where the health plan's network or student health plan's network has an absence of or an insufficient number or type of participating providers or facilities to provide a particular covered contraceptive service or supply, including over-the-counter contraceptives, in a timely manner appropriate for the enrollee's condition, the carrier must ensure that the covered person obtains the covered service or supply from a provider or facility within reasonable proximity of the enrollee at no greater cost to the enrollee than if the service or supply were obtained from network providers and facilities. The carrier must satisfy this obligation even if an alternate access delivery request under WAC 284-170-210 has been submitted and is pending approval by the insurance commissioner.

(4) If a health plan or student health plan limits the quantity of covered contraceptive supplies or services, the carrier must have a written process for covered persons to request coverage of additional services or supplies. The process may not impose any restriction or delay on the coverage of contraceptive supplies in violation of RCW 48.43.072, 48.43.195, or any other state or federal law.

(5) Effective January 1, 2021, contraceptive supplies must also be covered when used exclusively for the prevention of sexually transmitted infections.

[Statutory Authority: RCW 48.02.060, 48.43.072, 48.43.073, and 2019 c 399. WSR 19-24-039, § 284-43-7240, filed 11/26/19, effective 12/27/19.]

WAC 284-43-7250 Filing requirements. (1) For health plans and student health plans subject to RCW 48.43.072 and 48.43.073, the carrier must ensure that the health plan and student health plan forms clearly inform covered persons of their rights to access contraceptive services and supplies, voluntary sterilization and abortion. The health plan and student health plan forms must clearly inform covered persons how they access these services and supplies.

(2) A health plan's forms and student health plan's forms must include a detailed description of the plan's benefits provided to covered persons that specifically instructs covered persons where and how they access coverage of contraceptive supplies, including over-the-counter supplies. This information must include:

(a) Whether covered supplies are available from in-network and out-of-network providers; and

(b) How to submit a claim including, at a minimum:

(i) Whether covered persons may purchase covered supplies and seek reimbursement from the carrier;

(ii) How to access and submit any necessary claim forms; and

(iii) Where to send a claim, such as a mailing address or instructions for submitting a claim electronically.

(3) If a health plan or student health plan limits the number of covered over-the-counter contraceptive supplies, the health plan or student health plan must include with its filing supporting evidence showing that the limitation does not impose any restriction or delay on the coverage of contraceptive supplies in violation of RCW 48.43.072 or any other state or federal law.

(4) If a health plan or student health plan limits the number of covered contraceptive services or supplies, the plan forms must in-

clude a detailed description of the plan's benefits that specifically instructs covered persons how to request coverage of additional contraceptive services or supplies. The process may not impose any restrictions or delays on the coverage or access of contraceptive services or supplies in violation of RCW 48.43.072, or any other state or federal law.

[Statutory Authority: RCW 48.02.060 and 2021 c 53. WSR 21-24-032 (Matter No. R 2021-13), § 284-43-7250, filed 11/22/21, effective 12/23/21. Statutory Authority: RCW 48.02.060, 48.43.072, 48.43.073, and 2019 c 399. WSR 19-24-039, § 284-43-7250, filed 11/26/19, effective 12/27/19.]

WAC 284-43-7260 Deductibles for over-the-counter contraceptives and voluntary male sterilization in HSA qualifying plans. (1) A qualifying health plan and a qualifying student health plan for a health savings account ("HSA-qualifying plan") is subject to all of the requirements under RCW 48.43.072. An HSA-qualifying plan may apply a deductible to coverage of over-the-counter contraceptive supplies or services and voluntary male sterilization only 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 Federal Internal Revenue Service laws and regulations.

(2) The individual and family deductibles applied to over-the-counter contraceptive supplies and services and male sterilization under an HSA-qualifying plan must be the minimum deductibles set by the Federal Internal Revenue Service for a plan to be an HSA-qualifying plan under 26 U.S.C. Sec. 223 (c)(2)(A) and other Federal Internal Revenue Service laws, regulations, and guidance. For the 2019 plan year, IRS Bulletin 2018-12 allows HSA-qualifying plans to offer benefits for male sterilization or male contraceptives without a deductible or with a deductible below the standard minimum deductible for the 2019 plan year only. Therefore, for 2019, HSA-qualifying plans sold in this state may decide not to charge any deductible for male sterilization or male contraceptives for the 2019 plan year.

(a) The deductibles, if any, applied to over-the-counter contraceptive services and supplies and male sterilization must accrue to the overall individual and family plan deductibles.

(b) Once the individual and family plan deductibles that may apply to over-the-counter contraceptive services and supplies and male sterilization have been reached, all over-the-counter contraceptive services and supplies and male sterilization must be covered with no cost-sharing, even if the overall plan deductibles have not yet been met.

