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 action is the final step in the realignment of rules within Chapters 284-43 WAC and 284-170 WAC. Under this rulemaking, the following will occur:

1. Rules sections in Title 284 WAC which contain references to sections in either Chapter 284-43 WAC or Chapter 284-170 WAC will be revised to properly refer to the originally referenced WAC sections by their new number.

This will not change the existing rules or their application in any way other than their citation numbers.

Insurance Commissioner Matter No. R 2016-11

Citation of existing rules affected by this order:
Repealed: None
Amended: See attached list
Suspended: None

Statutory authority for adoption: RCW 48.02.060

Other authority:

PERMANENT RULE (Including Expedited Rule Making)
Adopted under notice filed as WSR **16-10-078** on May 3, 2016.
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:

Name: phone ( )
Address: fax ( )
e-mail

Date adopted: July 6, 2016

NAME (TYPE OR PRINT)
Mike Kreidler

SIGNATURE

TITLE
Insurance Commissioner

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: July 06, 2016
TIME: 8:33 AM

WSR 16-14-106

(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:

Federal statute:	New	0	Amended	0	Repealed	0
Federal rules or standards:	New	0	Amended	0	Repealed	0
Recently enacted state statutes:	New	0	Amended	0	Repealed	0

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

	New	0	Amended	0	Repealed	0

The number of sections adopted in the agency's own initiative:

	New	0	Amended	54	Repealed	0

The number of sections adopted in order to clarify, streamline, or reform agency procedures:

	New	0	Amended	54	Repealed	0

The number of sections adopted using:

Negotiated rule making:	New	0	Amended	0	Repealed	0
Pilot rule making:	New	0	Amended	0	Repealed	0
Other alternative rule making:	New	0	Amended	54	Repealed	0

List of rule sections amended:

WAC 284-43-0270
WAC 284-43-0290
WAC 284-43-0310
WAC 284-43-0330
WAC 284-43-1020
WAC 284-43-1040
WAC 284-43-1120
WAC 284-43-1140
WAC 284-43-3010
WAC 284-43-3150
WAC 284-43-3170
WAC 284-43-3190
WAC 284-43-4000
WAC 284-43-4040
WAC 284-43-4500
WAC 284-43-5040
WAC 284-43-5110
WAC 284-43-5170
WAC 284-43-5400
WAC 284-43-5410
WAC 284-43-5620
WAC 284-43-5622
WAC 284-43-5700
WAC 284-43-5702
WAC 284-43-5720
WAC 284-43-5740
WAC 284-43-5760
WAC 284-43-5780
WAC 284-43-5800
WAC 284-43-5820
WAC 284-43-5900
WAC 284-43-7010
WAC 284-43-7020
WAC 284-43-7100
WAC 284-43-7120
WAC 284-44-043
WAC 284-44A-010
WAC 284-46-507
WAC 284-46A-010
WAC 284-50-377
WAC 284-51-215
WAC 284-96-015
WAC 284-170-200
WAC 284-170-210
WAC 284-170-230
WAC 284-170-240
WAC 284-170-260
WAC 284-170-270
WAC 284-170-280
WAC 284-170-300
WAC 284-170-310
WAC 284-170-330
WAC 284-170-340
WAC 284-170-480

AMENDATORY SECTION (Amending WSR 16-01-081, filed 12/14/15, effective 12/14/15)

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 ((~~284-170-950~~)) 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 ((~~284-170-958~~)) 284-43-0330(1).

(4) WAC ((~~284-170-950 through 284-170-958~~)) 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.

AMENDATORY SECTION (Amending WSR 16-01-081, filed 12/14/15, effective 12/14/15)

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 ((~~284-170-955 and 284-170-958~~)) 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.

AMENDATORY SECTION (Amending WSR 16-01-081, filed 12/14/15, effective 12/14/15)

WAC 284-43-0310 Association health plan compliance with statutory or regulatory changes. (1) An issuer offering plans through an association or member-governed group must implement all new 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 member employer 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 ((~~284-170-958~~)) 284-43-0330(1), the same renewal date must apply to all participating employers and individuals, 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 ((~~284-170-958~~)) 284-43-0330(1), and the master group contract and the member group do not have the same renewal date, an issuer must provide notice of the discontinuation and replacement of the plan to the affected association member group or plan sponsor, and each enrollee in the affected member group, not fewer than ninety days prior to the 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.

AMENDATORY SECTION (Amending WSR 16-01-081, filed 12/14/15, effective 12/14/15)

WAC 284-43-0330 Transition of plans purchased by association members. (1) An issuer must not offer or issue a plan to individuals or small groups through an association or member-governed group as a

large group plan unless the association or member-governed group to whom the plan is issued constitutes an employer under 29 U.S.C. § 1002(5) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et. seq.), as amended, and the number of eligible employees is more than fifty.

(2) An issuer must make a good faith effort to ensure that any association or member-governed group to whom it issues a large group plan meets the requirements of subsection (1) of this section prior to submitting its form and rate filings to the commissioner, and prior to issuing such coverage. An issuer must maintain the documentation supporting the determination and provide it to the commissioner upon request. An issuer may reasonably rely upon an opinion from the U.S. Department of Labor as reasonable proof that the requirements of 29 U.S.C. 1002(5) are met by the association or member-governed group.

(3) 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 groups 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 ((~~284-170-950~~)) 284-43-0250 or in 45 C.F.R. 2590.715-1251(g) have occurred for any plan members.

(4) For each grandfathered plan issued to an association or member governed group under subsection (3) of this section, the issuer must include the following items in its rate filing:

(a) Plan number;

(b) Identification number assigned to each employer group, including employer groups of less than two;

(c) Initial contract or certificate date;

(d) Number of employees for each employer group, pursuant to RCW 48.43.005(11);

(e) Number of enrolled employees for each employer group for the prior calendar year;

(f) Current and proposed rate schedule for each employer group; and

(g) Description of the rating methodology and rate change for each employer group.

(5) WAC ((~~284-43-950~~)) 284-43-6540 applies for a single case rate closed pool under this section.

AMENDATORY SECTION (Amending WSR 16-01-081, filed 12/14/15, effective 12/14/15)

WAC 284-43-1020 Special enrollment requirements for small group plans. (1) A "special enrollment period" means a period of time out-

side 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 ((~~284-43-820~~)) 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 em-

ployees, even if that requires the issuer to permit the parent to switch benefit packages.

AMENDATORY SECTION (Amending WSR 16-01-081, filed 12/14/15, effective 12/14/15)

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 ((~~284-170-410~~)) 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 ((~~284-170-410~~)) 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.

AMENDATORY SECTION (Amending WSR 16-01-081, filed 12/14/15, effective 12/14/15)

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 condi-

tions specified in WAC ((~~284-170-425~~)) 284-43-1100, available to applicants who experience a qualifying event.

(2) In addition to the special enrollment qualifying events set forth in WAC ((~~284-170-425~~)) 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 ((~~284-170-425~~)) 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.

AMENDATORY SECTION (Amending WSR 16-01-081, filed 12/14/15, effective 12/14/15)

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 twentieth 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 ((~~284-43-820~~)) 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.

AMENDATORY SECTION (Amending WSR 16-01-081, filed 12/14/15, effective 12/14/15)

WAC 284-43-3010 Definitions. These definitions apply to the sections in this subchapter, WAC ((~~284-43-510 through 284-43-550~~)) 284-43-3030 through 284-43-3210:

"Adverse benefit determination" has the same meaning as defined in RCW 48.43.005 and WAC ((~~284-43-130~~)) 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 ((~~284-43-410~~)) 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.

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

"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.

AMENDATORY SECTION (Amending WSR 16-01-081, filed 12/14/15, effective 12/14/15)

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 ((~~284-43-515~~)) 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.

AMENDATORY SECTION (Amending WSR 16-01-081, filed 12/14/15, effective 12/14/15)

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 ((~~284-43-410~~)) 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 ((~~284-43-410~~)) 284-43-2000 may apply in an identical manner to an expedited review under this section.

AMENDATORY SECTION (Amending WSR 16-01-081, filed 12/14/15, effective 12/14/15)

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 ((~~284-43-410~~)) 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 ((~~284-43-540~~)) 284-43-3170 are not met. A carrier may not require exhaustion of internal review if an appellant requests concurrent expedited review.

AMENDATORY SECTION (Amending WSR 16-01-081, filed 12/14/15, effective 12/14/15)

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 ((~~284-43-615 through 284-43-630~~)) 284-43-4020 through 284-43-4060.

AMENDATORY SECTION (Amending WSR 16-01-081, filed 12/14/15, effective 12/14/15)

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.

(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 ((~~284-43-630~~)) 284-43-4060.

(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.

AMENDATORY SECTION (Amending WSR 16-01-081, filed 12/14/15, effective 12/14/15)

WAC 284-43-4500 Definition. This definition applies to subchapter G. "Grievant" means a person filing a grievance as defined in WAC ((~~284-43-130~~)) 284-43-0160, and who is not an appellant under either subchapter E or F of this chapter.

AMENDATORY SECTION (Amending WSR 16-01-081, filed 12/14/15, effective 12/14/15)

WAC 284-43-5040 Coverage for pharmacy services. (1) The commissioner may disapprove any contract issued or renewed after July 1, 2001, that includes coverage for pharmacy services if the following statement is not provided to covered persons at the time of enrollment:

YOUR RIGHT TO SAFE AND EFFECTIVE PHARMACY SERVICES

State and federal laws establish standards to assure safe and effective pharmacy services, and to guarantee your right to know what drugs are covered under this plan and what coverage limitations are in your contract. If you would like more information about the drug coverage policies under this plan, or if you have a question or a concern about your pharmacy benefit, please contact us (the health carrier) at 1-800-???-????.

If you would like to know more about your rights under the law, or if you think anything you received from this plan may not conform to the terms of your contract, you may contact the Washington State Office of Insurance Commissioner at 1-800-562-6900. If you have a concern about the pharmacists or pharmacies serving you, please call the State Department of Health at 360-236-4825.

(2) The commissioner may disapprove any contract issued or renewed after July 1, 2001, that includes coverage for pharmacy services if the carrier does not: Pose and respond in writing to the following questions in language that complies with WAC 284-50-010 through 284-50-230; offers to provide and provide upon request this information prior to enrollment; and ensures that this information is provided to covered persons at the time of enrollment:

(a) **"Does this plan limit or exclude certain drugs my health care provider may prescribe, or encourage substitutions for some drugs?"** The response must describe the process for developing coverage standards and formularies, including the principal criteria by which drugs are selected for inclusion, exclusion, restriction or limitation. If a determination of medical necessity is used, that term must be briefly

defined here. Coverage standards involving the use of substitute drugs, whether generic or therapeutic, are either an exception, reduction or limitation and must be discussed here. Major categories of drugs excluded, limited or reduced from coverage may be included in this response.

(b) **"When can my plan change the approved drug list (formulary)? If a change occurs, will I have to pay more to use a drug I had been using?"** The response must identify the process of changing formularies and coverage standards, including changes in the use of substitute drugs. If the plan gives prior notice of these changes or has provisions for "grandfathering" certain ongoing prescriptions, these practices may be discussed here.

(c) **"What should I do if I want a change from limitations, exclusions, substitutions or cost increases for drugs specified in this plan?"** The response must include a phone number to call with a request for a change in coverage decisions, and must discuss the process and criteria by which such a change may be granted. The response may refer to the appeals or grievance process without describing that process in detail here. The response must state the time within which requests for changes will be acted upon in normal circumstances and in circumstances where an emergency medical condition exists.

(d) **"How much do I have to pay to get a prescription filled?"** The response must list enrollee point-of-service cost-sharing dollar amounts or percentages for all coverage categories including at least name brand drugs, substitute drugs and any drugs which may be available, but which are not on the health plan's formulary.

(e) **"Do I have to use certain pharmacies to pay the least out of my own pocket under this health plan?"** If the answer to this question is "yes," the plan must state the approximate number of pharmacies in Washington at which the most favorable enrollee cost sharing will be provided, and some means by which the enrollee can learn which ones they are.

(f) **"How many days' supply of most medications can I get without paying another co-pay or other repeating charge?"** The response should discuss normal and exceptional supply limits, mail order arrangements and travel supply and refill requirements or guidelines.

