



**RULE-MAKING ORDER**

**CR-103P (May 2009)  
(Implements RCW 34.05.360)**

**Agency:** Office of the Insurance Commissioner

**Permanent Rule Only**

**Effective date of rule:**

**Permanent Rules**

**31 days after filing.**

**Other (specify) \_\_\_\_\_ (If less than 31 days after filing, a specific finding under RCW 34.05.380(3) is required and should be stated below)**

**Any other findings required by other provisions of law as precondition to adoption or effectiveness of rule?**

**Yes**     **No**    **If Yes, explain:**

**Purpose:** This new rule consolidates existing state mental health and chemical dependency insurance regulations, incorporates the Affordable Care Act (ACA)(Pub. L. 111-148, as amended), and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) (Pub. L. 110-343) and repeals WAC 284-53.

The new rule provides health carriers (issuers) with instructions on how to perform a parity analysis for provisions relating to financial requirements, treatment limitations, and non-quantitative treatment limitations. Compliance is demonstrated by filing supporting documentation used to make parity analysis decisions. In addition, special disclosure requirements apply to obtain reasons for a claim denial.

Insurance Commissioner Matter No. R 2012-29

**Citation of existing rules affected by this order:**

Repealed: chapter 284-53 WAC, Standards for Coverage of Chemical Dependency, WAC 284-53-005 & 284-53-010.

Amended:

Suspended:

**Statutory authority for adoption:** RCW 48.02.060, 48.43.715, 48.44.050, 48.46.200

**Other authority:** Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)(Pub. L. 110-343)

**PERMANENT RULE (Including Expedited Rule Making)**

Adopted under notice filed as WSR 14-20-072 on 09/26/2014.

Describe any changes other than editing from proposed to adopted version: None

If a preliminary cost-benefit analysis was prepared under RCW 34.05.328, a final cost-benefit analysis is available by contacting:

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**Date adopted:**

November 17, 2014

**NAME (TYPE OR PRINT)**

Mike Kreidler

**SIGNATURE**

**TITLE**

Insurance Commissioner

**CODE REVISER USE ONLY**

OFFICE OF THE CODE REVISER  
STATE OF WASHINGTON  
FILED

**DATE: November 17, 2014**

**TIME: 2:22 PM**

**WSR 14-23-057**

(COMPLETE REVERSE SIDE)

**Note: If any category is left blank, it will be calculated as zero.  
No descriptive text.**

**Count by whole WAC sections only, from the WAC number through the history note.  
A section may be counted in more than one category.**

**The number of sections adopted in order to comply with:**

<b>Federal statute:</b>	New	_____	Amended	_____	Repealed	_____
<b>Federal rules or standards:</b>	New	<u>8</u>	Amended	_____	Repealed	_____
<b>Recently enacted state statutes:</b>	New		Amended		Repealed	

**The number of sections adopted at the request of a nongovernmental entity:**

New	_____	Amended	_____	Repealed	_____
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**The number of sections adopted in the agency's own initiative:**

New	8	Amended		Repealed	<u>2</u>
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**The number of sections adopted in order to clarify, streamline, or reform agency procedures:**

New	_____	Amended	_____	Repealed	_____
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**The number of sections adopted using:**

<b>Negotiated rule making:</b>	New	_____	Amended	_____	Repealed	_____
<b>Pilot rule making:</b>	New	_____	Amended	_____	Repealed	_____
<b>Other alternative rule making:</b>	New	<u>8</u>	Amended		Repealed	<u>2</u>

SUBCHAPTER K  
MENTAL HEALTH AND SUBSTANCE USE DISORDER

NEW SECTION

**WAC 284-43-990 Scope and intent—Parity in mental health and substance use disorder benefits.** This subchapter applies to all health plans and issuers. The purpose of this rule is to consolidate existing state mental health and chemical dependency regulation with federal mental health and substance use disorder parity requirements into state regulation. This rule also provides health plans and issuers with the method of demonstrating compliance with these requirements.

NEW SECTION

**WAC 284-43-991 Definitions. Aggregate lifetime limit** means a dollar limitation on the total amount of specified benefits that may be paid under a health 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 twelve-month period under a health plan (or health insurance coverage offered in connection with a plan) for any coverage unit.

**Approved treatment program** means a discrete program of chemical dependency treatment provided by a treatment program certified by the department of social and health services as meeting standards adopted under chapter 70.96A RCW.

**Chemical dependency professional** means a person certified as a chemical dependency professional by the Washington state department of health under chapter 18.205 RCW.

**Classification of benefits** means a group into which all medical/surgical benefits and mental health or substance use disorder benefits offered by a health 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 health 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 maximums. 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 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 or mental health 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 284-43-865. 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 or 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(25).

**Health plan** has the same meaning as RCW 48.43.005(26).

**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 or as not 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 chemical dependency and 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 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 or as not being a mental health condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), the most current version of the *International Classification of Diseases* (ICD), or state guidelines).

**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.

**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.

**Substance use disorder** includes illness characterized by a physiological or psychological dependency, or both, on a controlled substance regulated under chapter 69.50 RCW and/or alcoholic beverages. It is further characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially impaired or endangered or his or her social or economic function is substantially disrupted. Any disorder defined by the plan as being or as not being a substance use disorder must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the DSM, the most current version of the ICD, or state guidelines).

**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 treat-

ment and supporting service rendered to an enrollee either within an approved treatment program or by a health care professional that meets the requirements of RCW 18.205.040(2), 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 284-43-993 (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 fifty 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.

#### NEW SECTION

**WAC 284-43-992 Classification of benefits.** (1) A health 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 benefits 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 health 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 health 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 health 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 health 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 done on a classification-by-classification basis.

(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 health 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 health 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 health 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 health 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 health 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 restrictive than the predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in that tier.

(d) If a health 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 health 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 284-43-993 and 284-43-994 must be performed within each subclassification.

(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.

#### NEW SECTION

**WAC 284-43-993 Measuring health 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 health 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 limitation 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 health 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 health 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 limitation 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 health plan or issuer must combine levels until the combination of levels applies to more than one-half of medical/surgical bene-

fits 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 health 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 health 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.

#### NEW SECTION

**WAC 284-43-994 Measuring health plan benefits—Nonquantitative treatment limitations.** (1) A health 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 health 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 health plan standards, such as in-and-out-of-network geographic limitations, limitations on inpatient services for situations where the participant 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 workers, and network adequacy, while not specifically enumerated in the illustrative list of NQTLs must be applied in a manner that complies with this subsection.

#### NEW SECTION

**WAC 284-43-995 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) Nothing in this section relieves a health 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.

#### NEW SECTION

**WAC 284-43-996 Required disclosures.** (1) Health plans and issuers must provide reasonable access to and copies of all documents, records, and other information relevant to an individual's claim. Health plans and issuers must provide disclosures consistent with WAC 284-43-620, 284-43-515, 284-43-525, and 284-43-410, within a reasonable time.

(2) Health 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 health plan issuer to any current or potential participant, beneficiary, or contracting provider upon request, within a reasonable time in compliance with WAC 284-43-410, 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 health 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.

(4) Compliance with these disclosure requirements is not determinative of compliance with any other provisions of applicable federal or state law.

(5) If a health 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.

#### NEW SECTION

**WAC 284-43-997 Compliance and reporting of quantitative parity analysis.** (1) Health plans and issuers must file a justification demonstrating the analysis of each plan's financial requirements and quantitative treatment limitations as required under WAC 284-43-993.

(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.

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 284-53-005

WAC 284-53-010

Definitions.

Standards for coverage of chemical dependency.