OFFICE of the INSURANCE COMMISSIONER
WASHINGTON STATE

Patty Kuderer - Insurance commissioner

As required by

The Washington State Administrative Procedures Act

Chapter 34.05 RCW

Matter No. **R2025-12**

CONCISE EXPLANATORY STATEMENT; RESPONSIVENESS SUMMARY; RULE DEVELOPMENT PROCESS; AND IMPLEMENTATION PLAN

Relating to the adoption of

Consolidated health care rule

December 19, 2025

TABLE OF CONTENTS

Section 1: Introduction

Revised Code of Washington (RCW) 34.05.325(6) requires the Office of Insurance Commissioner (OIC) to prepare a "concise explanatory statement" (CES) prior to filing a rule for permanent adoption. The CES shall:

1. Identify the Commissioner's reasons for adopting the rule;
2. Describe differences between the proposed rule and the final rule (other than editing changes) and the reasons for the differences; and
3. Summarize and respond to all comments received regarding the proposed rule during the official public comment period, indicating whether or not the comment resulted in a change to the final rule, or the Commissioner's reasoning in not incorporating the change requested by the comment; and
4. Be distributed to all persons who commented on the rule during the official public comment period and to any person who requests it.

Section 2: Reasons for Adopting the Rule

This rule is necessary to update existing rules to align with changes in state and federal law and insurance-related legislation. Currently, multiple provisions of health care and insurance regulations in the Washington Administrative Code (WAC) need to be updated by OIC to be consistent with legislation passed and codified in the Revised Code of Washington (RCW) and recent federal law changes. This consolidated rulemaking aims to implement Chapter 25, Laws of 2025, aligning the implementation of application programming interfaces for prior authorization with federal guidelines, Chapter 96, Laws of 2025 concerning coverage requirements for prosthetic limbs and custom orthotic braces, Chapter 336, Laws of 2024 concerning treatment of substance use disorders, Chapter 171, Laws of 2025 increasing access to prescription hormone therapy, updates to Essential Health Benefits Benchmark Plan, greater clarity around reporting responsibilities for ground ambulance locally set rates, and other related legislation and laws.

Section 3: Rule Development Process

The CR-101 for this rulemaking was filed with the Office of the Code Reviser on July 22, 2025 (WSR 25-15-145). The comment period for the CR-101 closed on August 22, 2025. No comments were received.

A prepublication draft was released on October 6, 2025. Comments were due originally on October 15, 2025. An extension was requested, and the deadline was extended to October 24, 2025. Five comments were received.

The CR-102 for this rulemaking was filed with the Office of the Code Reviser on November 5, 2025 (WSR 25-22-100). The comment period for the CR-102 closed on December 10, 2025. Two comments were received.

The Commissioner held a public hearing on the proposed rule text on December 9, 2025; the hearing was administered by Sydney Y. Rogalla as a virtual meeting. No testimony was given.

The CR-103 was submitted to the Code Reviser for adoption on December 19, 2025.

Section 4: Differences Between Proposed and Final Rule

The proposal included rules relating to the implementation of various state statutes and federal laws and regulations. It included necessary amendments to rules related to prior authorization interfaces, coverage of prosthetic limbs and custom orthotic braces, treatment of substance use disorder, access to prescription hormone therapy, updates to the state's Essential Health Benefits Benchmark Plan, and greater clarity around ground ambulance locally set rate reporting requirements.

The final rule does not differ from the rule proposed in the CR-102 filing.

Section 5: Responsiveness Summary

The OIC received a total of seven written comments and suggestions regarding R2025-12, inclusive of the CR-101, prepublication draft, and the CR-102. The following information contains descriptions of the comments, the OIC's response to the comments, and information about whether the OIC made changes to the proposed rule as a result of the comments.

The OIC received comments from:

- Ambetter— Coordinated Care Corporation
- Association of Washington Healthcare Plans
- Hearing Loss Association of America— Washington State Association
- Northwest Health Law Advocates
- Planned Parenthood Alliance Advocates
- Premera Blue Cross

Comments received on the CR-101, prepublication draft, and the CR-102:

Comment	OIC Response
General Comments	
The commentor requested that the comment period for the prepublication draft be extended to an additional 15 business days.	The OIC appreciates this comment. The OIC extended the deadline for comments on the prepublication draft from October 15, 2025, to October 24, 2025.
WAC 284-43-2050 Prior authorization processes.	
The commentor requested clarification on whether the 14-day guardrail applies to post-stabilization services only or if it applies to detoxification or acute services as well.	The 14-day authorization language applies to inpatient and residential SUD treatment services pursuant to RCW 71.24.618(2)(a)(i) and aligns with the initial medical necessity review process under RCW 71.24.618(2)(a) as required in ESHB 2642. These levels of care would equate to American Society of Addiction Medicine (ASAM) levels of care 3.7 Medically Monitored Intensive Inpatient Services, 3.5 Clinically Managed High Intensity Residential Services, 3.3. Clinically Managed Population – Specific High Intensity Residential Services, and 3.1 Clinically Managed Low-intensity residential services. Withdrawal management levels of care, such as 3.7 and 3.2, as

	well as hospital level of care 4.0, were not included.
The commentor requested that the OIC review the language in subsection (11)(a) and the references for carriers to use the DaVinci Burden Reduction Implementation Guides in their entirety when developing their application programming interface standards. The commentor notes that this is an unreasonable burden, as the Center for Medicaid and Medicare Services (CMS) rules on interoperability do not recommend adopting all of the guides, only that the DaVinci Burden Reduction Implementation Guides are an option for meeting the CMS interoperability standards. The commentor advised that the word "must" be replaced with "may" to clarify that carriers should comply with CMS guidance rather than mandating the use of a specific technical framework.	The OIC appreciates this comment. Language was changed in WAC 284-43-2050(11)(a), clarifying that carriers may use DaVinci Burden Reduction Implementation Guides to meet interoperability standards. Carriers must comply with CMS guidance on the matter.
WAC 284-43-2070 Forms for authorization of inpatient or residential substance use disorder treatment.	
The commentor requested the ability to provide comments on the universal prior authorization form draft prior to posting on the OIC website.	The OIC appreciates this comment. The universal format was developed as part of a legislatively directed workgroup, detailed below. Comments were solicited at the time of its development. The commentor may view the form and provide feedback to HCA if they have any concerns. ESSB 6228, Section 9, directed the Health Care Authority (HCA) to convene a workgroup with

	representatives from the OIC, commercial health carriers, Medicaid managed care organizations (MCOs), and behavioral health agencies that provide inpatient or residential substance use disorder (SUD) treatment services to develop recommendations to streamline processes related to authorization and reauthorization for inpatient or residential SUD treatment. HCA contracted with Comagine Health as part of the workgroup. Members of the work group were identified through outreach to the Association of Washington Healthcare Plans and outreach to the Association of Alcoholism and Addiction Programs of Washington State (AAP). The workgroup successfully achieved its goal and created recommendations on how to provide a more efficient and standardized approach to SUD treatment authorization, following best practice guidelines. The workgroup concluded in December 2024 and submitted a report with recommendations to the legislature. One of the recommendations was for the use of the universal prior authorization form. Comagine, HCA, and OIC, through the workgroup, scheduled and hosted workgroup meetings to present information collected, discuss options, and reach consensus on authorization and reauthorization requirements and

	processes. Provided several opportunities for participants to give feedback and ask questions outside the meeting times. The requirement to use this form was added to Medicaid MCO contracts by the Health Care Authority for implementation in July 2025. HCA continues to check in with MCOs and AAP members to monitor concerns and request feedback; to date, there have not been any concerns identified. The OIC is making this form available on our website for providers and carriers to utilize.
Two commentors requested that the OIC extend the implementation deadline for carriers to implement the new universal form or any changes from 30 days to 60 or 90 days to allow carriers sufficient time for system configuration, testing, and staff training. One commentor also requested clarification on when the new form will first be posted and the expected initial date by which carriers must begin accepting it.	The OIC appreciates this comment. The OIC finds that 30 days is sufficient time for a health carrier to implement the form and any subsequent changes. The universal form will be available on the OIC website on or before December 19, 2025. Carriers are expected to comply with the rules as stated in WAC 284-43-2070.
WAC 284-43-5151 Unfair practice relating to gender affirming treatment and services.	
Multiple commentors requested clarification on the added language in the prepublication draft released by the OIC. One commentor expressed in their comments on the prepublication draft and CR-102 their concern that the	The OIC appreciates these comments. In response to the concerns raised about the language proposed in the prepublication draft, the OIC amended the language in the CR-102 to be more consistent with the language in WAC 284-43-2000(3) and WAC 284-