(g) **"What other pharmacy services does my health plan cover?"** The response should include any "intellectual services," or disease management services reimbursed by the plan in addition to those required under state and federal law in connection with dispensing, such as disease management services for migraine, diabetes, smoking cessation, asthma, or lipid management.

(3) The commissioner may disapprove any contract issued or renewed after July 1, 2001, that includes coverage for pharmacy services if the general categories of drugs excluded from coverage are not provided to covered persons at the time of enrollment. Such categories may include items such as appetite suppressants, dental prescriptions, cosmetic agents or most over-the-counter medications. This subsection intends only to promote clearer enrollee understanding of the exclusions, reductions and limitations contained in a health plan, and not to suggest that any particular categories of coverage for drugs or pharmacy services should be excluded, reduced, or limited by a health plan.

(4) In complying with these requirements, a carrier may, where appropriate and consistent with the provisions of these rules, consolidate the information with other material required by disclosure provisions set forth in RCW 48.43.510 and WAC ((~~284-43-820~~)) 284-43-5130.

(5) This information may be provided in a narrative form to the extent that the content of both questions and answers is included.

(6) The commissioner may grant an extension or waive these requirements for good cause and if there is assurance that the information, required herein, is distributed in a timely manner consistent with the purpose and intent of these rules.

AMENDATORY SECTION (Amending WSR 16-01-081, filed 12/14/15, effective 12/14/15)

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 ((~~284-43-817 or 284-43-818~~)) 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) 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) 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 ((~~284-43-817 or 284-43-818~~)) 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.

AMENDATORY SECTION (Amending WSR 16-01-081, filed 12/14/15, effective 12/14/15)

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:

(a) A clear statement explaining that the health benefit plan, policy or agreement may cover brand name drugs or medication under the circumstances set forth in WAC ((~~284-43-817 or 284-43-818~~)) 284-43-5080 or 284-43-5100, including, if a formulary is part of the benefit design, brand name drugs or other medication not in the formulary.

(b) A clear explanation of the substitution process 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.

(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 web site 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.

AMENDATORY SECTION (Amending WSR 16-01-081, filed 12/14/15, effective 12/14/15)

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 ((~~284-43-849 through 284-43-885~~)) 284-43-5400 through 284-43-5820 explains the regulatory standards defining this coverage, and establishes supplementation of the base-benchmark plan consistent with PPACA and RCW 48.43.715, and the parameters of the state EHB-benchmark plan.

(1) WAC ((~~284-43-849 through 284-43-885~~)) 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), nor to a health benefit plan that qualifies as a grandfathered health plan as defined in RCW 48.43.005.

(2) WAC ((~~284-43-849 through 284-43-885~~)) 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 ((~~284-43-849 through 284-43-885~~)) 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.

AMENDATORY SECTION (Amending WSR 16-01-081, filed 12/14/15, effective 12/14/15)

WAC 284-43-5410 Definitions. The following definitions apply to WAC ((~~284-43-849 through 284-43-885~~)) 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 ((~~284-43-865(1)~~)) 284-43-5600(1) or 284-43-5602(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.

AMENDATORY SECTION (Amending WSR 16-01-081, filed 12/14/15, effective 12/14/15)

WAC 284-43-5620 Plan design. (1) A nongrandfathered individual or small group health benefit plan offered, issued, or renewed, on or after January 1, 2014, must provide coverage that is substantially equal to the EHB-benchmark plan, as described in WAC ((~~284-43-878, 284-43-879, and 284-43-880~~)) 284-43-5640, 284-43-5700, and 284-43-5780.

(a) For plans offered, issued, or renewed for a plan or policy year beginning on or after January 1, 2014, until December 31, 2016, an issuer must offer the EHB-benchmark plan without substituting benefits for the benefits specifically identified in the EHB-benchmark plan.

(b) For plan or policy years beginning on or after January 1, 2017, an issuer may substitute benefits to the extent that the actuarial value of the benefits in the category to which the substituted benefit is classified remains substantially equal to the EHB-benchmark plan.

(c) "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 ((~~284-43-878, 284-43-879, and 284-43-880~~)) 284-43-5640, 284-43-5700, and 284-43-5780 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 provider-type services, and not a benefit for purposes of the essential health benefits package.

(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) Unless an age based reference limitation is specifically included in the base-benchmark plan or a supplemental base-benchmark plan for a category set forth in WAC ((~~284-43-878, 284-43-879, or 284-443-880~~)) 284-43-5640, 284-43-5700, or 284-43-5780, an issuer's scope of coverage for those categories of benefits must cover both pediatric and adult populations.

(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).

(10) An issuer must not impose annual or lifetime dollar limits on an essential health benefit, other than those permitted as reference based limitations pursuant to WAC ((~~284-43-878, 284-43-879, and 284-43-880~~)) 284-43-5640, 284-43-5700, and 284-43-5780.

(11) This section expires on December 31, 2016.

AMENDATORY SECTION (Amending WSR 16-01-081, filed 12/14/15, effective 12/14/15)

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 ((~~284-43-8781,~~

~~284-43-8791, and 284-43-8801~~)) 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 ((~~284-43-8781, 284-43-8791, and 284-43-8801~~)) 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 (add RCW citation for SSB 5175 when it becomes available).

(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 ((~~284-43-8781, 284-43-8791, or 284-43-8801~~)) 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).

(10) An issuer must not impose annual or lifetime dollar limits on an essential health benefit, other than those permitted under WAC ((~~284-43-8781, 284-43-8791, and 284-43-8801~~)) 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.

AMENDATORY SECTION (Amending WSR 16-01-081, filed 12/14/15, effective 12/14/15)

WAC 284-43-5700 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 nineteen.

(1) For benefit years beginning January 1, 2015, 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 (3) of this section is offered in the health benefit exchange for that benefit year.

(2) The requirements of WAC ((~~284-43-878 and 284-43-880~~)) 284-43-5640 and 284-43-5780 are not applicable to the stand-alone dental plan. A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. The supplemental base-benchmark plan specifically excludes oral implants, and an issuer should not include benefits for oral implants in establishing a plan's actuarial value.

(3) **Supplementation:** The base-benchmark plan covers pediatric services for the categories set forth in WAC ((~~284-43-878~~)) 284-43-5640, but does not cover pediatric oral services. Because the base-benchmark plan does not cover pediatric oral benefits, the state EHB-benchmark plan requirements are supplemented for pediatric oral benefits. The Washington state CHIP plan is designated as the supplemental base-benchmark plan for pediatric dental benefits. 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 supplemental 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;

(f) Periodontics;

(g) Crown and fixed bridge;

(h) Removable prosthetics; and

(i) Medically necessary orthodontia.

(4) The supplemental 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;

(b) Bitewing X ray once a year;

(c) Panoramic X rays once every three years;

(d) Prophylaxis every six months beginning at age six months;

(e) Fluoride three times in a twelve-month period for ages six and under; two times in a twelve-month period for ages seven and older; three times in a twelve-month period during orthodontic treatment; sealant once every three years for occlusal surfaces only; oral hygiene instruction two times in twelve months for ages eight and under if not billed on the same day as a prophylaxis treatment;

(f) Every two years for the same restoration (fillings);

(g) Frenulectomy or frenuloplasty covered for ages six and under without prior authorization;

(h) Root canals on baby primary posterior teeth only;

(i) Root canals on permanent anterior, bicuspid and molar teeth, excluding teeth 1, 16, 17 and 32;

(j) Periodontal scaling and root planing once per quadrant in a two-year period for ages thirteen and older, with prior authorization;

(k) Periodontal maintenance once per quadrant in a twelve-month period for ages thirteen and older, with prior authorization;

(l) Stainless steel crowns for primary anterior teeth once every three years; if age thirteen and older with prior authorization;

(m) Stainless steel crowns for permanent posterior teeth once every three years;

(n) Metal/porcelain crowns and porcelain crowns on anterior teeth only, with prior authorization;

(o) Space maintainers for missing primary molars A, B, I, J, K, L, S, and T;

(p) One resin based partial denture, if provided at least three years after the seat date;

(q) One complete denture upper and lower, and one replacement denture per lifetime after at least five years from the seat date;

(r) Rebasing and relining of complete or partial dentures once in a three-year period, if performed at least six months from the seat date.

(5) This section expires on December 31, 2016.

AMENDATORY SECTION (Amending WSR 16-01-081, filed 12/14/15, effective 12/14/15)

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 nineteen. Plans must provide this coverage for enrollees until at least the end of the month in which the enrollee turns age nineteen.

(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 ((~~284-43-8781 and 284-43-8801~~)) 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 ((~~284-43-8781~~)) 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 twelve-month period for ages six and under; two times in a twelve-month period for ages seven and older; and three times in a twelve-month period during orthodontic treatment;

(j) Sealant once every three years for permanent bicuspids and molars only;

(k) Oral hygiene instruction two times in twelve 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 thirteen and older;

(q) Periodontal maintenance once per quadrant in a twelve-month period for ages thirteen and older;

(r) Stainless steel crowns for primary anterior teeth once every three years, if age thirteen 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 twelve 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.

AMENDATORY SECTION (Amending WSR 16-01-081, filed 12/14/15, effective 12/14/15)

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 ((~~284-170-810~~)) 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.

AMENDATORY SECTION (Amending WSR 16-01-081, filed 12/14/15, effective 12/14/15)

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 ((~~284-43-879(3)~~)) 284-43-5700(3) or 284-43-5702(3).

AMENDATORY SECTION (Amending WSR 16-01-081, filed 12/14/15, effective 12/14/15)

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 ((~~284-170-800~~)) 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 ((~~284-43-879~~)) 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.

AMENDATORY SECTION (Amending WSR 16-01-081, filed 12/14/15, effective 12/14/15)

WAC 284-43-5780 Pediatric vision services. A health benefit plan must include "pediatric vision services" in its essential health benefits package. The base-benchmark plan covers pediatric services for the categories set forth in WAC ((~~284-43-878~~)) 284-43-5640 (1) through (9), but does not include pediatric vision services. Pediatric vision services are vision services delivered to enrollees under age nineteen.

(1) A health benefit plan must cover pediatric vision services as an embedded set of services.

(2) **Supplementation:** The state EHB-benchmark plan requirements for pediatric vision benefits must be offered at a substantially equal level and classified consistent with the designated supplemental base-benchmark plan for pediatric vision services, the Federal Employees Vision Plan with the largest enrollment and published by the U.S. Department of Health and Human Services at www.cciioo.cms.gov on July 2, 2012.

(a) The vision services included in the pediatric vision services category are:

(i) Routine vision screening; and

(ii) A comprehensive eye exam for children, including dilation as professionally indicated and with refraction every calendar year;

(iii) 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;

(iv) 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;

(v) 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;

(vi) Low vision optical devices including low vision services, training and instruction to maximize remaining usable vision as follows:

(A) One comprehensive low vision evaluation every five years;

(B) High power spectacles, magnifiers and telescopes as medically necessary, with reasonable limitations permitted; and

(C) Follow-up care of four visits in any five year period, with prior approval.

(b) The pediatric vision supplemental base-benchmark specifically excludes, and issuer must not include in its actuarial value for the category:

(i) Visual therapy, which is otherwise covered under the medical/surgical benefits of the plan;

(ii) Two pairs of glasses may not be ordered in lieu of bifocals;

(iii) Medical treatment of eye disease or injury, which is otherwise covered under the medical/surgical benefits of the plan;

(iv) Nonprescription (Plano) lenses; and

(v) Prosthetic devices and services, which are otherwise covered under the rehabilitative and habilitative benefit category.

(3) This section expires on December 31, 2016.

AMENDATORY SECTION (Amending WSR 16-01-081, filed 12/14/15, effective 12/14/15)

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 three hundred 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) An issuer may not require cost-sharing for preventive services delivered by network providers, specifically related to those with an A or B rating in the most recent recommendations of the United States Preventive Services Task Force, women's preventive health care services recommended by the U.S. Health Resources and Services Administration (HRSA) and HRSA Bright Futures guideline designated pediatric services. An issuer must post on its web site a list of the specific preventive and wellness services mandated by PPACA 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 ((~~284-43-130~~)) 284-43-0160(8).

(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.

AMENDATORY SECTION (Amending WSR 16-01-081, filed 12/14/15, effective 12/14/15)

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 ((~~284-43-849 through 284-43-882~~)) 284-43-5400 through 284-43-5800. This requirement applies to any health benefit plan offered on or off the Washington health benefit exchange.

