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WSR 20-24-040

RULE-MAKING ORDER
PERMANENT RULE ONLY

CR-103P (October 2017)
(Implements RCW 34.05.360)

Agency: Office of the Insurance Commissioner

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:

In 2019 and 2020, the legislature enacted SHB 2338, ESHB 2642, ESHB 1879 and SSB 5889 and related health care legislation that address accessing and receiving health care services and benefits through health plans, short term limited duration medical plans and student health plans. Multiple provisions of OIC rules in chapter 284-43 WAC need amendments to be consistent with the new laws, including rules related to carrier utilization review processes, essential health benefits, mental health parity and protection of individuals from discrimination by carriers.

Citation of rules affected by this order:

New: WAC 284-43-5935, 284-43-5960, 284-43-5965, 284-43-5970, 284-43-5975, 284-43-5980

Repealed:

Amended: WAC 284-43-0160, 284-43-2000, 284-43-5642, 284-43-5940, 284-43-5950, 284-43-7000, 284-43-7010, 284-43-7020, 284-43-7040, 284-43-7060, 284-43-7080, 284-43-7100, 284-43-7120

Suspended:

Statutory authority for adoption: RCW 48.02.060, 48.20.460, 48.43.0128, 48.44.050, 48.46.200

Other authority:

PERMANENT RULE (Including Expedited Rule Making)

Adopted under notice filed as WSR 20-20-116 on October 6, 2020 (date).

Describe any changes other than editing from proposed to adopted version:

The final rule differs from the proposed rule in the following respects:

- The final rule makes a clarifying change to language related to coverage of hormone therapy in WAC 284-43-5940(1)(b)(iv).
- The final rule makes a technical correction to replace the term "covered entity" with "issuer" in WAC 284-43-5965(3) and WAC 284-43-5980(9).
- The final rule makes a technical correction to WAC sections referenced in WAC 284-43-7100. The reference to WAC 284-43-3070 is corrected to read WAC 284-43-3170.
- The final rule modifies WAC 284-43-5940(5) to clarify how the Commissioner assesses an issuer's actions to comply with WAC 284-43-5940.

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

Name: Tabba Alam
Address: PO Box 40260, Olympia, WA 98504-0260
Phone: 360-725-7170
Fax:
TTY:
Email: TabbaA@oic.wa..gov
Web site: www.insurance.wa.gov
Other:

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		Amended		Repealed	
Federal rules or standards:	New		Amended		Repealed	
Recently enacted state statutes:	New	6	Amended	13	Repealed	

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

	New		Amended		Repealed	

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

	New		Amended		Repealed	

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

	New		Amended		Repealed	

The number of sections adopted using:

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

Date Adopted: November 23, 2020	**Signature:** 
Name: Mike Kreidler	
Title: Insurance Commissioner	

AMENDATORY SECTION (Amending WSR 17-12-069, filed 6/5/17, effective 7/6/17)

WAC 284-43-0160 Definitions. Except as defined in other subchapters and unless the context requires otherwise, the following definitions shall apply throughout this chapter.

(1) "Adverse determination" has the same meaning as the definition of adverse benefit determination in RCW 48.43.005, and includes:

(a) The determination includes any decision by a health carrier's designee utilization review organization that a request for a benefit under the health carrier's health benefit plan does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part for the benefit;

(b) The denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit based on a determination by a health carrier or its designee utilization review organization of a covered person's eligibility to participate in the health carrier's health benefit plan;

(c) Any prospective review or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment in whole or in part for a benefit;

(d) A rescission of coverage determination; or

(e) A carrier's denial of an application for coverage.

(2) "Authorization" or "certification" means a determination by the carrier that an admission, extension of stay, or other health care service has been reviewed and, based on the information provided, meets the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness in relation to the applicable health plan.

(3) "Behavioral health agency" means an agency licensed or certified under RCW 71.24.037.

(4) Clinical review criteria" means the written screens or screening procedures, decision rules, medical protocols, or clinical practice guidelines used by the carrier as an element in the evaluation of medical necessity and appropriateness of requested admissions, procedures, and services, including prescription drug benefits, under the auspices of the applicable plan. Clinical approval criteria has the same meaning as clinical review criteria.

((~~(4)~~)) (5) "Covered health condition" means any disease, illness, injury or condition of health risk covered according to the terms of any health plan.

((~~(5)~~)) (6) "Covered person" or "enrollee" means an individual covered by a health plan including a subscriber, policyholder, or beneficiary of a group plan.

((~~(6)~~)) (7) "Emergency fill" means a limited dispensed amount of medication that allows time for the processing of a preauthorization request. Emergency fill only applies to those circumstances where a patient presents at a contracted pharmacy with an immediate therapeutic need for a prescribed medication that requires a prior authorization.

((~~(7)~~)) (8) "Emergency medical condition" means the emergent and acute onset of a symptom or symptoms, including severe pain or emotional distress, that would lead a prudent layperson acting reasonably

to believe that a health condition exists that requires immediate medical, mental health or substance use disorder treatment attention, if failure to provide medical, mental health or substance use disorder treatment attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

((~~(8)~~)) (9) "Emergency services" has the meaning set forth in RCW 48.43.005.

((~~(9)~~)) (10) "Enrollee point-of-service cost-sharing" or "cost-sharing" means amounts paid to health carriers directly providing services, health care providers, or health care facilities by enrollees and may include copayments, coinsurance, or deductibles.

((~~(10)~~)) (11) "Expedited prior authorization request" means any request by a provider or facility for approval of a service where the passage of time could seriously jeopardize the life or health of the enrollee, seriously jeopardize the enrollee's ability to regain maximum function, or, in the opinion of a provider or facility with knowledge of the enrollee's medical condition, would subject the enrollee to severe pain that cannot be adequately managed without the service that is the subject of the request.

((~~(11)~~)) (12) "Facility" means an institution providing health care services((~~,~~)) including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory, and imaging centers, and rehabilitation and other therapeutic settings, and as defined in RCW 48.43.005.

((~~(12)~~)) (13) "Formulary" means a listing of drugs used within a health plan. A formulary must include drugs covered under an enrollee's medical benefit.

((~~(13)~~)) (14) "Grievance" has the meaning set forth in RCW 48.43.005.

((~~(14)~~)) (15) "Health care provider" or "provider" means:

(a) A person regulated under Title 18 RCW or chapter 70.127 RCW, to practice health or health-related services or otherwise practicing health care services in this state consistent with state law; or

(b) An employee or agent of a person described in (a) of this subsection, acting in the course and scope of his or her employment.

((~~(15)~~)) (16) "Health care service" or "health service" means that service offered or provided by health care facilities and health care providers relating to the prevention, cure, or treatment of illness, injury, or disease.

((~~(16)~~)) (17) "Health carrier" or "carrier" means a disability insurance company regulated under chapter 48.20 or 48.21 RCW, a health care service contractor as defined in RCW 48.44.010, and a health maintenance organization as defined in RCW 48.46.020, and includes "issuers" as that term is used in the Patient Protection and Affordable Care Act (P.L. 111-148, as amended (2010)).