(c) No person covered under an HSA-qualifying individual plan may be required to pay a higher deductible for over-the-counter contraceptive services and supplies and male sterilization than the minimum individual deductible set by the Federal Internal Revenue Service for a plan to be an HSA-qualifying plan. No person covered under an HSA-qualifying family plan may be required to pay a higher deductible for over-the-counter contraceptive services and supplies and male sterilization than the minimum family deductible set by the Federal Internal Revenue Service for a plan to be an HSA-qualifying plan, even if the applicable plan's family deductible has not yet been met. Example: A plan's family deductible for an HSA-qualifying family plan may be more than the minimum family deductible. However, the deductible applicable

to over-the-counter contraceptive supplies and services and male sterilization must be at the minimum family deductible, which is two thousand seven hundred dollars in 2019.

[Statutory Authority: RCW 48.02.060, 48.43.072, 48.43.073, and 2019 c 399. WSR 19-24-039, § 284-43-7260, filed 11/26/19, effective 12/27/19.]

WAC 284-43-7270 Access to prenatal vitamins and breast pumps. Effective January 1, 2021, health plans and student plans are required under RCW 48.43.072 to cover prenatal vitamins for covered persons expecting the birth of a child and breast pumps for covered persons expecting the birth or adoption of a child.

(1) Pursuant to RCW 48.43.072, prenatal vitamins and breast pumps can be subject to copayment, deductibles and other forms of cost sharing, except:

(a) In accordance with the Affordable Care Act and the *Women's Preventative Services Guidelines*, folic acid is currently required to be covered as a preventative service without copayment, deductibles, or other forms of cost-sharing for covered persons. This requirement does not apply to grandfathered plans.

(b) In accordance with the Affordable Care Act and the *Women's Preventative Services Guidelines*, breast pumps are currently required to be covered as a preventative service without copayments, deductibles, or other forms of cost-sharing for covered persons. This requirement does not apply to grandfathered plans.

(2) A prescription can be required to trigger coverage of prenatal vitamins, including folic acid and breast pumps.

[Statutory Authority: RCW 48.02.060, 48.43.072, 48.43.073, and 2019 c 399. WSR 19-24-039, § 284-43-7270, filed 11/26/19, effective 12/27/19.]

SUBCHAPTER M
SHORT-TERM LIMITED DURATION MEDICAL PLANS

WAC 284-43-8000 Definition of short-term limited duration medical plan. (1) "Short-term limited duration medical plan" means a policy, contract or agreement offered or issued by a health carrier with an effective date on or after January 1, 2019, that:

(a) Provides comprehensive major medical coverage, that includes, at a minimum, the following benefits:

(i) Hospital, surgical and medical expense coverage, to an aggregate maximum of not less than one million dollars and copayment or coinsurance by the covered person not to exceed fifty percent of covered charges;

(ii) The coverage for hospital services must include:

(A) Inpatient services and other miscellaneous services associated with admission to a hospital for diagnosis and treatment of a covered condition. "Miscellaneous services" includes medically necessary services delivered in a hospital setting, including professional services, anesthesia, facility fees, supplies, imaging, laboratory, pharmacy services and prescription drugs, treatments, therapy, or other services delivered on an inpatient basis;

(B) Outpatient services, including medically necessary services ordered by the member's attending health care practitioner and rendered on an ambulatory basis for diagnosis and treatment of a covered condition, including office and clinic visits, diagnostic imaging, laboratory services, radiation therapy, physical/speech/occupational therapy, and hemodialysis; and

(C) An extension of the medical plan term while hospitalized. If a member is hospitalized as an inpatient on the expiration date of the medical plan, the member's coverage under the medical plan will continue for purposes of that covered medical condition without payment of additional premium. The coverage will continue until the date the member is discharged from the hospital or until the date on which the applicable benefit maximums are reached, whichever occurs first.

(iii) The coverage for surgical services for diagnosis and treatment of a covered condition must include inpatient and outpatient surgical services at a hospital, ambulatory surgical facility, surgical suite or provider's office. "Surgical services" includes medically necessary services delivered in a hospital, ambulatory surgical facility, surgical suite or provider's office related to provision of a surgical service, including professional services, anesthesiology, facility fees, supplies, laboratory, pharmacy services and prescription drugs related to, or required as a result of, the surgical procedure; and

(iv) The coverage for medical services for diagnosis and treatment of a covered condition must include office visits.