AMENDATORY SECTION (Amending WSR 16-01-081, filed 12/14/15, effective 12/14/15)

WAC 284-43-5900 Effective date. The effective date of WAC ((~~284-43-130, 284-43-200, 284-43-251, 284-43-400, 284-43-410, 284-43-610, 284-43-615, 284-43-620, 284-43-630, and 284-43-820~~)) 284-43-0160, 284-170-200, 284-170-360, 284-43-2000, 284-43-4020, 284-43-4040, 284-43-4060, and 284-43-5130 is July 1, 2001.

AMENDATORY SECTION (Amending WSR 16-01-081, filed 12/14/15, effective 12/14/15)

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 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~~)) 284-43-5600 or 284-43-5602, 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 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 treatment 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~~)) 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 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.

AMENDATORY SECTION (Amending WSR 16-01-081, filed 12/14/15, effective 12/14/15)

WAC 284-43-7020 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~~)) 284-43-7040 and 284-43-7060 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.

AMENDATORY SECTION (Amending WSR 16-01-081, filed 12/14/15, effective 12/14/15)

WAC 284-43-7100 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~~)) 284-43-4040, 284-43-3070, 284-43-3110, and 284-43-2000, 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~~)) 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 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.

AMENDATORY SECTION (Amending WSR 16-01-081, filed 12/14/15, effective 12/14/15)

WAC 284-43-7120 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~~)) 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.

AMENDATORY SECTION (Amending WSR 99-24-075, filed 11/29/99, effective 12/30/99)

WAC 284-44-043 Experimental and investigational prescriptions, treatments, procedures, or services—Definition required—Standard for definition—Written notice of denial required—Appeal process required. (1) Every health care service contract which excludes or limits, or reserves the right to exclude or limit, benefits for any treatment, procedure, facility, equipment, drug, drug usage, medical device, or supply (hereinafter individually and collectively referred to as services) for one or more medical condition or illness because such services are deemed to be experimental or investigational must include within the contract and any certificate of coverage issued thereunder, a definition of experimental or investigational.

(2) The definition of experimental or investigational services must include an identification of the authority or authorities which will make a determination of which services will be considered to be experimental or investigational. If the health care service contractor specifies that it, or an affiliated entity, is the authority making the determination, the criteria it will utilize to determine whether a service is experimental or investigational must be set forth in the contract and any certificate of coverage issued thereunder. As an example, and not by way of limitation, the requirement to set forth criteria in the contract and any certificate of coverage issued thereunder may be satisfied by using one or more of the following statements, or other similar statements:

(a) "In determining whether services are experimental or investigational, the plan will consider whether the services are in general use in the medical community in the state of Washington, whether the services are under continued scientific testing and research, whether the services show a demonstrable benefit for a particular illness or disease, and whether they are proven to be safe and efficacious."

(b) "In determining whether services are experimental or investigational, the plan will consider whether the services result in greater benefits for a particular illness or disease than other generally available services, and do not pose a significant risk to health or safety of the patient."

The supporting documentation upon which the criteria are established must be made available for inspection upon written request in all instances and may not be withheld as proprietary.

(3) Every health care service contractor that denies a request for benefits or that refuses to approve a request to preauthorize services, whether made in writing or through other claim presentation or preauthorization procedures set out in the contract and any certificate of coverage thereunder, because of an experimental or investigational exclusion or limitation, must do so in writing within twenty working days of receipt of a fully documented request. The health care service contractor may extend the review period beyond twenty days only with the informed written consent of the covered individual. The denial letter must identify by name and job title the individual making the decision and fully disclose:

(a) The basis for the denial of benefits or refusal to preauthorize services;

(b) The procedure through which the decision to deny benefits or to refuse to preauthorize services may be appealed;

(c) What information the appellant is required to submit with the appeal; and

(d) The specific time period within which the company will reconsider its decision.

(4)(a) Every health care service contractor must establish a reasonable procedure under which denials of benefits or refusals to preauthorize services because of an experimental or investigational exclusion or limitation may be appealed. The appeals procedure may be considered reasonable if it provides that:

(i) A final determination must be made and provided to the appellant in writing within twenty working days of receipt of the fully documented appeal. The health care service contractor may extend the review period beyond twenty days only with the informed written consent of the covered individual;

(ii) The appeal must be reviewed by a person or persons qualified by reasons of training, experience and medical expertise to evaluate it; and

(iii) The appeal must be reviewed by a person or persons other than the person or persons making the initial decision to deny benefits or to refuse to preauthorize services.

(b) When the initial decision to deny benefits or to refuse to preauthorize services is upheld upon appeal, the written notice shall set forth:

(i) The basis for the denial of benefits or refusal to preauthorize services; and

(ii) The name and professional qualifications of the person or persons reviewing the appeal.

(c) Disclosure of the existence of an appeal procedure shall be made by the health care service contractor in each contract and any certificate of coverage issued thereunder which contains an experimental or investigational exclusion or limitation.

(5) Whenever a covered person appeals the health care service contractor's decision and delay would jeopardize the covered person's life or health, the health care service contractor must follow the appeal procedures and time frames in WAC ((~~284-43-620~~)) 284-43-4040(2).

AMENDATORY SECTION (Amending WSR 10-01-118, filed 12/17/09, effective 1/17/10)

WAC 284-44A-010 Definitions that apply to this chapter. The definitions in this section apply throughout this chapter.

(1) "Complete filing" means a package of information containing forms, supporting information, documents and exhibits submitted to the commissioner electronically using the system for electronic rate and form filing (SERFF).

(2) "Date filed" means the date a complete filing has been received and accepted by the commissioner.

(3) "Filer" means:

(a) A person, organization or other entity that files forms or rates with the commissioner for an HCSC; or

(b) A person employed by the HCSC to file under this chapter.

(4) "Form" means a:

(a) "Contract" as defined in WAC ((~~284-43-910~~)) 284-43-6020; and includes:

(i) Applications;

(ii) Certificates of coverage;

(iii) Disclosure forms;

(iv) Enrollment forms;

(v) Policy forms, including riders;

(vi) Termination notice forms;

(vii) Short form filing summary, as outlined in the SERFF filing instructions; and

(viii) All other forms that are part of the contract.

(b) "Contract form" as defined in WAC ((~~284-43-910~~)) 284-43-6020;

(c) Network enrollment forms described in WAC ((~~284-43-220(2)~~)) 284-170-280(3);

(d) Participating provider agreements as required by RCW 48.44.070; and

(e) Medicare supplement forms required to be filed under chapter 48.66 RCW.

(5) "Health care service contractor" or "HCSC" means the same as in RCW 48.44.010.

(6) "NAIC" means the National Association of Insurance Commissioners.

(7) "Objection letter" means correspondence created in SERFF and sent by the commissioner to the filer that:

(a) Requests clarification, documentation or other information;

(b) Explains errors or omissions in the filing; or

(c) Disapproves a form under RCW 48.44.020 or 48.44.070.

(8) "Rate" or "rates" means all classification manuals, rate manuals, rating schedules, class rates, and rating rules that must be filed under RCW 48.44.040 or 48.66.035.

(9) "Rate schedule" means the same as in WAC ((~~284-43-910~~)) 284-43-6020.

(10) "SERFF" means the system for electronic rate and form filing. SERFF is a proprietary NAIC computer-based application that allows insurers and other entities to create and submit rate, rule and form filings electronically to the commissioner.

(11) "Type of insurance" or "TOI" means a specific type of health care coverage listed in the *Uniform Life, Accident and Health, Annuity and Credit Coding Matrix* published by the NAIC and available at www.naic.org.

AMENDATORY SECTION (Amending WSR 99-24-075, filed 11/29/99, effective 12/30/99)

WAC 284-46-507 Experimental and investigational prescriptions, treatments, procedures, or services—Definition required—Standard for definition—Written notice of denial required—Appeal process required. (1) Every health maintenance agreement which excludes or limits, or reserves the right to exclude or limit, benefits for any treatment, procedure, facility, equipment, drug, drug usage, medical device, or supply (hereinafter individually and collectively referred to as services) for one or more medical condition or illness because such services are deemed to be experimental or investigational must include within the agreement and any certificate of coverage issued thereunder, a definition of experimental or investigational.

(2) The definition of experimental or investigational services must include an identification of the authority or authorities which will make a determination of which services will be considered to be experimental or investigational. If the health maintenance organization specifies that it, or an affiliated entity, is the authority making the determination, the criteria it will utilize to determine whether a service is experimental or investigational must be set forth in the agreement and any certificate of coverage issued thereunder. As an example, and not by way of limitation, the requirement to set forth criteria in the agreement or any certificate of coverage thereunder may be satisfied by using one or more of the following statements, or other similar statements:

(a) "In determining whether services are experimental or investigational, the plan will consider whether the services are in general use in the medical community in the state of Washington, whether the services are under continued scientific testing and research, whether the services show a demonstrable benefit for a particular illness or disease, and whether they are proven to be safe and efficacious."

(b) "In determining whether services are experimental or investigational, the plan will consider whether the services result in greater benefits for a particular illness or disease than other generally available services, and do not pose a significant risk to health or safety of the patient."

The supporting documentation upon which the criteria are established must be made available for inspection upon written request in all instances and may not be withheld as proprietary.

(3) Every health maintenance organization that denies a request for benefits or that refuses to approve a request to preauthorize services, whether made in writing or through other claim presentation or preauthorization procedures set out in the agreement and any certificate of coverage thereunder, because of an experimental or investigational exclusion or limitation, must do so in writing within twenty working days of receipt of a fully documented request. The health maintenance organization may extend the review period beyond twenty days only with the informed written consent of the covered individual. The denial letter must identify by name and job title the individual making the decision and fully disclose:

(a) The basis for the denial of benefits or refusal to preauthorize services;

(b) The procedure through which the decision to deny benefits or to refuse to preauthorize services may be appealed;

(c) What information the appellant is required to submit with the appeal; and

(d) The specific time period within which the company will reconsider its decision.

(4)(a) Every health maintenance organization must establish a reasonable procedure under which denials of benefits or refusals to preauthorize services because of an experimental or investigational exclusion or limitation may be appealed. The appeals procedure may be considered reasonable if it provides that:

(i) A final determination must be made and provided to the appellant in writing within twenty working days of receipt of the fully documented appeal. The health maintenance organization may extend the review period beyond twenty days only with the informed written consent of the covered individual;

(ii) The appeal must be reviewed by a person or persons qualified by reasons of training, experience and medical expertise to evaluate it; and

(iii) The appeal must be reviewed by a person or persons other than the person or persons making the initial decision to deny benefits or to refuse to preauthorize services.

(b) When the initial decision to deny benefits or to refuse to preauthorize services is upheld upon appeal, the written notice shall set forth:

(i) The basis for the denial of benefits or refusal to preauthorize services; and

(ii) The name and professional qualifications of the person or persons reviewing the appeal.

(c) Disclosure of the existence of an appeal procedure shall be made by the health maintenance organization in each agreement and any certificate of coverage issued thereunder which contains an experimental or investigational exclusion or limitations.

(5) Whenever a covered person appeals the decision of the health maintenance organization and delay would jeopardize the covered person's life or health, the health maintenance organization must follow the appeal procedures and time frames in WAC ((~~284-43-620~~)) 284-43-4040(2).

AMENDATORY SECTION (Amending WSR 10-01-118, filed 12/17/09, effective 1/17/10)

WAC 284-46A-010 Definitions that apply to this chapter. The definitions in this section apply throughout this chapter.

(1) "Complete filing" means a package of information containing forms, supporting information, documents and exhibits submitted to the commissioner electronically using the system for electronic rate and form filing (SERFF).

(2) "Date filed" means the date a complete filing has been received and accepted by the commissioner.

(3) "Filer" means:

(a) A person, organization or other entity that files forms or rates with the commissioner for an HMO; or

(b) A person employed by the HMO to file under this chapter.

(4) "Form" means a:

(a) "Contract" as defined in WAC ((~~284-43-910~~)) 284-43-6020; and includes:

(i) Applications;

(ii) Certificates of coverage;

(iii) Disclosure forms;

(iv) Enrollment forms;

(v) Policy forms, including riders;

(vi) Termination notice forms;

(vii) Short form filing summary, as outlined in the SERFF filing instructions; and

(viii) All other forms that are part of the contract.