((~~(17)~~)) (18) "Health plan" or "plan" means any individual or group policy, contract, or agreement offered by a health carrier to provide, arrange, reimburse, or pay for health care service except the following:

(a) Long-term care insurance governed by chapter 48.84 RCW;

(b) Medicare supplemental health insurance governed by chapter 48.66 RCW;

(c) Limited health care service offered by limited health care service contractors in accordance with RCW 48.44.035;

(d) Disability income;

(e) Coverage incidental to a property/casualty liability insurance policy such as automobile personal injury protection coverage and homeowner guest medical;

(f) Workers' compensation coverage;

(g) Accident only coverage;

(h) Specified disease and hospital confinement indemnity when marketed solely as a supplement to a health plan;

(i) Employer-sponsored self-funded health plans;

(j) Dental only and vision only coverage; and

(k) Plans deemed by the insurance commissioner to have a short-term limited purpose or duration, or to be a student-only plan that is guaranteed renewable while the covered person is enrolled as a regular full-time undergraduate or graduate student at an accredited higher education institution, after a written request for such classification by the carrier and subsequent written approval by the insurance commissioner.

((~~(18)~~)) (19) "Immediate therapeutic needs" means those needs where passage of time without treatment would result in imminent emergency care, hospital admission or might seriously jeopardize the life or health of the patient or others in contact with the patient.

((~~(19)~~)) (20) "Indian health care provider" means:

(a) The Indian Health Service, an agency operated by the U.S. Department of Health and Human Services established by the Indian Health Care Improvement Act, Section 601, 25 U.S.C. §1661;

(b) An Indian tribe, as defined in the Indian Health Care Improvement Act, Section 4(14), 25 U.S.C. §1603(14), that operates a health program under a contract or compact to carry out programs of the Indian Health Service pursuant to the Indian Self-Determination and Education Assistance Act (ISDEAA), 25 U.S.C. §450 et seq.;

(c) A tribal organization, as defined in the Indian Health Care Improvement Act, Section 4(26), 25 U.S.C. §1603(26), that operates a health program under a contract or compact to carry out programs of the Indian Health Service pursuant to the ISDEAA, 25 U.S.C. §450 et seq.;

(d) An Indian tribe, as defined in the Indian Health Care Improvement Act, Section 4(14), 25 U.S.C. §1603(14), or tribal organization, as defined in the Indian Health Care Improvement Act, Section 4(26), 25 U.S.C. §1603(26), that operates a health program with funding provided in whole or part pursuant to 25 U.S.C. §47 (commonly known as the Buy Indian Act); or

(e) An urban Indian organization that operates a health program with funds in whole or part provided by Indian Health Service under a grant or contract awarded pursuant to Title V of the Indian Health Care Improvement Act, Section 4(29), 25 U.S.C. §1603(29).

((~~(20)~~)) (21) "Managed care plan" means a health plan that coordinates the provision of covered health care services to a covered person through the use of a primary care provider and a network.

((~~(21)~~)) (22) "Medically necessary" or "medical necessity" in regard to mental health services and pharmacy services is a carrier determination as to whether a health service is a covered benefit because the service is consistent with generally recognized standards within a relevant health profession.

((~~(22)~~)) (23) "Mental health provider" means a health care provider or a health care facility authorized by state law to provide mental health services.

((~~(23)~~)) (24) "Mental health services" means in-patient or outpatient treatment((~~,~~)) including, but not limited to, partial hospi-

talization ((~~or~~)), residential treatment, out-patient facility-based treatment, intensive outpatient treatment, emergency services, or prescription drugs to manage, stabilize or ameliorate the effects of a mental disorder listed in the most current version of the *Diagnostic and Statistical Manual of Mental Disorders (DSM) ((~~IV~~))* published by the American Psychiatric Association, ((~~excluding~~)) including diagnoses and treatment((~~s~~)) for substance ((~~abuse, 291.0 through 292.9 and 303.0 through 305.9~~)) use disorder.

((~~(24)~~)) (25) "Network" means the group of participating providers and facilities providing health care services to a particular health plan or line of business (individual, small, or large group). A health plan network for issuers offering more than one health plan may be smaller in number than the total number of participating providers and facilities for all plans offered by the carrier.

((~~(25) "Out-patient therapeutic visit" or "out-patient visit" means a clinical treatment session with a mental health provider of a duration consistent with relevant professional standards used by the carrier to determine medical necessity for the particular service being rendered, as defined in *Physicians Current Procedural Terminology*, published by the American Medical Association.~~))

(26) "Participating provider" and "participating facility" means a facility or provider who, under a contract with the health carrier or with the carrier's contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, from the health carrier rather than from the covered person.

(27) "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing.

(28) "Pharmacy services" means the practice of pharmacy as defined in chapter 18.64 RCW and includes any drugs or devices as defined in chapter 18.64 RCW.

(29) "Predetermination request" means a voluntary request from an enrollee or provider or facility for a carrier or its designated or contracted representative to determine if a service is a benefit, in relation to the applicable plan.

(30) "Preservice requirement" means any requirement that a carrier places on a provider or facility that may limit their ability to deliver a service that requires prior authorization. Examples include limits on the type of provider or facility delivering the service, a service that must be provided before a specific service will be authorized, site of care/place of service, and whether a provider administered medication needs to be obtained from a specialty pharmacy.

(31) "Primary care provider" means a participating provider who supervises, coordinates, or provides initial care or continuing care to a covered person, and who may be required by the health carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person.

(32) "Preexisting condition" means any medical condition, illness, or injury that existed any time prior to the effective date of coverage.

(33) "Premium" means all sums charged, received, or deposited by a health carrier as consideration for a health plan or the continuance of a health plan. Any assessment or any "membership," "policy," "contract," "service," or similar fee or charge made by a health carrier in consideration for a health plan is deemed part of the premium.

"Premium" shall not include amounts paid as enrollee point-of-service cost-sharing.

(34) "Prior authorization" means a mandatory process that a carrier or its designated or contracted representative requires a provider or facility to follow to determine if a service is a benefit and meets the requirements for medical necessity, clinical appropriateness, level of care, or effectiveness in relation to the applicable plan. Prior authorization occurs before the service is delivered. For purposes of WAC 284-43-2050 and 284-43-2060, any term used by a carrier or its designated or contracted representative to describe this process is prior authorization. For example, prior authorization has also been referred to as "prospective review," "preauthorization," or "precertification."

(35) "Service area" means the geographic area or areas where a specific product is issued, accepts members or enrollees, and covers provided services. A service area must be defined by the county or counties included unless, for good cause, the commissioner permits limitation of a service area by zip code. Good cause includes geographic barriers within a service area, or other conditions that make offering coverage throughout an entire county unreasonable.

(36) "Small group plan" means a health plan issued to a small employer as defined under RCW 48.43.005(33) comprising from one to fifty eligible employees.