(b) Limits the look-back period for any preexisting medical condition, illness or injury to no more than twenty-four months prior to the date of application for the medical plan, if coverage of preexisting conditions is excluded. For purposes of this section, "preexisting medical condition" means a condition for which medical advice, diagnosis, care or treatment was received or recommended; and

(c) Has an expiration date specified in the contract (taking into account any extensions that may be elected by the member with or without the carrier's consent) that is not more than three months after the original effective date of the policy, contract or agreement.

(2) Any carrier offering a short-term limited duration medical plan must offer at least one such plan with a deductible stated on a per person basis of two thousand dollars or less.

(3) A short-term limited duration medical plan cannot be issued if it would result in a person being covered by a short-term limited duration medical plan for more than three months in any twelve-month period.

(4) A carrier must not issue a short-term limited duration medical plan during an annual open enrollment period, as defined in WAC 284-43-1080, for coverage beginning in the upcoming year.

(5) Short-term limited duration medical plan has the same meaning as short-term limited duration insurance, as used in 26 C.F.R. 54.9801-2, 29 C.F.R. 2590.701-2 and 45 C.F.R. 144.103, except that:

(a) The duration of a short-term limited duration medical plan cannot exceed three months;

(b) A short-term limited duration medical plan cannot be renewed or extended, except as provided in subsection (1)(a)(ii)(C) of this section; and

(c) A short-term limited duration medical plan cannot be issued if it would result in a person being covered by a short-term limited duration medical plan for more than three months in any twelve-month period.

[Statutory Authority: RCW 48.43.005(26), 48.02.060, 48.44.050, and 48.46.200. WSR 18-21-116, § 284-43-8000, filed 10/17/18, effective 11/17/18.]

WAC 284-43-8010 Standard disclosure form for short-term limited duration medical plans. (1) All carriers offering or issuing a short-term limited duration medical plan with an effective date on or after January 1, 2019, must issue a standard disclosure form for each short-term limited duration medical plan in the same format and with the same content as the disclosure form included in this section. The standard disclosure form must be displayed prominently in the medical plan contract and in any application materials provided in connection with enrollment in such coverage, and must be provided as a distinct, separate document to the person upon initial receipt of the medical plan application.

(2) Every carrier must have a mechanism in place to verify delivery of the standard disclosure form to the applicant and obtain the applicant's acknowledgment of receipt of the form. The carrier must retain each acknowledged disclosure form for five years. The forms must be available for review by the commissioner upon request.

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

(4) The standard disclosure form must not be used until it has been filed with and approved by the commissioner.

(5) The standard disclosure form must include, at a minimum, the following information and must be presented in the following format:

(Carrier's name and address)

IMPORTANT INFORMATION
ABOUT THE LIMITS OF THE COVERAGE
YOU ARE BEING OFFERED

Save this document! It may be important to you in the future.

CAUTION:

This plan may not cover pre-existing conditions, including any medical or mental health condition you've been treated for in the past.

It provides limited benefits and does *not* include benefits required by the Affordable Care Act.

It's temporary and may not cover your costs for most hospital or other medical services, or some essential health benefits.

Read carefully what the plan does and doesn't cover before you sign up.

Before enrolling, check to see if you can buy a health plan through Washington State's Exchange, at www.wahealthplanfinder.org or 1-855-923-4633. If so, you may get help lowering your premium. Health plans sold through the Exchange provide more coverage and protections. If you missed the annual open enrollment period, see if you qualify for a special enrollment period here: www.insurance.wa.gov/when-can-i-buy-individual-health-plan

This medical plan is not a Medicare supplement plan.

This medical plan is not required to comply with certain federal market requirements for health insurance, principally those contained in

the Affordable Care Act. Be sure to check your medical plan carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your medical plan might also have lifetime and/or annual dollar limits on health benefits.

This disclosure form is not a complete description of this medical plan. To understand what is and isn't covered, please read your plan. The plan will include information about your rights and the company's responsibilities.

Short-Term Limited Duration Medical Plan Disclosure

Below is a summary of the key benefits provided by this short-term limited duration medical plan:

Type of coverage: Short-term limited duration medical plan

How long does coverage last? *(Provide the number of days or months of coverage)*

Does this policy cover pre-existing conditions? *("Yes" or "No, it limits/excludes coverage for medical or behavioral health conditions for which medical advice, diagnosis, care or treatment was received by or recommended to you, including taking prescription medication, in the 24 months prior to the date you apply for coverage under the plan. See policy for details.").*

Who is NOT eligible for coverage? *(List all excluded categories, e.g. over a certain age, Medicare/Medicaid eligible, pregnant women, those with certain preexisting conditions, etc.)*
Can the policy be renewed? No