(b) "Contract form" as defined in WAC ((~~284-43-910~~)) 284-43-6020;

(c) Network enrollment forms described in WAC ((~~284-43-220(2)~~)) 284-170-280(3);

(d) Prepayment agreements described in RCW 48.46.060;

(e) Participating provider agreements as required by RCW 48.46.243; and

(f) Medicare supplement forms required to be filed under chapter 48.66 RCW.

(5) "Health maintenance organization" or "HMO" means the same as in RCW 48.46.020.

(6) "NAIC" means the National Association of Insurance Commissioners.

(7) "Objection letter" means correspondence created in SERFF and sent by the commissioner to the filer that:

(a) Requests clarification, documentation or other information;

(b) Explains errors or omissions in the filing; or

(c) Disapproves a form under RCW 48.46.060 or 48.46.243.

(8) "Rate" or "rates" means all classification manuals, rate manuals, rating schedules, class rates, and rating rules that must be filed under RCW 48.46.060 or 48.66.035.

(9) "Rate schedule" means the same as in WAC ((~~284-43-910~~)) 284-43-6020.

(10) "SERFF" means the system for electronic rate and form filing. SERFF is a proprietary NAIC computer-based application that allows insurers and other entities to create and submit rate, rule and form filings electronically to the commissioner.

(11) "Type of insurance" or "TOI" means a specific type of health care coverage listed in the *Uniform Life, Accident and Health, Annuity*

and Credit Coding Matrix published by the NAIC and available at www.naic.org.

AMENDATORY SECTION (Amending WSR 99-24-075, filed 11/29/99, effective 12/30/99)

WAC 284-50-377 Experimental and investigational prescriptions, treatments, procedures, or service—Definition required—Standard for definition—Written notice of denial required—Appeal process required. (1) Every individual disability insurance policy which excludes or limits, or reserves the right to exclude or limit, benefits for any treatment, procedure, facility, equipment, drug, drug usage, medical device, or supply (hereinafter individually and collectively referred to as services) for one or more medical condition or illness because such services are deemed to be experimental or investigational must include within the policy a definition of experimental or investigational.

(2) The definition of experimental or investigational services must include an identification of the authority or authorities which will make a determination of which services will be considered to be experimental or investigational. If the individual disability insurer specifies that it, or an affiliated entity, is the authority making the determination, the criteria it will utilize to determine whether a service is experimental or investigational must be set forth in the policy. As an example, and not by way of limitation, the requirement to set forth criteria in the policy may be satisfied by using one or more of the following statements, or other similar statements:

(a) "In determining whether services are experimental or investigational, we will consider whether the services are in general use in the medical community in the state of Washington, whether the services are under continued scientific testing and research, whether the services show a demonstrable benefit for a particular illness or disease, and whether they are proven to be safe and efficacious."

(b) "In determining whether services are experimental or investigational, we will consider whether the services result in greater benefits for a particular illness or disease than other generally available services, and do not pose a significant risk to health or safety of the patient."

The supporting documentation upon which the criteria are established must be made available for inspection upon written request in all instances and may not be withheld as proprietary.

(3) Every individual disability insurer that denies a request for benefits or that refuses to approve a request to preauthorize services, whether made in writing or through other claim presentation or preauthorization procedures set out in the policy, because of an experimental or investigational exclusion or limitation, must do so in writing within twenty working days of receipt of a fully documented request. The individual disability insurer may extend the review period beyond twenty days only with the informed written consent of the covered individual. The denial letter must identify by name and job title the individual making the decision and fully disclose:

(a) The basis for the denial of benefits or refusal to preauthorize services;

(b) The procedure through which the decision to deny benefits or to refuse to preauthorize services may be appealed;

(c) What information the appellant is required to submit with the appeal; and

(d) The specific time period within which the company will reconsider its decision.

(4)(a) Every individual disability insurer must establish a reasonable procedure under which denials of benefits or refusals to preauthorize services because of an experimental or investigational exclusion or limitation may be appealed. The appeals procedure may be considered reasonable if it provides that:

(i) A final determination must be made and provided to the appellant in writing within twenty working days of receipt of the fully documented appeal. The individual disability insurer may extend the review period beyond twenty days only with the informed written consent of the covered individual;

(ii) The appeal must be reviewed by a person or persons qualified by reasons of training, experience and medical expertise to evaluate it; and

(iii) The appeal must be reviewed by a person or persons other than the person or persons making the initial decision to deny benefits or to refuse to preauthorize services.

(b) When the initial decision to deny benefits or to refuse to preauthorize services is upheld upon appeal, the written notice shall set forth:

(i) The basis for the denial of benefits or refusal to preauthorize services; and

(ii) The name and professional qualifications of the person or persons reviewing the appeal.

(c) Disclosure of the existence of an appeal procedure shall be made by the individual disability insurer in each policy which contains an experimental or investigational exclusion or limitation.

(5) Whenever a covered person appeals the insurer's decision and delay would jeopardize the covered person's life or health, the insurer must follow the appeal procedures and time frames in WAC ((~~284-43-620~~)) 284-43-4040(2).

AMENDATORY SECTION (Amending WSR 09-16-073, filed 7/30/09, effective 9/1/09)

WAC 284-51-215 Time limit. (1) Each issuer must establish time limits for payment of a claim and may not unreasonably delay payment through the application of a coordination of benefits provision. Time limits established by a primary plan must be no less favorable than those contained in WAC ((~~284-43-321~~)) 284-170-431. Primary plans must pay ninety-five percent of clean claims subject to this chapter within thirty calendar days of receipt or of determining they are the primary plan, and must pay all clean claims subject to this chapter within sixty calendar days of receipt or of determining they are the primary plan. Any time limit established by a secondary plan that is in excess of thirty days from receipt of a claim, with the primary plan's explanation of benefit information or other primary payment details needed to process the claim, will be considered unreasonable. The deadlines established in this subsection may be extended for the length of time a primary or secondary plan must wait for information needed from the provider (e.g., medical records) or from the enrollee (e.g., motor vehicle accident information), in order to adjudicate the claim.

(2) The specific time limits for coordination of benefits processing include:

(a) When an issuer has been notified that more than one plan covers an enrollee who has submitted a claim, the issuer shall resolve with the other plan in not more than thirty calendar days which plan is primary. This deadline may be extended in situations involving court orders for dependent coverage, if the court order contains information needed to determine which plan is primary and has not been provided to the issuer. If agreement cannot be reached, both plans shall pay as set forth in WAC 284-51-205 (4)(f).

(b) Once the primary plan and secondary plan have been established, if the secondary plan receives a claim without the primary plan's explanation of benefit information or other primary payment details needed to process the claim, including at least the paid amount and the allowed amount, the secondary plan will notify the submitting provider and/or enrollee as soon as possible and within thirty calendar days of receipt of the claim, that the secondary claim is incomplete without such primary plan information. The secondary plan will promptly process the claim after it has been resubmitted with the explanation of benefit information from the primary payer.

(c) If a primary plan has not adjudicated a claim within sixty calendar days of receipt of the claim and all supporting documentation, and if the primary plan is not waiting for information from the provider (e.g., medical records) or from the enrollee (e.g., motor vehicle accident information), needed to adjudicate the claim, the provider or enrollee may submit the claim and notice of the primary plan's failure to pay to the secondary plan which shall pay the provider's claim as primary within thirty calendar days.

(3) When payment is necessarily delayed for reasons other than the application of a coordination of benefits provision, investigation of other plan coverage must be conducted concurrently to avoid delay in the ultimate payment of benefits. Any issuer that is required by the time limit in subsection (2) of this section to make payment as the primary plan may exercise its rights under its "right of recovery" provision for recovery of any excess payments. After payment informa-

tion is received from the primary plan, the secondary plan may recover any excess amount paid under its "right of recovery" provision.

(4) The provisions in this section do not apply when medicare is the primary payer; in such cases federal medicare law governs.

AMENDATORY SECTION (Amending WSR 99-24-075, filed 11/29/99, effective 12/30/99)

WAC 284-96-015 Experimental and investigational prescriptions, treatments, procedures, or services—Definition required—Standard for definition—Written notice of denial required—Appeal process required. (1) Every group disability insurance policy which excludes or limits, or reserves the right to exclude or limit, benefits for any treatment, procedure, facility, equipment, drug, drug usage, medical device, or supply (hereinafter individually and collectively referred to as services) for one or more medical condition or illness because such services are deemed to be experimental or investigational must include within the policy and any certificate of coverage issued thereunder, a definition of experimental or investigational.

(2) The definition of experimental or investigational services must include an identification of the authority or authorities which will make a determination of which services will be considered to be experimental or investigational. If the group disability insurer specifies that it, or an affiliated entity, is the authority making the determination, the criteria it will utilize to determine whether a service is experimental or investigational must be set forth in the policy and any certificate of coverage issued thereunder. As an example, and not by way of limitation, the requirement to set forth criteria in the policy and any certificate of coverage issued thereunder may be satisfied by using one or more of the following statements, or other similar statements:

(a) "In determining whether services are experimental or investigational, we will consider whether the services are in general use in the medical community in the state of Washington, whether the services are under continued scientific testing and research, whether the services show a demonstrable benefit for a particular illness or disease, and whether they are proven to be safe and efficacious."

(b) "In determining whether services are experimental or investigational, we will consider whether the services result in greater benefits for a particular illness or disease than other generally available services, and do not pose a significant risk to health or safety of the patient."

The supporting documentation upon which the criteria are established must be made available for inspection upon written request in all instances and may not be withheld as proprietary.

(3) Every group disability insurer that denies a request for benefits or that refuses to approve a request to preauthorize services, whether made in writing or through other claim presentation or preauthorization procedures set out in the policy and any certificate of coverage thereunder, because of an experimental or investigational exclusion or limitation, must do so in writing within twenty working days of receipt of a fully documented request. The group disability insurer may extend the review period beyond twenty days only with the informed written consent of the covered individual. The denial letter must identify by name and job title the individual making the decision and fully disclose:

(a) The basis for the denial of benefits or refusal to preauthorize services;

(b) The procedure through which the decision to deny benefits or to refuse to preauthorize services may be appealed;

(c) What information the appellant is required to submit with the appeal; and

(d) The specific time period within which the company will reconsider its decision.

(4)(a) Every group disability insurer must establish a reasonable procedure under which denials of benefits or refusals to preauthorize services because of an experimental or investigational exclusion or limitation may be appealed. The appeals procedure may be considered reasonable if it provides that:

(i) A final determination must be made and provided to the appellant in writing within twenty working days of receipt of the fully documented appeal. The group disability insurer may extend the review period beyond twenty days only with the informed written consent of the covered individual;

(ii) The appeal must be reviewed by a person or persons qualified by reasons of training, experience and medical expertise to evaluate it; and

(iii) The appeal must be reviewed by a person or persons other than the person or persons making the initial decision to deny benefits or to refuse to preauthorize services.

(b) When the initial decision to deny benefits or to refuse to preauthorize services is upheld upon appeal, the written notice shall set forth:

(i) The basis for the denial of benefits or refusal to preauthorize services; and

(ii) The name and professional qualifications of the person or persons reviewing the appeal.

(c) Disclosure of the existence of an appeal procedure shall be made by the group disability insurer in each policy and any certificate of coverage issued thereunder which contains an experimental or investigational exclusion or limitation.

(5) Whenever a covered person appeals the insurer's decision and delay would jeopardize the covered person's life or health, the group disability insurer must follow the appeal procedures and time frames in WAC ((~~284-43-620~~)) 284-43-4040(2).

AMENDATORY SECTION (Amending WSR 16-07-144, filed 3/23/16, effective 4/23/16)

WAC 284-170-200 Network access—General standards. (1) An issuer must maintain each provider network for each health plan in a manner that is sufficient in numbers and types of providers and facilities to assure that, to the extent feasible based on the number and type of providers and facilities in the service area, all health plan services provided to enrollees will be accessible in a timely manner appropriate for the enrollee's condition. An issuer must demonstrate that for each health plan's defined service area, a comprehensive range of primary, specialty, institutional, and ancillary services are readily available without unreasonable delay to all enrollees and that emergency services are accessible twenty-four hours per day, seven days per week without unreasonable delay.

(2) Each enrollee must have adequate choice among health care providers, including those providers which must be included in the network under WAC ((~~284-43-205~~)) 284-170-270, and for qualified health plans and qualified stand-alone dental plans, under WAC ((~~284-43-222~~)) 284-170-310.