(37) "Standard prior authorization request" means a request by a provider or facility for approval of a service where the request is made in advance of the enrollee obtaining a service that is not required to be expedited.

(38) "Step therapy protocol" means a drug utilization management prior authorization protocol or program that establishes the specific sequence in which prescription drugs are covered by a health carrier for a medical condition.

(39) "Substance use disorder" means a substance-related or addictive disorder listed in the most current version of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* published by the American Psychiatric Association.

(40) "Substitute drug" means a prescription medication, drug or therapy that a carrier covers based on an exception request. When the exception request is based on therapeutic equivalence, a substitute drug means a therapeutically equivalent substance as defined in chapter 69.41 RCW.

((~~(39)~~)) (41) "Supplementary pharmacy services" or "other pharmacy services" means pharmacy services involving the provision of drug therapy management and other services not required under state and federal law but that may be rendered in connection with dispensing, or that may be used in disease prevention or disease management.

(42) "Withdrawal management services" means twenty-four hour medically managed or medically monitored detoxification and assessment and treatment referral for adults or adolescents withdrawing from alcohol or drugs, which may include induction of medications for addiction recovery.

AMENDATORY SECTION (Amending WSR 17-12-069, filed 6/5/17, effective 1/1/18)

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

(2) These definitions apply to this section:

(a) "Concurrent care review request" means:

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

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

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

((~~(2)~~)) (3) Each issuer must maintain a documented utilization review program description and written clinical review criteria based on reasonable medical evidence. The program must include a method for reviewing and updating criteria. Issuers must make clinical review criteria available upon request to participating providers and facilities. An issuer need not use medical evidence or standards in its utilization review of religious nonmedical treatment or religious nonmedical nursing care.

((~~(3)~~)) (4) The utilization review program must meet accepted national certification standards such as those used by the National Committee for Quality Assurance except as otherwise required by this chapter and must have staff who are properly qualified, trained, supervised, and supported by explicit written clinical review criteria and review procedures.

((~~(4)~~)) (5) Each issuer when conducting utilization review must:

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

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

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

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

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

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

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

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

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

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

((~~(5)~~)) (6) Each issuer must reimburse reasonable costs of medical record duplication for reviews.

((~~(6)~~)) (7) Each issuer must have written procedures to assure that reviews and second opinions are conducted in a timely manner.

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

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

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

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

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

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

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

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

((~~(7)~~)) (8) Concurrent care review requests related to authorization for coverage of continued withdrawal management or extension of inpatient or residential substance use disorder treatment services al-

so must adhere to the requirements of RCW 48.43.761. In the event of a conflict between RCW 48.43.761 and the requirements of subsections (4) through (8) of this section, RCW 48.43.761 governs.

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

AMENDATORY SECTION (Amending WSR 20-03-114, filed 1/16/20, effective 2/16/20)

WAC 284-43-5642 Essential health benefit categories. (1) A health benefit plan must cover "ambulatory patient services" in a manner substantially equal to the base-benchmark plan. For purposes of determining a plan's actuarial value, an issuer must classify as "ambulatory patient services" those medically necessary services delivered to enrollees in settings other than a hospital or skilled nursing facility, which are generally recognized and accepted for diagnostic or therapeutic purposes to treat illness or injury.

(a) A health benefit plan must include the following services, which are specifically covered by the base-benchmark plan, and classify them as ambulatory patient services:

(i) Home and outpatient dialysis services;

(ii) Hospice and home health care, including skilled nursing care as an alternative to hospitalization consistent with WAC 284-44-500, 284-46-500, and 284-96-500;

(iii) Provider office visits and treatments, and associated supplies and services, including therapeutic injections and related supplies;

(iv) Urgent care center visits, including provider services, facility costs and supplies;

(v) Ambulatory surgical center professional services, including anesthesiology, professional surgical services, surgical supplies and facility costs;

(vi) Diagnostic procedures including colonoscopies, cardiovascular testing, pulmonary function studies and neurology/neuromuscular procedures; and

(vii) Provider contraceptive services and supplies including, but not limited to, vasectomy, tubal ligation and insertion or extraction of FDA-approved contraceptive devices.

(b) A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. The base-benchmark plan specifically excludes these services. If an issuer includes these benefits in a health plan, the issuer should not include the following benefits in establishing actuarial value for the ambulatory category:

(i) Infertility treatment and reversal of voluntary sterilization;

(ii) Routine foot care for those that are not diabetic;

(iii) Coverage of dental services following injury to sound natural teeth. However, health plans must cover oral surgery related to trauma and injury. Therefore, a plan may not exclude services or appliances necessary for or resulting from medical treatment if the

service is either emergency in nature or requires extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease;

(iv) Private duty nursing for hospice care and home health care, to the extent consistent with state and federal law;

(v) Adult dental care and orthodontia delivered by a dentist or in a dentist's office;

(vi) Nonskilled care and help with activities of daily living;

(vii) Hearing care, routine hearing examinations, programs or treatment for hearing loss including, but not limited to, externally worn or surgically implanted hearing aids, and the surgery and services necessary to implant them. However, plans must cover cochlear implants and hearing screening tests that are required under the preventive services category, unless coverage for these services and devices are required as part of and classified to another essential health benefits category; and

(viii) Obesity or weight reduction or control other than:

(A) Covered nutritional counseling; and

(B) Obesity-related services for which the U.S. Preventive Services Task Force for prevention and chronic care has issued A and B recommendations on or before the applicable plan year, which issuers must cover under subsection (9) of this section.

(c) The base-benchmark plan's visit limitations on services in the ambulatory patient services category include:

(i) Ten spinal manipulation services per calendar year without referral;

(ii) Twelve acupuncture services per calendar year without referral;

(iii) Fourteen days respite care on either an inpatient or outpatient basis for hospice patients, per lifetime; and

(iv) One hundred thirty visits per calendar year for home health care.

(d) State benefit requirements classified to the ambulatory patient services category are:

(i) Chiropractic care (RCW 48.44.310);

(ii) TMJ disorder treatment (RCW 48.21.320, 48.44.460, and 48.46.530); and

(iii) Diabetes-related care and supplies (RCW 48.20.391, 48.21.143, 48.44.315, and 48.46.272).

(2) A health benefit plan must cover "emergency medical services" in a manner substantially equal to the base-benchmark plan. For purposes of determining a plan's actuarial value, an issuer must classify as emergency medical services the care and services related to an emergency medical condition.

(a) A health benefit plan must include the following services which are specifically covered by the base-benchmark plan and classify them as emergency services:

(i) Ambulance transportation to an emergency room and treatment provided as part of the ambulance service;

(ii) Emergency room and department based services, supplies and treatment, including professional charges, facility costs, and outpatient charges for patient observation and medical screening exams required to stabilize a patient experiencing an emergency medical condition;

(iii) Prescription medications associated with an emergency medical condition, including those purchased in a foreign country.