What benefits are covered and what is the financial responsibility of the member? *(For each benefit listed below, if not covered, list "Not covered". If covered, list applicable cost-sharing, including whether or not the deductible applies, the member's percentage of coinsurance, copayment, any quantitative treatment limitations and any cap on the amount the policy will pay for the service.*

Examples include: "Covered after deductible, $45 copay plus 20% coinsurance, limited to only $1,000 of coverage"; "Covered without deductible, $50 copay, limited to 30 visits total or per year"; "Covered after deductible, limited to treatment of involuntary complications of pregnancy")

- **Deductible:** $_____ *(If there is more than one deductible, list each deductible with a description of the services to which it applies.)*
- **Plan coinsurance (amount member must pay per service) ____%** *(Must be expressed in terms of the percentage to be paid by the member. If coinsurance applies up to a maximum amount, provide that information here. Example: "This policy has a 50% coinsurance up to $10,000, after which benefits are paid at 100%.")*
- **The maximum amount a member will pay out-of-pocket for cost-sharing for the term of the plan:** $_____ *(If there is no out-of-pocket maximum, clearly state that there is no limit on the amount a member will have to pay for out-of-pocket cost-sharing. If there is an out of pocket maximum,*

clearly state which member payments are applied to this maximum, such as deductibles, copayments and coinsurance.)

- **The maximum dollar amount this plan will pay:** $_____ *(Also include lifetime limit, if applicable. Example: "$1 Million under this plan; lifetime limit of $2 Million")*
- **Emergency Room Services:**
- **Ambulance Services:**
- **Inpatient Hospital Services:**
- **Outpatient Hospital Services:**
- **Services at an Urgent Care Facility:**
- **Primary Care Visit to Treat an Injury or Illness:**
- **Specialist Visit:**
- **Physical therapy, speech therapy, occupational therapy:**
- **Mental Health Outpatient Services**
- **Mental Health Inpatient Services**
- **Substance Use Disorder Outpatient Services:**
- **Substance Use Disorder Inpatient Services;**
- **Imaging (CT/PET Scans, MRIs):**
- **Laboratory testing and services:**
- **Durable medical equipment:**
- **Preventive Care/Screening/Immunization:**
- **Prescription drugs:**
- **Skilled Nursing Facility:**
- **Services in an Ambulatory Surgical Center:**

Does the policy exclude, eliminate, restrict, reduce, limit, or delay coverage for any benefits NOT listed above? *("No" or if "Yes", include details)*

Does the policy require that the member use a specific network of health care providers or pharmacies? *("No" or if "Yes", include details)*

Can a member be charged additional costs for covered services, in addition to their coinsurance or copays? *(If members can be balance billed for any covered service, answer "Yes" and explain when this would occur. You must answer "Yes" for plan designs that do not use a provider network, or that use in-network facilities where not all services may be provided by in-network providers. If other situations apply, include any further explanation about when balance billing is possible.)*

If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage. This coverage is **not** considered comprehensive and would not qualify you for a special enrollment period.

Open enrollment for individual health plans begins November 1 each year for coverage that begins January 1 of the upcoming year.

You will need to complete and confirm all medical information you provide when applying for this plan. Your producer (also referred to as insurance agent) is not allowed to fill out any of this information for you.

Consumer acknowledgment:

I confirm that I have reviewed the content of this disclosure form and that I understand the limitations of this short-term limited-duration medical plan.

Consumer signature/name: _____

Date: _____

This notice has important information about this short-term limited duration medical plan. If you, or someone you're helping, has questions about this document or complaints about this medical plan and how it was sold to you, call the Washington State Office of the Insurance Commissioner at 1-800-562-6900. If you need help speaking to us in your preferred language, we will find an interpreter for you at no cost.

[Statutory Authority: RCW 48.43.005(26), 48.02.060, 48.44.050, and 48.46.200. WSR 18-21-116, § 284-43-8010, filed 10/17/18, effective 11/17/18.]

WAC 284-43-8020 Commissioner's approval required. (1) A short-term limited duration medical plan form, application form, or disclosure form must not be issued, delivered, or used unless it has been filed with and approved in writing by the commissioner.

(2) Rates, or modification of rates, for short-term limited duration medical plans must not be used until filed with and approved in writing by the commissioner.

(3) The commissioner may disapprove any forms or rates if the benefit provided therein is unreasonable in relation to the premium charged. The commissioner's order disapproving any form or rate shall state the grounds therefor.

(4) A form or rate must not knowingly be issued, delivered, or used if the commissioner's approval does not then exist.