(3) An issuer's service area must not be created in a manner designed to discriminate or that results in discrimination against persons because of age, gender, gender identity, sexual orientation, disability, national origin, sex, family structure, ethnicity, race, health condition, employment status, or socioeconomic status.

(4) An issuer must establish sufficiency and adequacy of choice of providers based on the number and type of providers and facilities necessary within the service area for the plan to meet the access requirements set forth in this subchapter. Where an issuer establishes medical necessity or other prior authorization procedures, the issuer must ensure sufficient qualified staff is available to provide timely prior authorization decisions on an appropriate basis, without delays detrimental to the health of enrollees.

(5) In any case where the issuer has an absence of or an insufficient number or type of participating providers or facilities to provide a particular covered health care service, the issuer must ensure through referral by the primary care provider or otherwise that the enrollee obtains the covered service from a provider or facility within reasonable proximity of the enrollee at no greater cost to the enrollee than if the service were obtained from network providers and facilities. An issuer must satisfy this obligation even if an alternate access delivery request has been submitted and is pending commissioner approval.

An issuer may use facilities in neighboring service areas to satisfy a network access standard if one of the following types of facilities is not in the service area, or if the issuer can provide substantial evidence of good faith efforts on its part to contract with the facilities in the service area. Such evidence of good faith efforts to contract will include documentation about the efforts to contract but not the substantive contract terms offered by either the issuer or the facility. This applies to the following types of facilities:

(a) Tertiary hospitals;

(b) Pediatric community hospitals;

(c) Specialty or limited hospitals, such as burn units, rehabilitative hospitals, orthopedic hospitals, and cancer care hospitals;

(d) Neonatal intensive care units; and

(e) Facilities providing transplant services, including those that provide solid organ, bone marrow, and stem cell transplants.

(6) An issuer must establish and maintain adequate arrangements to ensure reasonable proximity of network providers and facilities to the business or personal residence of enrollees, and located so as to not result in unreasonable barriers to accessibility. Issuers must make reasonable efforts to include providers and facilities in networks in a manner that limits the amount of travel required to obtain covered benefits.

(7) A single case provider reimbursement agreement must be used only to address unique situations that typically occur out-of-network and out of service area, where an enrollee requires services that extend beyond stabilization or one time urgent care. Single case provider reimbursement agreements must not be used to fill holes or gaps in the network and do not support a determination of network access.

(8) An issuer must disclose to enrollees that limitations or restrictions on access to participating providers and facilities may arise from the health service referral and authorization practices of the issuer. A description of the health plan's referral and authorization practices, including information about how to contact customer service for guidance, must be set forth as an introduction or preamble to the provider directory for a health plan. In the alternative, the description of referral and authorization practices may be included in the summary of benefits and explanation of coverage for the health plan.

(9) To provide adequate choice to enrollees who are American Indians/Alaska Natives, each health issuer must maintain arrangements that ensure that American Indians/Alaska Natives who are enrollees have access to covered medical and behavioral health services provided by Indian health care providers.

Issuers must ensure that such enrollees may obtain covered medical and behavioral health services from the Indian health care provider at no greater cost to the enrollee than if the service were obtained from network providers and facilities, even if the Indian health care provider is not a contracted provider. Issuers are not responsible for credentialing providers and facilities that are part of the Indian health system. Nothing in this subsection prohibits an issuer from limiting coverage to those health services that meet issuer standards for medical necessity, care management, and claims administration or from limiting payment to that amount payable if the health service were obtained from a network provider or facility.

(10) An issuer must have a demonstrable method and contracting strategy to ensure that contracting hospitals in a plan's service area have the capacity to serve the entire enrollee population based on normal utilization.

(11) At a minimum, an issuer's provider network must adequately provide for mental health and substance use disorder treatment, including behavioral health therapy.

(a) Adequate networks include crisis intervention and stabilization, psychiatric inpatient hospital services, including voluntary psychiatric inpatient services, and services from mental health providers. There must be mental health providers of sufficient number and type to provide diagnosis and medically necessary treatment of conditions covered by the plan through providers acting within their scope

of license and scope of competence established by education, training, and experience to diagnose and treat conditions found in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* or other recognized diagnostic manual or standard.

(b) An issuer must establish a reasonable standard for the number and geographic distribution of mental health providers who can treat serious mental illness of an adult and serious emotional disturbances of a child, taking into account the various types of mental health practitioners acting within the scope of their licensure.

The issuer must measure the adequacy of the mental health network against this standard at least twice a year, and submit an action plan with the commissioner if the standard is not met.

(c) Emergency mental health services, including crisis intervention and crisis stabilization services, must be included in an issuer's provider network.

(d) An issuer must include a sufficient number and type of mental health and substance use disorder treatment providers and facilities within a service area based on normal utilization patterns.

(e) An issuer must ensure that an enrollee can identify information about mental health services and substance use disorder treatment including benefits, providers, coverage, and other relevant information by calling a customer service representative during normal business hours.

(12) The provider network must include preventive and wellness services, including chronic disease management and smoking cessation services as defined in RCW 48.43.005(37) and WAC ((~~284-43-878(9)~~)) 284-43-5640(9) and 284-43-5642(9). If these services are provided through a quit-line or help-line, the issuer must ensure that when follow-up services are medically necessary, the enrollee will have access to sufficient information to access those services within the service area. Contracts with quit-line or help-line services are subject to the same conditions and terms as other provider contracts under this section.

(13) For the essential health benefits category of ambulatory patient services, as defined in WAC ((~~284-43-878(1)~~)) 284-43-5640(1) and 284-43-5642(1), an issuer's network is adequate if:

(a) The issuer establishes a network that affords enrollee access to urgent appointments without prior authorization within forty-eight hours, or with prior authorization, within ninety-six hours of the referring provider's referral.

(b) For primary care providers the following must be demonstrated:

(i) The ratio of primary care providers to enrollees within the issuer's service area as a whole meets or exceeds the average ratio for Washington state for the prior plan year;

(ii) The network includes such numbers and distribution that eighty percent of enrollees within the service area are within thirty miles of a sufficient number of primary care providers in an urban area and within sixty miles of a sufficient number of primary care providers in a rural area from either their residence or work; and

(iii) Enrollees have access to an appointment, for other than preventive services, with a primary care provider within ten business days of requesting one.

(c) For specialists:

(i) The issuer documents the distribution of specialists in the network for the service area in relation to the population distribution within the service area; and

(ii) The issuer establishes that when an enrollee is referred to a specialist, the enrollee has access to an appointment with such a specialist within fifteen business days for nonurgent services.

(d) For preventive care services, and periodic follow-up care including, but not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological or imaging monitoring for recurrence of disease, the issuer permits scheduling such services in advance, consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice.

(14) The network access requirements in this subchapter apply to stand-alone dental plans offered through the exchange or where a stand-alone dental plan is offered outside of the exchange for the purpose of providing the essential health benefit category of pediatric oral benefits. All such stand-alone dental plans must ensure that all covered services to enrollees will be accessible in a timely manner appropriate for the enrollee's conditions.

(a) An issuer of such stand-alone dental plans must demonstrate that, for the dental plan's defined service area, all services required under WAC ((~~284-43-879(3)~~)) 284-43-5700(3) and 284-43-5702(4), as appropriate, are available to all enrollees without unreasonable delay.

(b) Dental networks for pediatric oral services must be sufficient for the enrollee population in the service area based on expected utilization.

(15) Issuers must meet all requirements of this subsection for all provider networks. An alternate access delivery request under WAC ((~~284-43-201~~)) 284-170-210 may be proposed only if:

(a) There are sufficient numbers and types of providers or facilities in the service area to meet the standards under this subchapter but the issuer is unable to contract with sufficient providers or facilities to meet the network standards in this subchapter; or

(b) An issuer's provider network has been previously approved under this section, and a provider or facility type subsequently becomes unavailable within a health plan's service area; or

(c) A county has a population that is fifty thousand or fewer, and the county is the sole service area for the plan, and the issuer chooses to propose an alternative access delivery system for that county; or

(d) A qualified health plan issuer is unable to meet the standards for inclusion of essential community providers, as provided under WAC ((~~284-43-222~~)) 284-170-310(3).

(16) This section is effective for all plans, whether new or renewed, with effective dates on or after January 1, 2015.

AMENDATORY SECTION (Amending WSR 16-07-144, filed 3/23/16, effective 4/23/16)

WAC 284-170-210 Alternate access delivery request. (1) Where an issuer's network meets one or more of the criteria in WAC ((~~284-43-200~~)) 284-170-200 (15)(a) through (d), the issuer may submit an alternate access delivery request for the commissioner's review and

approval. The alternate access delivery request must be made using the Alternate Access Delivery Request Form C, as provided in WAC ((~~284-43-220~~)) 284-170-280 (3)(d).

(a) An alternate access delivery system must provide enrollees with access to medically necessary care on a reasonable basis without detriment to their health.

(b) The issuer must ensure that the enrollee obtains all covered services in the alternate access delivery system at no greater cost to the enrollee than if the service was obtained from network providers or facilities or must make other arrangements acceptable to the commissioner.

(i) Copayments and deductible requirements must apply to alternate access delivery systems at the same level they are applied to in-network services.

(ii) The alternate access delivery system may result in issuer payment of billed charges to ensure network access.

(c) An issuer must demonstrate in its alternate access delivery request a reasonable basis for not meeting a standard as part of its filing for approval of an alternate access delivery system, and include an explanation of why the alternate access delivery system provides a sufficient number or type of the provider or facility to which the standard applies to enrollees.

(d) An issuer must demonstrate a plan and practice to assist enrollees to locate providers and facilities in neighboring service areas in a manner that assures both availability and accessibility. Enrollees must be able to obtain health care services from a provider or facility within the closest reasonable proximity of the enrollee in a timely manner appropriate for the enrollee's health needs.

Alternate access delivery systems include, but are not limited to, such provider network strategies as use of out-of-state and out of county or service area providers, and exceptions to network standards based on rural locations in the service area.

(2) The commissioner will not approve an alternate access delivery system unless the issuer provides substantial evidence of good faith efforts on its part to contract with providers or facilities, and can demonstrate that there is not an available provider or facility with which the issuer can contract to meet provider network standards under WAC ((~~284-43-200~~)) 284-170-200.

(a) Such evidence of good faith efforts to contract, where required, will be submitted as part of the issuer's Alternate Access Delivery Request Form C submission, as described in WAC ((~~284-43-220~~)) 284-170-280 (3)(d).

(b) Evidence of good faith efforts to contract will include documentation about the efforts to contract but not the substantive contract terms offered by either the issuer or the provider.

(3) The practice of entering into a single case provider reimbursement agreement with a provider or facility in relation to a specific enrollee's condition or treatment requirements is not an alternate access delivery system for purposes of establishing an adequate provider network. A single case provider reimbursement agreement must be used only to address unique situations that typically occur out of network and out of service area, where an enrollee requires services that extend beyond stabilization or one time urgent care. Single case provider reimbursement agreements must not be used to fill holes or gaps in a network for the whole population of enrollees under a plan, and do not support a determination of network access.

(4) This section is effective for all plans, whether new or renewed, with effective dates on or after January 1, 2015.

AMENDATORY SECTION (Amending WSR 16-07-144, filed 3/23/16, effective 4/23/16)

WAC 284-170-230 Maintenance of sufficient provider networks. (1) An issuer must maintain and monitor its provider networks on an ongoing basis for compliance with the network access standards set forth in WAC ((~~284-43-200~~)) 284-170-200. This includes an issuer of a stand-alone dental plan offered through the exchange or a stand-alone dental plan offered outside the exchange for the purpose of providing the essential health benefit category of pediatric oral benefits, which must maintain and monitor its networks for compliance with WAC ((~~284-43-200~~)) 284-170-200(14). An issuer must report to the commissioner, within the time frames stated in this section, any changes affecting the ability of its network providers and facilities to furnish covered services to enrollees.

(2) An issuer must notify the OIC in writing within five business days of either receiving or issuing a written notice of potential contract termination that would affect the network's ability to meet the standards set forth in WAC ((~~284-43-200~~)) 284-170-200. Notice of potential termination must include an issuer's preliminary determination of whether an alternate access delivery request must be filed and the documentation supporting that determination. The issuer's notice must be submitted electronically following the submission instructions on the commissioner's web site.