(b) The base-benchmark plan does not specifically exclude services classified to the emergency medical services category.

(c) The base-benchmark plan does not establish visit limitations on services in the emergency medical services category.

(d) State benefit requirements classified to the emergency medical services category include services necessary to screen and stabilize a covered person (RCW 48.43.093).

(3) A health benefit plan must cover "hospitalization" in a manner substantially equal to the base-benchmark plan. For purposes of determining a plan's actuarial value, an issuer must classify as hospitalization services the medically necessary services delivered in a hospital or skilled nursing setting including, but not limited to, professional services, facility fees, supplies, laboratory, therapy or other types of services delivered on an inpatient basis.

(a) A health benefit plan must include the following services which are specifically covered by the base-benchmark plan and classify them as hospitalization services:

(i) Hospital visits, facility costs, provider and staff services and treatments delivered during an inpatient hospital stay, including inpatient pharmacy services;

(ii) Skilled nursing facility costs, including professional services and pharmacy services and prescriptions filled in the skilled nursing facility pharmacy;

(iii) Transplant services, supplies and treatment for donors and recipients, including the transplant or donor facility fees performed in either a hospital setting or outpatient setting;

(iv) Dialysis services delivered in a hospital;

(v) Artificial organ transplants based on an issuer's medical guidelines and manufacturer recommendations;

(vi) Respite care services delivered on an inpatient basis in a hospital or skilled nursing facility;

(vii) Inpatient hospitalization where mental illness is the primary diagnosis.

(b) A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. The base-benchmark plan specifically excludes these services. If an issuer includes these benefits in a health plan, the issuer should not include the following benefits in establishing actuarial value for the hospitalization category:

(i) Cosmetic or reconstructive services and supplies except in the treatment of a congenital anomaly, to restore a physical bodily function lost as a result of injury or illness, or related to breast reconstruction following a medically necessary mastectomy;

(ii) The following types of surgery:

(A) Bariatric surgery and supplies;

(B) Orthognathic surgery and supplies unless due to temporomandibular joint disorder or injury, sleep apnea or congenital anomaly.

(iii) Reversal of sterilizations; and

(iv) Surgical procedures to correct refractive errors, astigmatism or reversals or revisions of surgical procedures which alter the refractive character of the eye.

(c) The base-benchmark plan establishes specific limitations on services classified to the hospitalization category that conflict with state or federal law as of January 1, 2017. Health plans may not include the base-benchmark plan limitations listed below and must cover all services consistent with federal rules and guidance implementing 42 U.S.C. 18116, Sec. 1557, including those codified at 81 Fed. Reg. 31375 et seq. (2016), that were in effect on January 1, 2017, RCW 48.30.300, 48.43.0128, 48.43.072, 48.43.073, 49.60.040 and 49.60.178:

(i) The base-benchmark plan allows a waiting period for transplant services;

(ii) The base-benchmark plan excludes coverage for sexual reassignment treatment, surgery, or counseling services; and

(iii) The base-benchmark plan excludes coverage for hospitalization where mental illness or a substance use disorder is the primary diagnosis.

(d) The base-benchmark plan's visit limitations on services in the hospitalization category include:

(i) Sixty inpatient days per calendar year for illness, injury or physical disability in a skilled nursing facility;

(ii) Thirty inpatient rehabilitation service days per calendar year. For purposes of determining actuarial value, this benefit may be classified to the hospitalization category or to the rehabilitation services category, but not to both.

(e) State benefit requirements classified to the hospitalization category are:

(i) General anesthesia and facility charges for dental procedures for those who would be at risk if the service were performed elsewhere and without anesthesia (RCW 48.43.185);

(ii) Reconstructive breast surgery resulting from a mastectomy that resulted from disease, illness or injury (RCW 48.20.395, 48.21.230, 48.44.330, and 48.46.280);

(iii) Coverage for treatment of temporomandibular joint disorder (RCW 48.21.320, 48.44.460, and 48.46.530); and

(iv) Coverage at a long-term care facility following hospitalization (RCW 48.43.125).

(4) A health benefit plan must cover "maternity and newborn services" in a manner substantially equal to the base-benchmark plan. For purposes of determining a plan's actuarial value, an issuer must classify as maternity and newborn services the medically necessary care and services delivered to women during pregnancy and in relation to delivery and recovery from delivery and to newborn children.

(a) A health benefit plan must cover the following services which are specifically covered by the base-benchmark plan and classify them as maternity and newborn services:

(i) In utero treatment for the fetus;

(ii) Vaginal or cesarean childbirth delivery in a hospital or birthing center, including facility fees;

(iii) Nursery services and supplies for newborns, including newly adopted children;

(iv) Infertility diagnosis;

(v) Prenatal and postnatal care and services, including screening;

(vi) Complications of pregnancy such as, but not limited to, fetal distress, gestational diabetes, and toxemia; and

(vii) Termination of pregnancy((~~. Termination of pregnancy may be included in an issuer's essential health benefits package, and be consistent with 42 U.S.C. 18023 (b)(a)(A)(i) and 45 C.F.R. 156.115, as those sections do not require, but do not prohibit, an issuer from offering the benefit. This subsection does not relieve an issuer of requirements of current state law related to coverage for termination of pregnancy~~)) coverage that is substantially equivalent to coverage for maternal care or services, as provided in RCW 48.43.073.

(b) A health benefit plan may, but is not required to, include genetic testing of the child's father as part of the EHB-benchmark package. The base-benchmark plan specifically excludes this service.

If an issuer covers this benefit, the issuer may not include this benefit in establishing actuarial value for the maternity and newborn category.

(c) The base-benchmark plan's limitations on services in the maternity and newborn services category include coverage of home birth by a midwife or nurse midwife only for low risk pregnancy.

(d) State benefit requirements classified to the maternity and newborn services category include:

(i) Maternity services that include diagnosis of pregnancy, prenatal care, delivery, care for complications of pregnancy, physician services, and hospital services (RCW 48.43.041);

(ii) Newborn coverage that is not less than the postnatal coverage for the mother, for no less than three weeks (RCW 48.43.115); and

(iii) Prenatal diagnosis of congenital disorders by screening/diagnostic procedures if medically necessary (RCW 48.20.430, 48.21.244, 48.44.344, and 48.46.375).

(5) A health benefit plan must cover "mental health and substance use disorder services, including behavioral health treatment" in a manner substantially equal to the base-benchmark plan. For purposes of determining a plan's actuarial value, an issuer must classify as mental health and substance use disorder services, including behavioral health treatment, the medically necessary care, treatment and services for mental health conditions and substance use disorders categorized in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* published by the American Psychiatric Association, including behavioral health treatment for those conditions.