(5) The commissioner may withdraw any approval at any time for cause. The commissioner's withdrawal of a previous approval shall state the grounds therefor.

[Statutory Authority: RCW 48.43.005(26), 48.02.060, 48.44.050, and 48.46.200. WSR 18-21-116, § 284-43-8020, filed 10/17/18, effective 11/17/18.]

WAC 284-43-8030 Short-term limited duration medical plan cancellation and rescission. (1) As used in this section:

(a) "Rescission" or "rescind" means the undoing or retroactive cancellation of a short-term limited duration medical plan. Rescission returns the carrier and member to the same positions as if the medical plan had never existed.

(b) "Cancellation" or "cancel" means termination of a short-term limited duration medical plan before the end of the coverage period under the plan.

(2) A short-term limited duration medical plan cannot be rescinded by the carrier during the coverage period except for a member's committing fraudulent acts as to the carrier or a member's intentional nondisclosure regarding his or her coverage under a short-term limited duration medical plan during the twelve-month period prior to the date of application. If the plan is rescinded, the carrier must refund to the member all payments made by or on behalf of the member prior to the rescission date or the expiration date of the short-term limited duration medical plan.

(3) A short-term limited duration medical plan cannot be canceled by the carrier during the coverage period except for the following:

(a) Nonpayment of premium;

(b) Violation of published policies of the carrier approved by the insurance commissioner;

(c) A member's committing fraudulent acts as to the carrier;

(d) A member's material breach of the medical plan; or

(e) Change or implementation of federal or state laws that no longer permit the continued offering of the coverage.

(4) No oral or written misrepresentation or warranty made in the process of applying for a short-term limited duration medical plan, by the person applying for coverage or on his or her behalf, will be deemed material or allows the carrier to cancel or rescind the medical plan, unless the misrepresentation or warranty is made with actual intent to deceive.

(5) In any application for a short-term limited duration medical plan made in writing by a person or on his or her behalf, all statements in the application by the person applying for coverage or on his or her behalf are, in the absence of fraud, deemed representations and not warranties. The falsity of any statement shall not bar the right to recovery under the contract unless the false statement was made with actual intent to deceive.

(6) Nothing in this section shall be construed to provide the member with any benefits they would not otherwise be entitled to under their short-term limited duration medical plan.

(7)(a) When cancellation is for nonpayment of premium, the carrier must notify the member in writing ten days prior to the cancellation date that his or her short-term limited duration medical plan will be canceled, unless payment is made prior to the cancellation date.

(b) When cancellation or rescission is for any other reason allowed under this section, the carrier must notify the member in writing twenty days prior to the cancellation or rescission date or the expiration date of the short-term limited duration medical plan, whichever occurs first. A carrier may provide notice less than twenty days prior to the cancellation or rescission date only if the remaining duration of the short-term limited duration medical plan would make it impossible for the carrier to provide notice twenty days prior to the cancellation or rescission date. In such case, notice must be provided no later than ten days prior to the cancellation or rescission date or the expiration date of the short-term limited duration medical plan, whichever occurs first. The notice must specifically state the reason(s) for the cancellation or rescission.

(c) The written communications required by this subsection must be phrased in simple language that is readily understood.

[Statutory Authority: RCW 48.43.005(26), 48.02.060, 48.44.050, and 48.46.200. WSR 18-21-116, § 284-43-8030, filed 10/17/18, effective 11/17/18.]

WAC 284-43-8100 Definitions. (1) "Department" means the United States (U.S.) Department of Labor.

(2) "Employer member" means an employer that participates in the health plan.

(3) "Pathway 1 Association Health Plan" means a bona fide group or association of employers to whom a health plan is issued that con-

stitutes an employer under section 3(5) of the Employee Retirement Income Security Act of 1974 (ERISA) (29 U.S.C. Sec. 1002(5)), and U.S. Department of Labor guidance related to Pathway 1 Association Health Plans.

(4) "Member-governed group" means a group consisting of multiple employers, organized as an entity other than an association, that constitutes an employer under section 3(5) of the Employee Retirement Income Security Act of 1974 (ERISA) (29 U.S.C. Sec. 1002(5)), and U.S. Department of Labor guidance.

[Statutory Authority: RCW 48.02.060 and 48.43.733. WSR 19-22-032, § 284-43-8100, filed 10/30/19, effective 11/30/19.]