(a) If the issuer determines that an alternate access delivery request must be submitted to comply with WAC ((~~284-43-200~~)) 284-170-200(15), the issuer has ten business days to submit the request and supporting documentation for the alternate access delivery request in accordance with WAC ((~~284-43-220~~)) 284-170-280 (3)(d).

(b) If, after reviewing the issuer's preliminary determination that an alternate access delivery request is not necessary, the OIC determines that an alternate access delivery request is required to comply with WAC ((~~284-43-200~~)) 284-170-200(15), the issuer has five business days to submit the request and supporting documentation for the alternate access delivery request in accordance with WAC ((~~284-43-220~~)) 284-170-280 (3)(d).

(c) If the OIC determines that a network is out of compliance with WAC ((~~284-43-200~~)) 284-170-200 and the issuer has failed to report this change to the OIC, the issuer must, within one business day of notification by the OIC, submit an alternate access delivery request in accordance with WAC ((~~284-43-200~~)) 284-170-200(15) and supporting documentation for the alternate access delivery request in accordance with WAC ((~~284-43-220~~)) 284-170-280 (3)(d).

(3) An issuer of a health plan must maintain and monitor, on an ongoing basis, the ability and clinical capacity of its network providers and facilities to furnish covered health plan services to enrollees. An issuer must notify the commissioner in writing within fifteen days of a change in its network as described below:

(a) A reduction, by termination or otherwise, of ten percent or more in the number of either specialty providers, mental health providers, or facilities participating in the network;

(i) The initial time frame for measuring this reduction is from the network's initial approval date until the January 1st following the initial approval date.

(ii) After the January 1st following the network's initial approval date, the time frame for measuring this reduction is from January 1st to the following January 1st.

(b) Termination or reduction of a specific type of specialty provider on the American Board of Medical Specialties list of specialty and subspecialty certificates, where there are fewer than two of the specialists in a service area;

(c) An increase or reduction of twenty-five percent or more in the number of enrollees in the service area since the annual approval date;

(d) A reduction of five percent or more in the number of primary care providers in the service area who are accepting new patients;

(e) The termination or expiration of a contract with a hospital or any associated hospital-based medical group within a service area;

(f) A fifteen percent reduction in the number of providers or facilities for a specific chronic condition or disease participating in the network where the chronic condition or disease affects more than five percent of the issuer's enrollees in the service area. For purposes of monitoring, chronic illnesses are those conditions identified (or recognized) by the Centers for Medicare and Medicaid Services within the most current version of the Centers for Medicare and Medicaid Chronic Conditions Data Warehouse (CCW) data base available on the CMS.gov web site; or

(g) Written notice to the commissioner must include the issuer's preliminary determination whether the identified changes in the network require an alternate access delivery request in accordance with WAC ((~~284-43-220~~)) 284-170-280 (3)(d).

(i) If the issuer determines that an alternate access delivery request must be submitted, the issuer has ten business days to submit the request and supporting documentation for the alternate access delivery request in accordance with WAC ((~~284-43-220~~)) 284-170-280 (3)(d).

(ii) If, after reviewing the issuer's preliminary determination that an alternate access delivery request is not required, the OIC determines that an alternate access delivery request is required, the issuer has five business days to submit the request and supporting documentation for the alternate access delivery request in accordance with WAC ((~~284-43-220~~)) 284-170-280 (3)(d).

(iii) If the OIC determines that a network is out of compliance with these standards and the issuer has failed to report this change to the OIC, the issuer must, within one business day of notification by the OIC, submit an alternate access delivery request in accordance with WAC ((~~284-43-200~~)) 284-170-200(15) and supporting documentation for the alternate access delivery request in accordance with WAC ((~~284-43-220~~)) 284-170-280 (3)(d).

(4) An issuer of a stand-alone dental plan offered through the exchange or of a stand-alone dental plan offered outside the exchange for the purpose of providing the essential health benefit category of pediatric oral benefits must maintain and monitor, on an ongoing basis, the ability and clinical capacity of its network providers and facilities to furnish covered services to enrollees. An issuer must notify the commissioner in writing within fifteen days of the change in its network as described below:

(a) A reduction, by termination or otherwise, of ten percent or more in the number of specialty providers in the network since the initial approval date;

(b) An increase or reduction of twenty-five percent or more in the number of enrollees in the service area since the annual approval date;

(c) A reduction of five percent or more in the number of providers of preventive and general dentistry accepting new patients in the service area;

(d) Notice to the commissioner must include the issuer's preliminary determination whether an alternate access delivery request must be submitted with supporting documentation in accordance with WAC ((~~284-43-220~~)) 284-170-280 (3)(d).

(i) If the issuer determines that an alternate access delivery request must be submitted, the issuer has ten business days to submit the request and supporting documentation in accordance with WAC ((~~284-43-220~~)) 284-170-280 (3)(d).

(ii) If after reviewing the issuer's preliminary determination that an alternate access delivery request is not required, the OIC determines that an alternate access delivery request is required, the issuer has five business days to submit the request and supporting documentation for the request in accordance with WAC ((~~284-43-220~~)) 284-170-280 (3)(d).

(iii) If the OIC determines that a network is not in compliance with these standards and the issuer has failed to report this change to the OIC, the issuer must, within one business day of notification by the OIC, submit an alternate access delivery request in accordance with WAC ((~~284-43-200~~)) 284-170-200(15) and supporting documentation for the request in accordance with WAC ((~~284-43-220~~)) 284-170-280 (3)(d).

(5) The following network access standards must be met on an ongoing basis:

(a) The actuarial projections of health care costs submitted as part of a premium rate filing must continue to be based on the actual network the issuer proposes for the health plan's service areas.

(b) A practice that is not currently accepting new patients may be included in a provider network for purposes of reporting network access, but must not be used to justify network access for anticipated enrollment growth.

(c) An issuer must have and maintain in its network a sufficient number and type of providers to whom direct access is required under RCW 48.43.515 (2) and (5) and 48.42.100 to accommodate all new and existing enrollees in the service areas.

(d) Issuers that use the following network models must maintain and monitor the continuity and coordination of care that enrollees receive: Networks that include medical home or medical management services in lieu of providing access to specialty or ancillary services through primary care provider referral, and networks where the issuer requires providers to whom an enrollee has direct access to notify the enrollee's primary care provider of treatment plans and services delivered. For these models, an issuer must perform continuity and coordination of care in a manner consistent with professionally recognized evidence-based standards of practice, across the health plan network. The baseline for such coordination is maintenance and monitoring as often as is necessary, but not less than once a year:

(i) The systems or processes for integration of health care services by medical and mental health providers;

(ii) The exchange of information between primary and specialty providers;

(iii) Appropriate diagnosis, treatment, and referral practices;

(iv) Access to treatment and follow-up for enrollees with coexisting conditions including, but not limited to, a mental health condition coexisting with a chronic health condition.

(6) This section is effective for all plans, whether new or renewed, with effective dates on or after January 1, 2016.

AMENDATORY SECTION (Amending WSR 16-07-144, filed 3/23/16, effective 4/23/16)

WAC 284-170-240 Use of subcontracted networks. (1) The primary contractor with each provider and facility in an issuer's network must be specifically identified in network report filings with the commissioner. An issuer may use subcontracted networks as part of a provider network for a service area, subject to the following requirements:

(a) An issuer must not elect to use less than one hundred percent of the subcontracted network or networks in its service area.

(b) An issuer may use a combination of directly contracting with providers and use of a subcontracted network in the same service area.

(2) Upon request by the commissioner, an issuer must produce an executed copy of its agreement with a subcontracted network, and certify to the commissioner that there is reasonable assurance the providers listed as part of the subcontracted network are under enforceable contracts with the subcontractor. The contract with the subcontracted network's administrator must provide the issuer with the ability to require providers to conform to the requirements in chapter ((~~284-43~~)) 284-170 WAC, subchapter B.

(3) If an issuer permits a facility or provider to delegate functions, the issuer must require the facility or provider to:

(a) Include the requirements of this subchapter in its contracting documents with the subcontractor, including providing the commissioner with access to any pertinent information related to the contract during the contract term, for up to ten years from the final date of the contract period, and in certain instances, where required by federal or state law, periods in excess of ten years;

(b) Provide the issuer with the right to approve, suspend or terminate any such arrangement.

(4) This section is effective for all plans, whether new or renewed, with effective dates on or after January 1, 2015.

AMENDATORY SECTION (Amending WSR 16-07-144, filed 3/23/16, effective 4/23/16)

WAC 284-170-260 Provider directories. (1) Provider directories must be updated at least monthly, and must be offered to accommodate individuals with limited-English proficiency or disabilities. An issuer must post the current provider directory for each health plan online, and must make a printed copy of the current directory available to an enrollee upon request as required under RCW 48.43.510 (1)(g).

(2) For each health plan, the associated provider directory must include the following information for each provider:

(a) The specialty area or areas for which the provider is licensed to practice and included in the network;

(b) Any in-network institutional affiliation of the provider, such as hospitals where the provider has admitting privileges or provider groups with which a provider is a member;

(c) Whether the provider may be accessed without referral;

(d) Any languages, other than English, spoken by the provider.

(3) An issuer must include in its electronic posting of a health plan's provider directory a notation of any primary care, chiropractor, women's health care provider, or pediatrician whose practice is closed to new patients.

(4) If an issuer maintains more than one provider network, its posted provider directory or directories must make it reasonably clear to an enrollee which network applies to which health plan.

(5) Information about any available telemedicine services must be included and specifically described.

(6) Information about any available interpreter services, communication and language assistance services, and accessibility of the physical facility must be identified in the directory, and the mechanism by which an enrollee may access such services.

(7) An issuer must include information about the network status of emergency providers as required by WAC ((~~284-43-252~~)) 284-170-370.

(8) This section is effective for all plans, whether new or renewed, with effective dates on or after January 1, 2015.

AMENDATORY SECTION (Amending WSR 16-07-144, filed 3/23/16, effective 4/23/16)

WAC 284-170-270 Every category of health care providers. (1) Issuers must not exclude any category of providers licensed by the state of Washington who provide health care services or care within the scope of their practice for services covered as essential health benefits, as defined in WAC ((~~284-43-878~~)) 284-43-5640 and 284-43-5642 and RCW 48.43.715, for individual and small group plans; and as covered by the basic health plan, as defined in RCW 48.43.005(4), for plans other than individual and small group.

For individual and small group plans, the issuer must not exclude a category of provider who is licensed to provide services for a covered condition, and is acting within the scope of practice, unless such services would not meet the issuer's standards pursuant to RCW 48.43.045 (1)(a). For example, if the issuer covers outpatient treatment of lower back pain as part of the essential health benefits, any category of provider that provides cost-effective and clinically efficacious outpatient treatment for lower back pain within its scope of practice and otherwise abides by standards pursuant to RCW 48.43.045 (1)(a) must not be excluded from the network.

(2) RCW 48.43.045 (1)(a) permits issuers to require providers to abide by certain standards. These standards may not be used in a manner designed to exclude categories of providers unreasonably. For example, issuers must not decide that a particular category of provider can never render any cost-effective or clinically efficacious services

and thereby exclude that category of provider completely from health plans on that basis.

(3) Health plans are not prohibited by this section from placing reasonable limits on individual services rendered by specific categories of providers based on relevant information or evidence of the type usually considered and relied upon in making determinations of cost-effectiveness or clinical efficacy. However, health plans must not contain unreasonable limits, and must not include limits on the type of provider permitted to render the covered service unless such limits comply with RCW 48.43.045 (1)(a).

(4) This section does not prohibit health plans from using restricted networks. Issuers offering plans with restricted networks may select the individual providers in any category of provider with whom they will contract or whom they will reimburse. An issuer is not required by RCW 48.43.045 or this section to accede to a request by any individual provider for inclusion in any network for any health plan.

(a) Health plan networks that use "gatekeepers" or "medical homes" for access to specialist providers may use them for access to specified categories of providers.

(b) For purposes of this section:

(i) "Gatekeeper" means requiring a referral from a primary care or direct access provider or practitioner to access specialty or inpatient services.

(ii) "Medical home" means a team based health care delivery model for patient centered primary care that provides comprehensive and continuous medical care to patients with the goal of obtaining maximized health outcomes as modified and updated by the Agency for Healthcare Research and Quality, the U.S. Department of Health and Human Services (HRSA), and other state and federal agencies.