(a) A health benefit plan must include the following services, which are specifically covered by the base-benchmark plan, and classify them as mental health and substance use disorder services, including behavioral health treatment:

(i) Inpatient, residential, and outpatient mental health and substance use disorder treatment, including diagnosis, partial hospital programs or inpatient services;

(ii) Chemical dependency detoxification;

(iii) Behavioral treatment for a DSM category diagnosis;

(iv) Services provided by a licensed behavioral health provider for a covered diagnosis in a skilled nursing facility;

(v) Prescription medication including medications prescribed during an inpatient and residential course of treatment;

(vi) Acupuncture treatment visits without application of the visit limitation requirements, when provided for chemical dependency.

(b) A health benefit plan may, but is not required to, include ((~~the following services~~)) court-ordered mental health treatment that is not medically necessary as part of the EHB-benchmark package. The base-benchmark plan specifically excludes ((~~these~~)) this service((~~s~~)). If an issuer includes ((~~these~~)) this benefit((~~s~~)) in a health plan, the issuer may not include ((~~these~~)) this benefit((~~s~~)) in establishing actuarial value for the category of mental health and substance use disorder services including behavioral health treatment((~~:~~

~~(i) Counseling in the absence of illness, other than family counseling when the patient is a child or adolescent with a covered diagnosis and the family counseling is part of the treatment for mental health services;~~

~~(ii) Mental health treatment for diagnostic codes 302 through 302.9 in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, or for "V code" diagnoses except for medically necessary services for parent-child relational problems for~~

~~children five years of age or younger, neglect or abuse of a child for children five years of age or younger, bereavement for children five years of age or younger, and gender dysphoria consistent with federal rules and guidance implementing 42 U.S.C. 18116, Sec. 1557, as of January 1, 2017, including those found at 81 Fed. Reg. 31375 et seq. (2016), RCW 48.30.300 and 49.60.040, unless this exclusion is preempted by federal law; and~~

~~(iii) Court-ordered mental health treatment which is not medically necessary~~)).

(c) The base-benchmark plan establishes specific limitations on services classified to the mental health and substance abuse disorder services category that conflict with state or federal law as of January 1, 2017. The state EHB-benchmark plan requirements for these services are: The base-benchmark plan does not provide coverage for mental health services and substance use disorder treatment delivered in a home health setting in parity with medical surgical benefits consistent with state and federal law. Health plans must cover mental health services and substance use disorder treatment that is delivered in parity with medical surgical benefits, consistent with state and federal law.

(d) The base-benchmark plan's visit limitations on services in this category include court-ordered treatment only when medically necessary.

(e) State benefit requirements classified to this category include:

(i) Mental health services (RCW 48.20.580, 48.21.241, 48.44.341, and 48.46.285);

(ii) Chemical dependency detoxification services (RCW 48.21.180, 48.44.240, 48.44.245, 48.46.350, and 48.46.355); and

(iii) Services delivered pursuant to involuntary commitment proceedings (RCW 48.21.242, 48.44.342, and 48.46.292).

(f) The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343) (MHPAEA) applies to a health benefit plan subject to this section. Coverage of mental health and substance use disorder services, along with any scope and duration limits imposed on the benefits, must comply with the MHPAEA, and all rules, regulations and guidance issued pursuant to Section 2726 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26) including where state law is silent, or where federal law preempts state law.

(6) A health benefit plan must cover "prescription drug services" in a manner substantially equal to the base-benchmark plan. For purposes of determining a plan's actuarial value, an issuer must classify as prescription drug services medically necessary prescribed drugs, medication and drug therapies.

(a) A health benefit plan must include the following services, which are specifically covered by the base-benchmark plan, and classify them as prescription drug services:

(i) Drugs and medications both generic and brand name, including self-administrable prescription medications, consistent with the requirements of (b) through (e) of this subsection;

(ii) Prescribed medical supplies, including diabetic supplies that are not otherwise covered as durable medical equipment under the rehabilitative and habilitative services category, including test strips, glucagon emergency kits, insulin and insulin syringes;

(iii) All FDA-approved contraceptive methods, and prescription-based sterilization procedures;

(iv) Certain preventive medications including, but not limited to, aspirin, fluoride, and iron, and medications for tobacco use cessation, according to, and as recommended by, the United States Preventive Services Task Force, when obtained with a prescription order; and

(v) Medical foods to treat inborn errors of metabolism in accordance with RCW 48.44.440, 48.46.510, 48.20.520, 48.21.300, and 48.43.176.

(b) A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. The base-benchmark plan specifically excludes these services for the prescription drug services category. If an issuer includes these services, the issuer may not include the following benefits in establishing actuarial value for the prescription drug services category:

(i) Insulin pumps and their supplies, which are classified to and covered under the rehabilitation and habilitation services category; and

(ii) Weight loss drugs.

(c) The base-benchmark plan's visit limitations on services in the prescription drug services category include:

(i) Prescriptions for self-administrable injectable medication are limited to thirty day supplies at a time, other than insulin, which may be offered with more than a thirty day supply. This limitation is a floor, and an issuer may permit supplies greater than thirty days as part of its health benefit plan;

(ii) Teaching doses of self-administrable injectable medications are limited to three doses per medication per lifetime.

(d) State benefit requirements classified to the prescription drug services category include:

(i) Medical foods to treat inborn errors of metabolism (RCW 48.44.440, 48.46.510, 48.20.520, 48.21.300, and 48.43.176);

(ii) Diabetes supplies ordered by the physician (RCW 48.44.315, 48.46.272, 48.20.391, and 48.21.143). Inclusion of this benefit requirement does not bar issuer variation in diabetic supply manufacturers under its drug formulary;

(iii) Mental health prescription drugs to the extent not covered under the hospitalization or skilled nursing facility services, or mental health and substance use disorders categories (RCW 48.44.341, 48.46.291, 48.20.580, and 48.21.241);

(iv) Reproductive health-related over-the-counter drugs, devices, and products approved by the federal Food and Drug Administration.

(e) An issuer's formulary is part of the prescription drug services category. The formulary filed with the commissioner must be substantially equal to the base-benchmark plan formulary, both as to U.S. Pharmacopoeia therapeutic category and classes covered and number of drugs in each class. If the base-benchmark plan formulary does not cover at least one drug in a category or class, an issuer must include at least one drug in the uncovered category or class.

(i) An issuer must file its formulary quarterly, following the filing instructions defined by the insurance commissioner in WAC 284-44A-040, 284-46A-050, and 284-58-025.

(ii) An issuer's formulary does not have to be substantially equal to the base-benchmark plan formulary in terms of formulary placement.

(iii) An issuer may include over-the-counter medications in its formulary for purposes of establishing quantitative limits and administering the benefit.

(7) A health benefit plan must cover "rehabilitative and habilitative services" in a manner substantially equal to the base-benchmark plan.

(a) For purposes of determining a plan's actuarial value, an issuer must classify as rehabilitative services the medically necessary services that help a person keep, restore or improve skills and function for daily living that have been lost or impaired because a person was sick, hurt or disabled.

