

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 in-

cluding, 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.]