(5) Issuers must not offer coverage for health services for certain categories of providers solely as a separately priced optional benefit.

(6) The insurance commissioner may grant reasonable temporary extensions of time for implementation of RCW 48.43.045 or this section, or any part thereof, for good cause shown.

AMENDATORY SECTION (Amending WSR 16-07-144, filed 3/23/16, effective 4/23/16)

WAC 284-170-280 Network reports—Format. (1) An issuer must submit its provider network materials to the commissioner for approval prior to or at the time it files a newly offered health plan.

(a) For individual and small groups, the submission must occur when the issuer submits its plan under WAC ((~~284-170-870~~)) 284-43-0200. For groups other than individual and small, the submission must occur when the issuer submits a new health plan and as required in this section.

(b) The commissioner may extend the time for filing for good cause shown.

(c) For plan year 2015 only, the commissioner will permit a safe harbor standard. An issuer who can not meet the submission requirements in (e) and (f) of this subsection will be determined to meet the

requirements of those subsections even if the submissions are incomplete, provided that the issuer:

(i) Identifies specifically each map required under subsection (3)(e)(i) of this section, or Access Plan component required under subsection (3)(f) of this section, which has not been included in whole or part;

(ii) Explains the specific reason each map or component has not been included; and

(iii) Sets forth the issuer's plan to complete the submission, including the date(s) by which each incomplete map and component will be completed and submitted.

(2) Unless indicated otherwise, the issuer's reports must be submitted electronically and completed consistent with the posted submission instructions on the commissioner's web site, using the required formats.

(3) For plan years beginning January 1, 2015, an issuer must submit the following specific documents and data to the commissioner to document network access:

(a) **Provider Network Form A.** An issuer must submit a report of all participating providers by network.

(i) The Provider Network Form A must be submitted for each network being reviewed for network access. A network may be used by more than one plan.

(ii) An issuer must indicate whether a provider is an essential community provider as instructed in the commissioner's Provider Network Form A instructions.

(iii) An issuer must submit an updated, accurate Provider Network Form A on a monthly basis by the 5th of each month for each network and when a material change in the network occurs as described in subchapter B.

(iv) Filing of this data satisfies the reporting requirements of RCW 48.44.080 and the requirements of RCW 48.46.030 relating to filing of notices that describe changes in the provider network.

(b) **Provider directory certification.** An issuer must submit at the time of each Provider Network Form A submission a certification that the provider directory posted on the issuer's web site is specific to each plan, accurate as of the last date of the prior month. A certification signed by an officer of the issuer must confirm that the provider directory contains only providers and facilities with which the issuer has a signed contract that is in effect on the date of the certification.

(c) **Network Enrollment Form B.** The Network Enrollment Form B report provides the commissioner with an issuer's count of total covered lives for the prior year, during each month of the year, for each health plan by county.

(i) The report must be submitted for each network as a separate report. The report must contain all data items shown in and conform to the format of Network Enrollment Form B prescribed by and available from the commissioner.

(ii) An issuer must submit this report by March 31st of each year.

(d) **Alternate Access Delivery Request Form C.** For plan years that begin on or after January 1, 2015, alternate access delivery requests must be submitted when an issuer's network meets one or more of the criteria in WAC ((~~284-43-200~~)) 284-170-200 (15)(a) through (d). Alternate access delivery requests must be submitted to the commissioner using the Alternate Access Delivery Request Form C.

(i) The Alternate Access Delivery Request Form C submission must address the following areas, and may include other additional information as requested by the commissioner:

(A) A description of the specific issues the alternate access delivery system is intended to address, accompanied by supporting data describing how the alternate access delivery system ensures that enrollees have reasonable access to sufficient providers and facilities, by number and type, for covered services;

(B) A description and schedule of cost-sharing requirements for providers that fall under the alternate access delivery system;

(C) The issuer's proposed method of noting on its provider directory how an enrollee can access provider types under the alternate access delivery system;

(D) The issuer's marketing plan to accommodate the time period that the alternate access delivery system is in effect, and specifically describe how it impacts current and future enrollment and for what period of time;

(ii) Provider Network Form A and Network Enrollment Form B submissions are required in relation to an alternate access delivery system on the basis described in subsections (1) and (2) of this section.

(iii) If a network becomes unable to meet the network access standards after approval but prior to the health product's effective date, an alternate access delivery request must include a timeline to bring the network into full compliance with this subchapter.

(e) **Geographic Network Reports.**

(i) The geographic mapping criteria outlined below are minimum requirements and will be considered in conjunction with the standards set forth in WAC ((~~284-43-200 and 284-43-222~~)) 284-170-200 and 284-170-310. One map for each of the following provider types must be submitted:

(A) Hospital and emergency services. Map must identify provider locations, and demonstrate that each enrollee in the service area has access within thirty minutes in an urban area and sixty minutes in a rural area from either their residence or workplace to general hospital facilities including emergency services.

(B) Primary care providers. Map must demonstrate that eighty percent of the enrollees in the service area have access within thirty miles in an urban area and sixty miles in a rural area from either their residence or workplace to a primary care provider with an open practice. The provider type selected must have a license under Title 18 RCW that includes primary care services in the scope of license.

(C) Mental health and substance use disorder providers. For general mental health providers, such as licensed psychiatrists, psychologists, social workers, and mental health nurse practitioners, the map must demonstrate that eighty percent of the enrollees in the service area have access to a mental health provider within thirty miles in an urban area and sixty miles in a rural area from either their residence or workplace. For specialty mental health providers and substance use disorder providers, the map must demonstrate that eighty percent of the enrollees have access to the following types of service provider or facility: Evaluation and treatment, voluntary and involuntary inpatient mental health and substance use disorder treatment, outpatient mental health and substance use disorder treatment, and behavioral therapy. If one of the types of specialty providers is not available as required above, the issuer must propose an alternate access delivery system to meet this requirement.

(D) Pediatric services. For general pediatric services, the map must demonstrate that eighty percent of the covered children in the service area have access to a pediatrician or other provider whose license under Title 18 RCW includes pediatric services in the scope of license. This access must be within thirty miles in an urban area and sixty miles in a rural area of their family or placement residence. For specialty pediatric services, the map must demonstrate that eighty percent of covered children in the service area have access to pediatric specialty care within sixty miles in an urban area and ninety miles in a rural area of their family or placement residence. The pediatric specialty types include, but are not limited to, nephrology, pulmonology, rheumatology, hematology-oncology, perinatal medicine, neurodevelopmental disabilities, cardiology, endocrinology, and gastroenterology.

(E) Specialty services. An issuer must provide one map for the service area for specialties found on the American Board of Medical Specialties list of approved medical specialty boards. The map must demonstrate that eighty percent of the enrollees in the service area have access to an adequate number of providers and facilities in each specialty. Subspecialties are subsumed on the map.

(F) Therapy services. An issuer must provide one map that demonstrates that eighty percent of the enrollees have access to the following types of providers within thirty miles in an urban area and sixty miles in a rural area of their residence or workplace: Chiropractor, rehabilitative service providers and habilitative service providers.

(G) Home health, hospice, vision, and dental providers. An issuer must provide one map that identifies each provider or facility to which an enrollee has access in the service area for home health care, hospice, vision, and pediatric oral coverage, including allied dental professionals, dental therapists, dentists, and orthodontists.

(H) Covered pharmacy dispensing services. An issuer must provide one map that demonstrates the geographic distribution of the pharmacy dispensing services within the service area. If a pharmacy benefit manager is used by the issuer, the issuer must establish that the specifically contracted pharmacy locations within the service area are available to enrollees through the pharmacy benefit manager.

(I) Essential community providers. An issuer must provide one map that demonstrates the geographic distribution of essential community providers, by type of provider or facility, within the service area. This requirement applies only to qualified health plans as certified in RCW 43.71.065.

(ii) Each report must include the provider data points on each map, title the map as to the provider type or facility type it represents, include the network identification number the map applies to, and the name of each county included on the report.

(iii) For plan years beginning January 1, 2015, and every year thereafter, an issuer must submit reports as required in subsection (1) of this section to the commissioner for review and approval, or when an alternate access delivery request is submitted.

(f) **Access Plan.** An issuer must establish an access plan specific to each product that describes the issuer's strategy, policies, and procedures necessary to establishing, maintaining, and administering an adequate network.

(i) At a minimum, the issuer's policies and procedures referenced in the access plan must address:

(A) Referral of enrollees out-of-network, including criteria for determining when an out-of-network referral is required or appropriate;

(B) Copayment and coinsurance determination standards for enrollees accessing care out-of-network;

(C) Standards of accessibility expressed in terms of objectives and minimum levels below which corrective action will be taken, including the proximity of specialists and hospitals to primary care sources, and a method and process for documentation confirming that access will not result in delay detrimental to health of enrollees;

(D) Monitoring policies and procedures for compliance, including tracking and documenting network capacity and availability;

(E) Standard hours of operation, and after-hours, for prior authorization, consumer and provider assistance, and claims adjudication;

(F) Triage and screening arrangements for prior authorization requests;

(G) Prior authorization processes that enrollees must follow, including the responsibilities and scope of use of nonlicensed staff to handle enrollee calls about prior authorization;

(H) Specific procedures and materials used to address the needs of enrollees with limited-English proficiency and literacy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities;

(I) Assessment of the health status of the population of enrollees or prospective enrollees, including incorporation of the findings of local public health community assessments, and standardized outcome measures, and use of the assessment data and findings to develop network or networks in the service area;

(J) Notification to enrollees regarding personal health information privacy rights and restrictions, termination of a provider from the network, and maintaining continuity of care for enrollees when there is a material change in the provider network, insolvency of the issuer, or other cessation of operations;

(K) Issuer's process for corrective action for providers related to the provider's licensure, prior authorization, referral and access compliance. The process must include remedies to address insufficient access to appointments or services.

(ii) An access plan applicable to each product must be submitted with every Geographic Network Report when the issuer seeks initial certification of the network, submits its annual rate filing to the commissioner for review and approval, or when an alternative access delivery request is required due to a material change in the network.

(iii) The current access plan, with all associated data sets, policies and procedures, must be made available to the commissioner upon request, and a summary of the access plan's associated procedures must be made available to the public upon request.

(4) For purposes of this section, "urban area" means:

(a) A county with a density of ninety persons per square mile; or

(b) An area within a twenty-five mile radius around an incorporated city with a population of more than thirty thousand.

AMENDATORY SECTION (Amending WSR 16-07-144, filed 3/23/16, effective 4/23/16)

WAC 284-170-300 Essential community providers for exchange plans ——Definition. "Essential community provider" means providers listed on the Centers for Medicare and Medicaid Services Non-Exhaustive List of Essential Community Providers. This list includes providers and facilities that have demonstrated service to medicaid, low-income, and medically underserved populations in addition to those that meet the federal minimum standard, which includes:

(1) Hospitals and providers who participate in the federal 340B Drug Pricing Program;

(2) Disproportionate share hospitals, as designated annually;

(3) Those eligible for Section 1927 Nominal Drug Pricing;

(4) Those whose patient mix is at least thirty percent medicaid or medicaid expansion patients who have approved applications for the Electronic Medical Record Incentive Program;

(5) State licensed community clinics or health centers or community clinics exempt from licensure;

(6) Indian health care providers as defined in WAC ((~~284-43-130~~)) 284-170-130(16);

(7) Long-term care facilities in which the average residency rate is fifty percent or more eligible for medicaid during the preceding calendar year;

(8) School-based health centers as referenced for funding in Sec. 4101 of Title IV of ACA;

(9) Providers identified as essential community providers by the U.S. Department of Health and Human Services through subregulatory guidance or bulletins;

(10) Facilities or providers who waive charges or charge for services on a sliding scale based on income and that do not restrict access or services because of a client's financial limitations;

(11) Title X Family Planning Clinics and Title X look-alike Family Planning Clinics;

(12) Rural based or free health centers as identified on the Rural Health Clinic and the Washington Free Clinic Association web sites; and

(13) Federal qualified health centers (FQHC) or FQHC look-alikes.

AMENDATORY SECTION (Amending WSR 16-07-144, filed 3/23/16, effective 4/23/16)

WAC 284-170-310 Essential community providers for exchange plans ——Network access. (1) An issuer must include essential community providers in its provider network for qualified health plans and qualified stand-alone dental plans in compliance with this section and as defined in WAC ((~~284-43-221~~)) 284-170-300.