(b) A health benefit plan must include the following services, which are specifically covered by the base-benchmark plan, and classify them as rehabilitative services:

(i) Cochlear implants;

(ii) Inpatient rehabilitation facilities and professional services delivered in those facilities;

(iii) Outpatient physical therapy, occupational therapy and speech therapy for rehabilitative purposes;

(iv) Braces, splints, prostheses, orthopedic appliances and orthotic devices, supplies or apparatus used to support, align or correct deformities or to improve the function of moving parts; and

(v) Durable medical equipment and mobility enhancing equipment used to serve a medical purpose, including sales tax.

(c) A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. The base-benchmark plan specifically excludes these services. If an issuer includes the following benefits in a health plan, the issuer may not include these benefits in establishing actuarial value for the rehabilitative and habilitative services category:

(i) Off-the-shelf shoe inserts and orthopedic shoes;

(ii) Exercise equipment for medically necessary conditions;

(iii) Durable medical equipment that serves solely as a comfort or convenience item; and

(iv) Hearing aids other than cochlear implants.

(d) For purposes of determining a plan's actuarial value, an issuer must classify as habilitative services the range of medically necessary health care services and health care devices designed to assist a person to keep, learn or improve skills and functioning for daily living. Examples include services for a child who isn't walking or talking at the expected age, or services to assist with keeping or learning skills and functioning within an individual's environment, or to compensate for a person's progressive physical, cognitive, and emotional illness. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient or outpatient settings.

(i) As a minimum level of coverage, an issuer must establish limitations on habilitative services on parity with those for rehabilitative services. A health benefit plan may include such limitations only if the limitations take into account the unique needs of the individual and target measurable, and specific treatment goals appropriate for the person's age and physical and mental condition. When habilitative services are delivered to treat a mental health diagnosis categorized in the most recent version of the DSM, the mental health parity requirements apply and supersede any rehabilitative services parity limitations permitted by this subsection.

(ii) A health benefit plan must not limit an enrollee's access to covered services on the basis that some, but not all, of the services in a plan of treatment are provided by a public or government program.

(iii) An issuer may establish utilization review guidelines and practice guidelines for habilitative services that are recognized by the medical community as efficacious. The guidelines must not require a return to a prior level of function.

(iv) Habilitative health care devices may be limited to those that require FDA approval and a prescription to dispense the device.

(v) Consistent with the standards in this subsection, speech therapy, occupational therapy, physical therapy, and aural therapy are habilitative services. Day habilitation services designed to provide training, structured activities and specialized assistance to adults, chore services to assist with basic needs, vocational or custodial services are not classified as habilitative services.

(vi) An issuer must not exclude coverage for habilitative services received at a school-based health care center unless the habilitative services and devices are delivered pursuant to federal Individuals with Disabilities Education Act of 2004 (IDEA) requirements and included in an individual educational plan (IEP).

(e) The base-benchmark plan's visit limitations on services in the rehabilitative and habilitative services category include:

(i) Inpatient rehabilitation facilities and professional services delivered in those facilities are limited to thirty service days per calendar year; and

(ii) Outpatient physical therapy, occupational therapy and speech therapy are limited to twenty-five outpatient visits per calendar year, on a combined basis, for rehabilitative purposes.

(f) State benefit requirements classified to this category include:

(i) State sales tax for durable medical equipment; and

(ii) Coverage of diabetic supplies and equipment (RCW 48.44.315, 48.46.272, 48.20.391, and 48.21.143).

(g) An issuer must not classify services to the rehabilitative services category if the classification results in a limitation of coverage for therapy that is medically necessary for an enrollee's treatment for cancer, chronic pulmonary or respiratory disease, cardiac disease or other similar chronic conditions or diseases. For purposes of this subsection, an issuer must establish limitations on the number of visits and coverage of the rehabilitation therapy consistent with its medical necessity and utilization review guidelines for medical/surgical benefits. Examples of these are, but are not limited to, breast cancer rehabilitation therapy, respiratory therapy, and cardiac rehabilitation therapy. Such services may be classified to the ambulatory patient or hospitalization services categories for purposes of determining actuarial value.

(8) A health plan must cover "laboratory services" in a manner substantially equal to the base-benchmark plan. For purposes of determining actuarial value, an issuer must classify as laboratory services the medically necessary laboratory services and testing, including those performed by a licensed provider to determine differential diagnoses, conditions, outcomes and treatment, and including blood and blood services, storage and procurement, and ultrasound, X-ray, MRI, CAT scan and PET scans.

(a) A health benefit plan must include the following services, which are specifically covered by the base-benchmark plan, and classify them as laboratory services:

(i) Laboratory services, supplies and tests, including genetic testing;

(ii) Radiology services, including X-ray, MRI, CAT scan, PET scan, and ultrasound imaging; and

(iii) Blood, blood products, and blood storage, including the services and supplies of a blood bank.

(b) A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. The base-benchmark plan specifically excludes procurement and storage of personal blood supplies provided by a member of the enrollee's family when this service is not medically indicated. If an issuer includes this benefit in a health plan, the issuer may not include this benefit in establishing the health plan's actuarial value.

(9) A health plan must cover "preventive and wellness services, including chronic disease management" in a manner substantially equal to the base-benchmark plan. For purposes of determining a plan's actuarial value, an issuer must classify as preventive and wellness services, including chronic disease management, the services that identify or prevent the onset or worsening of disease or disease conditions, illness or injury, often asymptomatic; services that assist in the multidisciplinary management and treatment of chronic diseases; and services of particular preventative or early identification of disease or illness of value to specific populations, such as women, children and seniors.

(a) If a plan does not have in its network a provider who can perform the particular service, then the plan must cover the item or service when performed by an out-of-network provider and must not impose cost-sharing with respect to the item or service. In addition, a health plan must not limit sex-specific recommended preventive services based on an individual's sex assigned at birth, gender identity or recorded gender. If a provider determines that a sex-specific recommended preventive service is medically appropriate for an individual, and the individual otherwise satisfies the coverage requirements, the plan must provide coverage without cost-sharing.

(b) A health benefit plan must include the following services as preventive and wellness services, including chronic disease management:

(i) Immunizations recommended by the Centers for Disease Control's Advisory Committee on Immunization Practices;

(ii)(A) Screening and tests for which the U.S. Preventive Services Task Force for Prevention and Chronic Care have issued A and B recommendations on or before the applicable plan year.

(B) To the extent not specified in a recommendation or guideline, a plan may rely on the relevant evidence base and reasonable medical management techniques, based on necessity or appropriateness, to determine the frequency, method, treatment, or setting for the provision of a recommended preventive health service;

(iii) Services, tests and screening contained in the U.S. Health Resources and Services Administration ("HRSA") Bright Futures guidelines as set forth by the American Academy of Pediatricians; and

(iv) Services, tests, screening and supplies recommended in the HRSA women's preventive and wellness services guidelines:

(A) If the plan covers children under the age of nineteen, or covers dependent children age nineteen or over who are on the plan pursuant to RCW 48.44.200, 48.44.210, or 48.46.320, the plan must provide the child with the full range of recommended preventive services suggested under HRSA guidelines for the child's age group without cost-sharing. Services provided in this regard may be combined in one

visit as medically appropriate or may be spread over more than one visit, without incurring cost-sharing, as medically appropriate; and

(B) A plan may use reasonable medical management techniques to determine the frequency, method, treatment or setting for a recommended preventive service, including providing multiple prevention and screening services at a single visit or across multiple visits. Medical management techniques may not be used that limit enrollee choice in accessing the full range of contraceptive drugs, devices, or other products approved by the federal Food and Drug Administration.