language proposed by the OIC took medical necessity determination away from the providers of gender affirming care and placed this authority with the health carriers. They expressed concern that the language would create additional barriers for consumers seeking gender affirming care. They acknowledged that if the intent of the OIC was to prohibit blanket denials of care, this was already accomplished in WAC 284-43-5151(2). The other commentor requested clarification on the language used in the prepublication draft. Their concern was that the new language would require health carriers to conduct individualized reviews of every request for gender affirming care and would prohibit them from denying a service that lacked medical necessity when there was no clinical evidence supporting that type of care. They requested that the OIC clarify the language in this section and make clear that gender affirming care was not receiving different medical necessity standards than all other types of care.	43-2050(2) and (12), which cover prior authorization and medical necessity review criteria for other health care services. The OIC appreciates the follow-up comment on the CR-102 language and the concern for consumers facing barriers while accessing health care services; however, RCW 48.43.0128 allows carriers to review the medical necessity of proposed gender affirming treatment. WAC 284-43-2050 requires carriers to use evidence-based clinical review criteria when making prior authorization decisions. If the legislature's intent had been to require the carrier to accept a provider's medical necessity determination without further review, the legislature could have prohibited prior authorization for gender affirming care services.
WAC 284-43-5604 Essential health benefits package benchmark plan.	
One commentor requested that we include "hearing instruments" in the list of services and items covered by a health benefit plan in this section. Coverage of hearing instruments is a new Washington State Essential Health Benefit Benchmark Plan (EHB BP), and they would like to see it	The OIC appreciates this comment. The list in WAC 284-43-5604(2) is not meant to be an exhaustive list of all categories in the EHB BP. Other categories not included are pediatric services, such as dental and vision. Carriers have an obligation to know

included in this list to ensure carriers are aware of this benefit.	what is covered in the EHB BP and receive communications about this directly.
WAC 284-43-5624 Plan design.	
One commentor expressed concern regarding the following language in WAC 284-43-5624(9)(c)— *"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."* The commentor stated that this language could be interpreted to require the OIC to approve a plan design that meets the particular legal standards in the cited laws, rather than allowing the OIC the appropriate discretion to review all applicable nondiscrimination laws and standards. This is also contrary to how OIC regulates plans, as typically, the OIC will either place a plan on file or disapprove of that plan. Another concern expressed by this commentor was that this language could be interpreted as the OIC, when it places a plan on file, deeming it as	The OIC appreciates this comment. In response to this comment, the OIC changed the language in WAC 284-43-5624(9)(c) from "will approve" to "may approve" in the CR-102.

nondiscriminatory. It is the health carrier's responsibility to ensure compliance with nondiscrimination standards, and an OIC review is not a substitute for full compliance with state and federal law.	
Another commentor in the CR-102 phase expressed concern over the changes made in subsection (9)(c) between the prepublication draft and CR-102 phases. The commenter stated that those changes were inconsistent with the stated intent of the CR-102, which was focused on updates to the EHB BP requirements. The commentor opined that the OIC should continue to approve health plan designs if they are, at a minimum, consistent with current state and federal law.	The OIC appreciates this comment. The OIC did not change the language that was included in the CR-102. Subsection (9) addresses review of health plan filings to ensure that they are nondiscriminatory. The change made in the CR-102 is within the scope of the rulemaking as stated in the CR-101 and CR-102, i.e., in the stated intent, the OIC indicates the updates include but are not limited to updating the EHB BP requirements and finds that the "may" language is more consistent with existing legislation.
WAC 284-43-5935 Definitions.	
The commentor requests that the list of definitions in this section be included in other sections of the Consolidated Health Care rule where these required accommodations constitute a reasonable step to provide communication access.	The OIC appreciates this comment. This is beyond the scope of this rule.
WAC 284-43-5937 Hearing instrument coverage.	
The commentor expressed their appreciation for the OIC, including an expiration date of December 31, 2025, for this section and the creation of the new section WAC 284-43-5939.	The OIC appreciates this comment.
WAC 284-43-5939 Hearing instrument coverage.	