(2) An issuer must include a sufficient number and type of essential community providers in its provider network to provide reasonable access to the medically underserved or low-income in the service area, unless the issuer can provide substantial evidence of good faith efforts on its part to contract with the providers or facilities in the

service area. Such evidence of good faith efforts to contract will include documentation about the efforts to contract but not the substantive contract terms offered by either the issuer or the provider.

(3) The following minimum standards apply to establish adequate qualified health plan inclusion of essential community providers:

(a) Each issuer must demonstrate that at least thirty percent of available primary care providers, pediatricians, and hospitals that meet the definition of an essential community provider in each plan's service area participate in the provider network;

(b) The issuer's provider network must include access to one hundred percent of Indian health care providers in a service area, as defined in WAC ((~~284-43-130~~)) 284-170-130(16), such that qualified enrollees obtain all covered services at no greater cost than if the service was obtained from network providers or facilities;

(c) Within a service area, fifty percent of rural health clinics located outside an area defined as urban by the 2010 Census must be included in the issuer's provider network;

(d) For essential community provider categories of which only one or two exist in the state, an issuer must demonstrate a good faith effort to contract with that provider or providers for inclusion in its network, which will include documentation about the efforts to contract but not the substantive contract terms offered by either the issuer or the provider;

(e) For qualified health plans that include pediatric oral services or qualified dental plans, thirty percent of essential community providers in the service area for pediatric oral services must be included in each issuer's provider network;

(f) Ninety percent of all federally qualified health centers and FQHC look-alike facilities in the service area must be included in each issuer's provider network;

(g) At least one essential community provider hospital per county in the service area must be included in each issuer's provider network;

(h) At least fifteen percent of all providers participating in the 340B program in the service area, balanced between hospital and nonhospital entities, must be included in the issuer's provider network;

(i) By 2016, at least seventy-five percent of all school-based health centers in the service area must be included in the issuer's network.

(4) An issuer must, at the request of a school-based health center or group of school-based health centers, offer to contract with such a center or centers to reimburse covered health care services delivered to enrollees under an issuer's health plan.

(a) If a contract is not entered into, the issuer must provide substantial evidence of good faith efforts on its part to contract with a school-based health center or group of school-based health centers. Such evidence of good faith efforts to contract will include documentation about the efforts to contract but not the substantive contract terms offered by either the issuer or the provider.

(b) "School-based health center" means a school-based location for the delivery of health services, often operated as a partnership of schools and community health organizations, which can include issuers, which provide on-site medical and mental health services through a team of medical and mental health professionals to school-aged children and adolescents.

(5) An issuer must, at the request of an Indian health care provider, offer to contract with such a provider to reimburse covered health care services delivered to qualified enrollees under an issuer's health plan.

(a) Issuers are encouraged to use the current version of the Washington State Indian Health Care Provider Addendum, as posted on http://www.aihc-wa.com, to supplement the existing provider contracts when contracting with an Indian health care provider.

(b) If an Indian health care provider requests a contract and a contract is not entered into, the issuer must provide substantial evidence of good faith efforts on its part to contract with the Indian health care provider. Such evidence of good faith efforts to contract will include documentation about the efforts to contract but not the substantive contract terms offered by either the issuer or the provider.

(6) These requirements do not apply to integrated delivery systems pursuant to RCW 43.71.065.

AMENDATORY SECTION (Amending WSR 16-07-144, filed 3/23/16, effective 4/23/16)

WAC 284-170-330 Tiered provider networks. (1) "Tiered provider network" means a network that identifies and groups providers and facilities into specific groups to which different provider reimbursement, enrollee cost-sharing, or provider access requirements, or any combination thereof, apply as a means to manage cost, utilization, quality, or to otherwise incentivize enrollee or provider behavior.

(a) An issuer may use a term other than tiered network as long as the term is not misleading or susceptible to confusion with a specific licensee designation, such as accountable care organization.

(b) An issuer must not use tiered networks to limit access to certain categories of providers or facilities.

(2) When an issuer's contracts include the placement of providers or facilities in tiers, and the network design results in cost differentials for enrollees, the issuer must disclose to enrollees at the time of enrollment the cost difference and the basis for the issuer's placement of providers or facilities in one tier or another.

(3) The lowest cost-sharing tier of a tiered network must provide enrollees with adequate access and choice among health care providers and facilities for essential health benefits as set forth in WAC ((~~284-43-878, 284-43-879, and 284-43-880~~)) 284-43-5640 and 284-43-5642, 284-43-5700 and 284-43-5702, and 284-43-5780 and 284-43-5782.

(4) Cost-sharing differentials between tiers must not be imposed on an enrollee if the sole provider or facility type or category required to deliver a covered service is not available to the enrollee in the lowest cost-sharing tier of the network.

(a) All enrollees must have reasonable access to providers and facilities at the lowest cost tier of cost-sharing.

(b) Variations in cost-sharing between tiers must be reasonable in relation to the premium rate charged.

(5) An issuer must include with the Provider Compensation Agreement the metrics and methodology used to assign participating providers and facilities to tiers. An issuer must be able to demonstrate to

the commissioner's satisfaction that its assignment of providers and facilities to tiers, when based on a rating system, is consistent with the issuer's placement methodology.

(a) When an issuer revises or amends a quality, cost-efficiency or tiering program related to its provider network, it must provide notice to affected providers and facilities of the proposed change sixty days before notifying the public of the program. The notice must explain the methodology and data, if any, used for particular providers and facilities and include information on provider appeal rights as stated in the provider agreement.

(b) An issuer must make its physician cost profile available to providers and facilities under a tiered network, including the written criteria by which the provider's performance is measured.

(6) An issuer's provider and facility ranking program, and the criteria used to assign providers and facilities to different tiers, must not be described in advertising or plan documents so as to deceive consumers as to issuer rating practices and their affect on available benefits. When a tiered network is used, an issuer must provide detailed information on its web site and if requested, make available in paper form information about the tiered network including, but not limited to:

(a) The providers and facilities participating in the tiered network;

(b) The selection criteria, if any, used to place the providers and facilities, but not including the results of applying those selection criteria to a particular provider or facility;

(c) The potential for providers and facilities to move from one tier to another at any time; and

(d) The tier in which each participating provider or facility is assigned.

(7) For any health plan in effect on a tiered network's reassignment date, an issuer must make a good faith effort to provide information to affected enrollees at least sixty days before the reassignment takes effect. This information includes, but is not limited to, the procedure the enrollee must follow to choose an alternate provider or facility to obtain treatment at the same cost-sharing level. The specific classes of enrollees to whom notice must be sent are:

(a) Patients of a reassigned primary care provider if their primary care provider is reassigned to a higher cost-sharing level;

(b) A patient in the second or third trimester of pregnancy if a care provider or facility in connection with her pregnancy is reassigned to a higher cost-sharing level;

(c) A terminally ill patient if a provider or facility in connection with the illness is reassigned to a higher cost-sharing level; and

(d) Patients under active treatment for cancer or hematologic disorders, if the provider or facility that is delivering the care is reassigned to a higher cost-sharing level.

AMENDATORY SECTION (Amending WSR 16-07-144, filed 3/23/16, effective 4/23/16)

WAC 284-170-340 Assessment of access. (1) The commissioner will assess whether an issuer's provider network access meets the require-

ments of WAC ((~~284-43-200, 284-43-201, and 284-43-205~~)) 284-170-200, 284-170-210, and 284-170-270 such that all health plan services to enrollees will be accessible in a timely manner appropriate for the enrollee's condition. Factors considered by the commissioner will include the following:

(a) The location of the participating providers and facilities;

(b) The location of employers or enrollees in the health plan;

(c) The range of services offered by providers and facilities for the health plan;

(d) Health plan provisions that recognize and provide for extraordinary medical needs of enrollees that cannot be adequately treated by the network's participating providers and facilities;

(e) The number of enrollees within each service area living in certain types of institutions or who have chronic, severe, or disabling medical conditions, as determined by the population the issuer is covering and the benefits provided;

(f) The availability of specific types of providers who deliver medically necessary services to enrollees under the supervision of a provider licensed under Title 18 RCW;

(g) The availability within the service area of facilities under Titles 70 and 71 RCW;

(h) Accreditation as to network access by a national accreditation organization including, but not limited to, the National Committee for Quality Assurance (NCQA), the Joint Commission, Accreditation Association of Ambulatory Health Care (AAAHC), or URAC.

(2) In determining whether an issuer has complied with the provisions of WAC ((~~284-43-200~~)) 284-170-200, the commissioner will give due consideration to the relative availability of health care providers or facilities in the service area under consideration and to the standards established by state agency health care purchasers. Relative availability includes the willingness of providers or facilities in the service area to contract with the issuer under reasonable terms and conditions.

(3) If the commissioner determines that an issuer's proposed or current network for a health plan is not adequate, the commissioner may, for good cause shown, permit the issuer to propose changes sufficient to make the network adequate within a sixty-day period of time. The proposal must include a mechanism to ensure that new enrollees have access to an open primary care provider within ten business days of enrolling in the plan while the proposed changes are being implemented. This requirement is in addition to such enforcement action as is otherwise permitted under Title 48 RCW.

AMENDATORY SECTION (Amending WSR 16-07-144, filed 3/23/16, effective 4/23/16)

WAC 284-170-480 Participating provider—Filing and approval. (1) An issuer must file for prior approval all participating provider agreements and facility agreements thirty calendar days prior to use. If a carrier negotiates a provider or facility contract or a compensation agreement that deviates from an approved agreement, then the issuer must file that negotiated contract or agreement with the commissioner for approval thirty days before use. The commissioner must re-

ceive the filings electronically in accordance with chapters 284-44A, 284-46A, and 284-58 WAC.

(2)(a) An issuer may file a provider or facility contract template with the commissioner. A "contract template" is a sample contract and compensation agreement form that the issuer will use to contract with multiple providers or facilities. A contract template must be issued exactly as approved.

(i) When an issuer modifies the contract template, an issuer must refile the modified contract template for approval. All changes to the contract template must be indicated through strike outs for deletions and underlines for new material. The modified template must be issued to providers and facilities upon approval.

(ii) Alternatively, issuers may file the modified contract template for prospective contracting and a contract addendum or amendment that would be issued to currently contracted providers or facilities for prior approval. The filing must include any correspondence that will be sent to a provider or facility that explains the amendment or addendum. The correspondence must provide sufficient information to clearly inform the provider or facility what the changes to the contract will be. All changes to the contract template must be indicated through strike outs for deletions and underlines for new material.

(iii) Changes to a previously filed and approved provider compensation agreement modifying the compensation amount or terms related to compensation must be filed and are deemed approved upon filing if there are no other changes to the previously approved provider contract or compensation agreement.

(b)(i) All negotiated contracts and compensation agreements must be filed with the commissioner for approval thirty calendar days prior to use and include all contract documents between the parties.

(ii) If the only negotiated change is to the compensation amount or terms related to compensation, it must be filed and is deemed approved upon filing.

(3) If the commissioner takes no action within thirty calendar days after submission, the form is deemed approved except that the commissioner may extend the approval period an additional fifteen calendar days upon giving notice before the expiration of the initial thirty-day period. Approval may be subsequently withdrawn for cause.

(4) The issuer must maintain provider and facility contracts at its principal place of business in the state, or the issuer must have access to all contracts and provide copies to facilitate regulatory review upon twenty days prior written notice from the commissioner.

(5) Nothing in this section relieves the issuer of the responsibility detailed in WAC ((~~284-43-220~~)) 284-170-280 (3)(b) to ensure that all provider and facility contracts are current and signed if the provider or facility is listed in the network filed for approval with the commissioner.

(6) If an issuer enters into a reimbursement agreement that is tied to health outcomes, utilization of specific services, patient volume within a specific period of time, or other performance standards, the issuer must file the reimbursement agreement with the commissioner thirty days prior to the effective date of the agreement, and identify the number of enrollees in the service area in which the reimbursement agreement applies. Such reimbursement agreements must not cause or be determined by the commissioner to result in discrimination against or rationing of medically necessary services for enrollees with a specific covered condition or disease. If the commissioner fails to notify the issuer that the agreement is disapproved

within thirty days of receipt, the agreement is deemed approved. The commissioner may subsequently withdraw such approval for cause.