WAC 284-43-8110 Requirements for Pathway 1 Association Health Plan form filings related to the bona fide status of Pathway 1 Associations. (1) Carriers must file a group health plan, other than a small group health plan, rate and form filing as provided in RCW 48.43.733. The form filing for an association health plan submitted by a carrier must include documents related to "Evidence as an Employer." The documents must include, at a minimum:

(a) The member-governed group or association's bylaws, or other comparable controlling documents if no bylaws exist;

(b) A trust agreement or other organizational document that shows the purpose of the member-governed group or association and who governs the member-governed group or association;

(c) A statement of the member-governed group or association's history;

(d) An advisory opinion from the Department, if available, demonstrating that the member-governed group or association is qualified to purchase association health plan coverage; and

(e) If a Department advisory opinion is not available or if changes have been made to the documents related to "Evidence as an Employer" such that the Department advisory opinion no longer accurately reflects the composition, organization or structure of the member-governed group or association with respect to the factors included in (e)(ii) of this subsection, an opinion from an attorney attesting to the fact that the member-governed group or association qualifies as an employer under 29 U.S.C. Sec. 1002(5). The attorney attestation must explain how and why the member-governed group or association meets each of the criteria below, based upon the facts and circumstances of the member-governed group's or association's governance and operations during the twelve months immediately preceding submission of the form filing, with explicit references to relevant language drawn from the member-governed group or association's bylaws, trust agreement, or other organizational document:

(i) The member-governed group or association has been formed for some purpose other than the provision of health coverage or other employee benefits;

(ii) The employer members of the member-governed group or association are in the same trade, industry, line of business or profession. A list of the occupational categories/industrial classifications of the employers eligible to participate in the member-governed group or association must be submitted with the attestation, along with a description of the following:

(A) How employer members are solicited;

(B) Eligibility criteria to participate in the member-governed group or association;

(C) Employer members who are currently participating in the member-governed group or association;

(D) The process by which the member-governed group or association was formed;

(E) The purpose for the formation of the member-governed group or association;

(F) Preexisting relationships of any of the employer members of the member-governed group or association;

(G) The powers, rights, and privileges of employer members that exist by reason of their status as employers;

(H) The functions and activities of the member-governed group or association are controlled by its employer members, and the member-governed group's or association's employer members that participate in the group health plan control the plan. Control must be present both in form and substance.

(f) Each employer member of the member-governed group or association participating in the group health plan is a person acting directly as an employer of at least one employee who is a participant covered under the health plan.

(2) Disability insurers issuing a health plan to a member-governed group or association domiciled outside of Washington state that indicates on their most recently submitted Department Form M-1 that they are operating in the state of Washington must file their "Evidence as an Employer," as provided in subsection (1) of this section, within thirty working days after the earlier of:

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

(b) The date renewal premiums are implemented.

(3) The carrier's form filing also must include its most recently submitted Form M-1, as filed with and published by the Department.

(4) If required under subsection (1)(e) of this section, the attorney attestation identified in subsection (1)(e) of this section shall be filed as a supporting document with the carrier's form filing, in accordance with the following:

(a) Attorney attestations in compliance with subsection (1)(e) of this section must be filed for Plan Year 2020 and every five years thereafter, regardless of whether any changes have been made to the association or member-governed group's composition, organization, or structure that would change the conclusion in the attorney attestation;

(b) For the interceding four filing years, the attestation may be prepared by an officer of the carrier in lieu of an attorney, so long as:

(i) No changes have been made to the documents previously submitted as "Evidence as an Employer" that would impact the analysis in subsection (1)(e) of this section; and

(ii) Such attestation represents a good faith effort by the carrier to ensure that the association or member-governed group meets the requirements of subsection (1) of this section.

(c) Attorney attestations in compliance with subsection (1)(e) of this section must be filed each plan year that a member-governed group or association changes issuers and a benefit plan is issued by a new issuer.

If an attorney attestation in compliance with subsection (1)(e) of this section was filed within the last five years, the issuer may refile the same attorney attestation, provided there has been no

change to the association or member-governed group's composition, organization, or structure that would change the conclusion in the attorney attestation.

(5) An attorney attestation under this section must be specific to the member-governed group or association and need not be specific to the issuer offering the health plan to the member-governed group or association.

(6) This section applies to plans issued or renewed on or after January 1, 2020.

[Statutory Authority: RCW 48.02.060 and 48.43.733. WSR 19-22-032, § 284-43-8110, filed 10/30/19, effective 11/30/19.]

WAC 284-43-8120 Requirements for governmental plans. (1) Carriers must file a group health plan, other than a small group health plan, rate and form filing as provided in RCW 48.43.733.

(2) Carriers issuing a governmental plan under section 3(32) of the Employee Retirement Income Security Act of 1974 (ERISA) (29 U.S.C. Sec. 1002(32)) must submit with their form filing either an opinion letter from the Department demonstrating that the plan is a governmental plan under section 3(32), or an opinion from an attorney attesting to the fact that the entity establishing or maintaining the plan is a governmental entity as provided in section 3(32), citing the applicable law authorizing establishment of the entity.