During the prepublication draft, one commentor recommended that, per SB 5262, the language should read— "(…) which require health plans issued or renewed on or after January 1, 2026(…)" —otherwise, it created an exclusion for grandfathered-in health plans.	The OIC appreciates this comment and agrees. This language was added in the CR-102.
A commentor asked for clarification on the difference between every 36 months and no annual limit in subsection 2. They also expressed appreciation for ensuring that out-of-network providers are included in the coverage requirements of this subsection.	The OIC appreciates this comment. There is no annual limit, but carriers have to provide coverage every 36 months for each ear.
A commentor expressed concern that clarifying language from WAC 284-43-5967(4) that specified carriers are only required to provide in-network coverage for hearing instruments was not carried over into this new section. They requested that the OIC include this language in the new section to ensure consistency and avoid ambiguity regarding out-of-network obligations.	The OIC appreciates this comment and agrees. This language was added in the CR-102.
A commentor requested that the OIC change the language from 36 months to three years to be consistent with the language in the EHB BP approved by CMS in October 2024. The concern is due to operational challenges for health carriers and possible confusion for members.	The OIC appreciates this comment. 36 months is the language used in the statute governing the EHB BP. The language in the rule must reflect the language in the statute to avoid possible confusion or contradictions.
WAC 284-43-7210 Definitions	
A commentor requested that the OIC include language in this section	The OIC appreciates this comment.

discouraging carriers from using medical management techniques, such as step therapy or prior authorization, from delaying or denying coverage of a 12-month supply of prescription hormone therapy.	This is beyond the scope of the relevant legislation (ESHB 1971) and is beyond the scope of this rulemaking.

Section 6: Implementation Plan

A. Implementation and enforcement of the rule.

As described below, the rule will be implemented through numerous activities at the OIC. The Rates, Forms, and Provider Networks Division will rely on this rule when reviewing health plan filings and carrier network access filings. Questions related to compliance with this rule can be raised and addressed through the form review process and network access review process. Web Services will ensure that the correct materials are available on the OIC website for interested parties to access and utilize.

The Consumer Advocacy Program will respond to consumer complaints and give health care providers/facilities an opportunity to cure any violations of the rule. Through these complaints, the OIC will monitor the implementation of the rule. This monitoring will identify any need to conduct further stakeholder education regarding the rule. Enforcement will occur when a carrier is determined by the OIC to have violated the requirements of these rules, when a health professional is determined by the applicable disciplinary authority to have violated the requirements of the statute, or when a health care facility is determined by the Washington State Department of Health to have violated the requirements of the statute.

B. How the Agency intends to inform and educate affected persons about the rule.

Type of Inquiry	Division
Consumer assistance	Consumer Advocacy Program
Rule content	Policy & Legislative Affairs
Authority for rules	Legal Affairs
Enforcement of the rule	Legal Affairs

Market compliance	Company Supervision

C. How the Agency intends to promote and assist voluntary compliance with this rule.

The OIC has and will respond to inquiries from carriers, health care providers, health care facilities, ground ambulance services organizations, and consumers related to the implementation of these rules.

OIC also stands ready to meet with interested organizations to respond to questions and share perspectives on the implementation of the rule

D. How the Agency intends to evaluate whether the rule achieves the purpose for which it was adopted.

The goal of this rulemaking is to implement various federal and state-related health insurance legislation. The Rates Forms and Provider Networks Division will monitor health plan filings to ensure compliance with the new requirements in this rule. The OIC will monitor consumer and health care provider complaints on the various components of this rule and will conduct additional investigations of enforcement actions where appropriate.

Appendix A

CR-102 Hearing Summary

Summarizing Memorandum **To: Patty Kuderer** **Insurance Commissioner** **From: Sydney Y. Rogalla** **Presiding Official, Hearing on Rulemaking**
Matter No. R 2025-12
Topic of Rulemaking: Relation to the implementation of the Consolidated health care rule

This memorandum summarizes the hearing on the above-named rulemaking, held on December 9, 2025, at 2:00 pm via Zoom over which I presided in your stead.

The following agency personnel were present:

- Sydney Rogalla, Health Policy Analyst
- Joyce Brake, Policy & Rules Manager
- Remy McKnight, Administrative Assistant 2
- Heather Shimoji, Health Forms Manager
- Wendy Conway, Functional Program Analyst 4
- Julia Hinrichs, Functional Program Analyst 4
- Lakesha Bradley, Functional Program Analyst 3
- Paul DuBois, Functional Program Analyst 4
- Deanna Ogo, Attorney Manager

In attendance and testifying:

In attendance:

- Micheal Lozano
- Christina Mojica
- Jan Goetz
- Gregory Fann
- Denyse Bayer
- Katrina Jackson
- Jane Douthit
- Melanie Anderson
- Mark Varela
- Anthony Clark
- Kat Myers

Testified:

There was no testimony.

Contents of the presentations made at hearing:

There was no testimony.

The hearing was adjourned.

SIGNED this __9th__ day of __December , 2025 _

__Sydney Y. Rogalla____
Presiding Official