(v) Chronic disease management services, which typically include, but are not limited to, a treatment plan with regular monitoring, coordination of care between multiple providers and settings, medication management, evidence-based care, measuring care quality and outcomes, and support for patient self-management through education or tools; and

(vi) Wellness services.

(c) The base-benchmark plan establishes specific limitations on services classified to the preventive services category that conflict with state or federal law as of January 1, 2017, and should not be included in essential health benefit plans.

Specifically, the base-benchmark plan excludes coverage for obesity or weight control other than covered nutritional counseling. Health plans must cover certain obesity-related services that are listed as A or B recommendations by the U.S. Preventive Services Task Force, consistent with 42 U.S.C. 300gg-13 (a)(1) and 45 C.F.R. 147.130 (a)(1)(i).

(d) The base-benchmark plan does not establish visit limitations on services in this category. In accordance with Sec. 2713 of the Public Health Service Act (PHS Act) and its implementing regulations relating to coverage of preventive services, the base-benchmark plan does not impose cost-sharing requirements with respect to the preventive services listed under (b)(i) through (iv) of this subsection that are provided in-network.

(e) State benefit requirements classified in this category are:

(i) Colorectal cancer screening as set forth in RCW 48.43.043;

(ii) Mammogram services, both diagnostic and screening (RCW 48.21.225, 48.44.325, and 48.46.275); and

(iii) Prostate cancer screening (RCW 48.20.392, 48.21.227, 48.44.327, and 48.46.277).

(10) Some state benefit requirements are limited to those receiving pediatric services, but are classified to other categories for purposes of determining actuarial value.

(a) These benefits include:

(i) Neurodevelopmental therapy, consisting of physical, occupational and speech therapy and maintenance to restore or improve function based on developmental delay, which cannot be combined with rehabilitative services for the same condition (RCW 48.44.450, 48.46.520, and 48.21.310). This state benefit requirement may be classified to ambulatory patient services or mental health and substance abuse disorder including behavioral health categories; and

(ii) Treatment of congenital anomalies in newborn and dependent children (RCW 48.20.430, 48.21.155, 48.44.212, and 48.46.250). This state benefit requirement may be classified to hospitalization, ambulatory patient services or maternity and newborn categories.

(b) The base-benchmark plan contains limitations or scope restrictions that conflict with state or federal law as of January 1, 2017. Specifically, the plan covers outpatient neurodevelopmental

therapy services only for persons age six and under. Health plans must cover medically necessary neurodevelopmental therapy for any DSM diagnosis without blanket exclusions.

(11) Issuers must know and apply relevant guidance, clarifications and expectations issued by federal governmental agencies regarding essential health benefits. Such clarifications may include, but are not limited to, Affordable Care Act implementation and frequently asked questions jointly issued by the U.S. Department of Health and Human Services, the U.S. Department of Labor and the U.S. Department of the Treasury.

(12) Each category of essential health benefits must at a minimum cover services required by current state law and be consistent with federal rules and guidance implementing 42 U.S.C. 18116, Sec. 1557, including those codified at 81 Fed. Reg. 31375 et seq. (2016), that were in effect on January 1, 2017.

(13) This section applies to health plans that have an effective date of January 1, 2020, or later.

NEW SECTION

WAC 284-43-5935 Definitions. As used in WAC 284-43-5940 through 284-43-5980, the following terms have the following meaning:

(1) Auxiliary aids and services include:

(a) Qualified interpreters on-site or through video remote interpreting (VRI) services, as defined in 28 C.F.R. 35.104 and 36.303(b); note takers; real-time computer-aided transcription services; written materials; exchange of written notes; telephone handset amplifiers; assistive listening devices; assistive listening systems; telephones compatible with hearing aids; closed caption decoders; open and closed captioning, including real-time captioning; voice, text, and video-based telecommunication products and systems, text telephones (TTYs), videophones, and captioned telephones, or equally effective telecommunications devices; videotext displays; accessible electronic and information technology; or other effective methods of making aurally delivered information available to individuals who are deaf or hard of hearing;

(b) Qualified readers; taped texts; audio recordings; Braille materials and displays; screen reader software; magnification software; optical readers; secondary auditory programs; large print materials; accessible electronic and information technology; or other effective methods of making visually delivered materials available to individuals who are blind or have low vision;

(c) Acquisition or modification of equipment and devices; and

(d) Other similar services and actions.

(2) Individual with limited-English proficiency means an individual whose primary language for communication is not English and who has a limited ability to read, write, speak, or understand English.

(3) Language assistance services may include, but are not limited to:

(a) Oral language assistance, including interpretation in non-English languages provided in-person or remotely by a qualified interpreter for an individual with limited-English proficiency, and the use of qualified bilingual or multilingual staff to communicate directly with individuals with limited-English proficiency;

(b) Written translation, performed by a qualified translator, of written content in paper or electronic form into languages other than English; and

(c) Taglines.

(4) National origin includes, but is not limited to, an individual's, or his or her ancestor's, place of origin (such as country or world region) or an individual's manifestation of the physical, cultural, or linguistic characteristics of a national origin group.

(5) Plan means a nongrandfathered health plan as defined in RCW 48.43.005, a plan deemed by the commissioner to have a short-term limited purpose or duration, or a plan deemed by the commissioner to be a student-only plan that is guaranteed renewable while the covered person is enrolled as a regular, full-time undergraduate student at an accredited higher education institution.

(6) Qualified bilingual/multilingual staff means a member of an issuer's workforce who is designated by the issuer to provide oral language assistance as part of the individual's current, assigned job responsibilities and who has demonstrated to the issuer that he or she:

(a) Is proficient in speaking and understanding both spoken English and at least one other spoken language, including any necessary specialized vocabulary, terminology and phraseology; and

(b) Is able to effectively, accurately, and impartially communicate directly with individuals with limited-English proficiency in their primary languages.

(7) Qualified interpreter for an individual with a disability means an interpreter who via a remote interpreting service or an on-site appearance:

(a) Adheres to generally accepted interpreter ethics principles, including client confidentiality; and

(b) Is able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary, terminology and phraseology.

For an individual with a disability, qualified interpreters can include, for example, sign language interpreters, oral transliterators (individuals who represent or spell in the characters of another alphabet), and cued language transliterators (individuals who represent or spell by using a small number of handshapes).

(8) Qualified interpreter for an individual with limited-English proficiency means an interpreter who via a remote interpreting service or an on-site appearance:

(a) Adheres to generally accepted interpreter ethics principles, including client confidentiality;

(b) Has demonstrated proficiency in speaking and understanding both spoken English and at least one other spoken language; and

(c) Is able to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using any necessary specialized vocabulary, terminology and phraseology.