(3) An attorney attestation submitted in compliance with subsection (2) of this section is not required to comply with WAC 284-43-8110 (1)(e)(ii) regarding the contents of the attorney attestation, and needs only identify the legal and statutory authority for establishment of the entity.

(4) This section applies to plans issued or renewed on or after January 1, 2020.

[Statutory Authority: RCW 48.02.060 and 48.43.733. WSR 19-22-032, § 284-43-8120, filed 10/30/19, effective 11/30/19.]

WAC 284-43-8130 Association health plan compliance with statutory or regulatory changes. (1) Issuers must file a group health plan, other than a small group health plan, rate and form filing as provided in RCW 48.43.733. An issuer offering plans through an association or member-governed group must implement all new applicable federal or state health plan market requirements when they become effective. Replacement requirements for this section apply based on whether the purchaser is classified as an individual, small group, or large group purchaser. These requirements also apply to employer member groups of less than two or to individual member purchasers.

(2) An issuer providing plans of the type referenced in subsection (1) of this section must discontinue a noncompliant plan, and offer replacement plans effective on the renewal date of the master group contract for large groups, and on the group's anniversary renewal date for nongrandfathered small group and individual plans.

(3) If the association is a large group as defined in WAC 284-43-8140(1), the same renewal date must apply to all employer members and individual employer members, and the replacement coverage must take effect on the same date for each participant. The purchaser's anniversary date must not be used in lieu of this uniform renewal

date for purposes of discontinuation and replacement of noncompliant coverage.

(4) If the association is not a large group as defined in WAC 284-43-8140(1), and the master group contract and an employer member's contract do not have the same renewal date, an issuer must provide notice of the discontinuation and replacement of the plan to the affected employer member or plan sponsor, and each enrollee in the affected employer member plan, not fewer than ninety days prior to the employer member's anniversary renewal date.

(5) If an issuer does not have a replacement plan approved by the commissioner to offer in place of a discontinued plan, the issuer must assist each enrollee in identifying a replacement option offered by another issuer.

(6) For purposes of this section, "purchaser" means the group or individual whose eligibility for the plan is based in whole or in part on membership in the association or member-governed group.

(7) For purposes of this section, the "anniversary renewal date" means the initial or first date on which a purchasing group's health benefit plan coverage became effective with the issuer, regardless of whether the issuer is subject to other agreements, contracts or trust documents that establish requirements related to the purchaser's coverage in addition to the health benefit plan.

(8) An issuer must not adjust the master contract renewal or anniversary date to delay or prevent application of any federal or state health plan market requirement.

[Statutory Authority: RCW 48.02.060 and 48.43.733. WSR 21-22-057 (Matter R 2021-21), § 284-43-8130, filed 10/28/21, effective 11/28/21; WSR 19-22-032, amended and recodified as § 284-43-8130, filed 10/30/19, effective 11/30/19. Statutory Authority: RCW 48.02.060. WSR 16-14-106 (Matter No. R 2016-11), § 284-43-0310, filed 7/6/16, effective 8/6/16. WSR 16-01-081, recodified as § 284-43-0310, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.43.700, 48.43.715, 48.44.050, 48.46.200, and 45 C.F.R. 150.101(2). WSR 14-01-039 (Matter No. R 2013-13), § 284-170-955, filed 12/11/13, effective 1/11/14.]

WAC 284-43-8140 Transition of plans purchased by association members. (1) An issuer must not offer or issue a health plan to small groups through an association or member-governed group as a large group plan unless the collective number of eligible employees of all member employers is more than fifty, and the member-governed group or association health plan meets the requirements of WAC 284-43-8110 for a Pathway 1 Association Health Plan, or WAC 284-43-8120 for a governmental plan.

(2) For plans offered to association or member-governed groups that do not meet the requirements of subsection (1) of this section, the following specific requirements apply:

(a) An issuer must treat grandfathered plans issued under those purchasing arrangements as a closed pool, and file a single case closed pool rate filing. For purposes of this section, a single case closed pool rate filing means a rate filing which includes the rates and the rate filing information only for the issuer's closed pool enrollees.

(b) For each single case closed pool rate filing, an issuer must file a certification from an officer of the issuer attesting that:

(i) The employer members covered by the filing joined the association prior to or on March 23, 2010;

(ii) The issuer can establish with documentation in its files that none of the conditions triggering termination of grandfathered status set forth in WAC 284-43-0250 or in 45 C.F.R. 2590.715-1251(g) have occurred for any plan members.

(3) For each grandfathered plan issued to an association or member governed group under subsection (2) of this section, the issuer must include the following items in its rate filing:

(a) Plan number;

(b) Identification number assigned to each employer member, including employer members of less than two;

(c) Initial contract or certificate date;

(d) Number of employees for each employer member, pursuant to RCW 48.43.005(11);

(e) Number of enrolled employees for each employer member for the prior calendar year;

(f) Current and proposed rate schedule for each employer member; and

(g) Description of the rating methodology and rate change for each employer member.

(4) WAC 284-43-6540 applies for a single case rate closed pool under this section.

[Statutory Authority: RCW 48.02.060 and 48.43.733. WSR 19-22-032, amended and recodified as § 284-43-8140, filed 10/30/19, effective 11/30/19. Statutory Authority: RCW 48.02.060. WSR 16-14-106 (Matter No. R 2016-11), § 284-43-0330, filed 7/6/16, effective 8/6/16. WSR 16-01-081, recodified as § 284-43-0330, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.43.700, 48.43.715, 48.44.050, 48.46.200, and 45 C.F.R. 150.101(2). WSR 14-01-039 (Matter No. R 2013-13), § 284-170-958, filed 12/11/13, effective 1/11/14.]

SUBCHAPTER N
HEALTH CARE SHARING MINISTRIES

WAC 284-43-8210 Definitions. For the purposes of this subchapter:

(1) "Annual audit" means an audit occurring once a year at approximately the same time each year for the preceding calendar or fiscal year.

(2) "Continuously" means without a break or interruption.

(3) "Generally accepted accounting principles" means the compulsory accrual method of accounting for a public company.

(4) "Health care sharing ministry" means an organization:

(a) That is described in Section 501 (c)(3) of the Internal Revenue Code and is exempt from taxation under Section 501(a) of the Internal Revenue Code;

(b) That has members who share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs and without regard to the state in which a member resides or is employed;

(c) Whose members retain membership in the health care sharing ministry even after the member develops a medical condition;

(d) Which, or a predecessor of which, has been in existence at all times since December 31, 1999, and medical expenses of its members have been shared continuously and without interruption since at least December 31, 1999; and

(e) That conducts an annual audit, which is performed by an independent certified public accounting firm in accordance with generally accepted accounting principles and which is made available to the public upon request.

(5) "Independent certified public accounting firm" means a certified public accounting firm licensed by state boards of accountancy, the District of Columbia or U.S. territories that meets the standards of independence set forth by the American Institute of Certified Public Accountants (AICPA), the Public Company Accounting Oversight Board (PCAOB), or another similar body that oversees or sets standards for the accounting or auditing professions.

(6) "Organization" means an entity organized as a corporation, a limited liability company (LLC), an unincorporated association, or a trust. Entities must be organized under United States federal or state law.

(7) "Predecessor" means an organization that was acquired, merged with, or otherwise replaced by a successor organization, and the predecessor organization no longer shares medical expenses.

(8) "Share medical expenses" means providing for the medical needs and financial needs related to medical expenses of a participant through member contributions.

[Statutory Authority: RCW 48.02.060, 48.17.005, and 48.15.015. WSR 22-17-001 (Matter R 2021-17), § 284-43-8210, filed 8/3/22, effective 9/3/22.]

WAC 284-43-8220 Prompt reply to the commissioner required. Any entity claiming to be a health care sharing ministry shall timely reply in writing to an inquiry of the commissioner regarding their compliance with RCW 48.43.009, and any potential violations of RCW 48.05.030(1) and 48.15.020(1) and related regulations, including this regulation. A timely response is one that is received by the commissioner within 20 business days from receipt of the inquiry. A response may be provided via electronic mail.

[Statutory Authority: RCW 48.02.060, 48.17.005, and 48.15.015. WSR 22-17-001 (Matter R 2021-17), § 284-43-8220, filed 8/3/22, effective 9/3/22.]

WAC 284-43-8230 Continuously sharing medical expenses. A health care sharing ministry must share medical expenses among its members, and this sharing must be continuous and without interruption. In order for sharing between a predecessor organization and its successor organization to be continuous and without interruption, remaining predecessor organization members must share medical expenses with successor organization members, if any, at the time the successor organization acquires, merges with, or otherwise replaces the predecessor's medical expense sharing activities.

[Statutory Authority: RCW 48.02.060, 48.17.005, and 48.15.015. WSR 22-17-001 (Matter R 2021-17), § 284-43-8230, filed 8/3/22, effective 9/3/22.]