(9) Qualified translator means a translator who:

(a) Adheres to generally accepted translator ethics principles, including client confidentiality;

(b) Has demonstrated proficiency in writing and understanding both written English and at least one other written non-English language; and

(c) Is able to translate effectively, accurately, and impartially to and from such language(s) and English, using any necessary specialized vocabulary, terminology and phraseology.

(10) Taglines mean short statements written in non-English languages that indicate the availability of language assistance services free of charge and how to obtain them.

AMENDATORY SECTION (Amending WSR 20-03-114, filed 1/16/20, effective 2/16/20)

WAC 284-43-5940 Nondiscrimination in ((~~individual and small group~~)) health plans, short-term limited duration medical plans and student-only health plans. (1) An issuer offering a ((~~nongrandfathered individual or small group health~~)) plan, and the issuer's officials, employees, agents, or representatives may not:

(a) Design plan benefits, ((~~including formulary design,~~)) or implement its plan benefits, in a manner that results in discrimination against individuals because of their age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions; and

(b) With respect to ((~~health~~)) the plan including, but not limited to, administration, member communication, medical protocols or criteria for medical necessity or other aspects of ((~~health~~)) plan operations:

(i) Discriminate on the basis of race, color, national origin, sex, gender identity, sexual orientation, age, or disability;

(ii) Deny, cancel, limit, or refuse to issue or renew a ((~~health~~)) plan, or deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, on the basis of race, color, national origin, sex, gender identity, sexual orientation, age, or disability;

(iii) Have or implement marketing practices or benefit designs that discriminate on the basis of race, color, national origin, sex, gender identity, sexual orientation, age, or disability. In reviewing plan design, plan features that attempt to circumvent coverage of medically necessary benefits such as by labeling a benefit as a pediatric service, and thereby excluding adults, or by placing all or most drugs for a specific condition in the highest cost-sharing tier, absent an appropriate reason for the exclusion, are potentially discriminatory. In these or other instances, the commissioner may request a justification for the practice. If requested, issuers must identify an appropriate nondiscriminatory reason that supports their benefit design;

(iv) Deny or limit coverage, deny or limit coverage of a claim, issue automatic denials of coverage or impose additional cost sharing or other limitations or restrictions on coverage, for any health services that are ordinarily or exclusively available to individuals of one sex, ((~~to a transgender individual~~)) based on the fact that an individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily or exclusively available. For example, a denial of coverage for medically necessary hormone prescriptions for transgender, gender nonconforming, or intersex individuals because the dosages exceed those typically prescribed for cisgender people would be discriminato-

ry against transgender, nonbinary, gender nonconforming, or intersex individuals;

(v) Have or implement a categorical coverage exclusion or limitation for all medical, surgical, or behavioral health services related to ((~~gender transition~~)) a person's gender identity or sexual orientation; or

(vi) Otherwise deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for specific medical, surgical, or behavioral health services related to a person's gender ((~~transition~~)) identity or sexual orientation if such denial, limitation, or restriction results in discrimination against a transgender, nonbinary, gender nonconforming or intersex individual.

(2) The enumeration of specific forms of discrimination in subsection (1)(b)(ii) through (vi) of this section does not limit the general applicability of the prohibition in subsection (1)(b)(i) of this section.

(3) Nothing in this section may be construed to prevent an issuer from appropriately utilizing fair and reasonable medical management techniques. Appropriate use of medical management techniques includes use of evidence based criteria for determining whether a service or benefit is medically necessary and clinically appropriate.

(4) An issuer's obligation to comply with these requirements is nondelegable; an issuer is obligated to ensure compliance with WAC 284-43-5935 through 284-43-5980, even if they use a third-party vendor or subcontracting arrangement. An issuer is not exempt from any of these requirements because it relied upon a third-party vendor or subcontracting arrangement for administration of any aspect of its benefits or services.

(5) The commissioner ((~~will~~)) may determine whether an issuer's actions to comply with this section are consistent with current state law, the legislative intent underlying RCW 48.43.0128 to maintain the enrollee protections of the Affordable Care Act, and the federal regulations and guidance in effect as of January 1, 2017, including, but not limited to, those issued by the U.S. Department of Health and Human Services Office of Civil Rights and federal regulations implementing 42 U.S.C. Sec. 18116 (Sec. 1557 of the Affordable Care Act) as set forth in 81 Fed. Reg. 31375 et seq. (2016).

AMENDATORY SECTION (Amending WSR 20-03-114, filed 1/16/20, effective 2/16/20)

WAC 284-43-5950 Access for individuals with limited-English proficiency and individuals with disabilities. Each issuer offering a ((~~nongrandfathered individual or small group health~~)) plan, and the issuer's officials, employees, agents or representatives must take fair and reasonable steps to provide meaningful access to each enrollee or individual ((~~with~~)) likely to be encountered who has limited-English proficiency ((~~and each individual with~~)) or a disability consistent with federal rules and guidance in effect on January 1, 2017, including those implementing 42 U.S.C. Sec. 18116((~~,~~)) (Sec. 1557((~~, including those~~)) of the Affordable Care Act) as set forth in 81 Fed. Reg. 31375 et seq. (2016)((~~, that were in effect on January 1, 2017~~)).

NEW SECTION

WAC 284-43-5960 Meaningful access for individuals with limited-English proficiency. (1) **General requirement.** An issuer offering a plan shall take reasonable steps to provide meaningful access to each enrollee or individual likely to be encountered with limited-English proficiency.

(2) **Evaluation of compliance.** In evaluating whether an issuer has met its obligation under subsection (1) of this section, the commissioner will:

(a) Evaluate, and give substantial weight to, the nature and importance of access to the health services involved and the particular communication at issue, to the individual with limited-English proficiency; and

(b) Take into account other relevant factors, including whether an issuer has developed and implemented an effective written language access plan, that is appropriate to its particular circumstances, to be prepared to meet its obligations under this section.

(3) **Language assistance services requirements.** Language assistance services required under subsection (1) of this section must be provided free of charge, be accurate and timely, and protect the privacy and independence of the individual with limited-English proficiency, regardless of whether an associated health service is provided in person or through telehealth.

(4) **Specific requirements for interpreter and translation services.** Subject to subsection (1) of this section:

(a) An issuer shall offer a qualified interpreter to an individual with limited-English proficiency when oral interpretation is a reasonable step to provide meaningful access for that individual with limited-English proficiency; and

(b) An issuer shall use a qualified translator when translating written content in paper or electronic form.

(5) **Restricted use of certain persons to interpret or facilitate communication.** An issuer shall not:

(a) Require an individual with limited-English proficiency to provide their own interpreter;

(b) Rely on an adult accompanying an individual with limited-English proficiency to interpret or facilitate communication, except:

(i) In an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with limited-English proficiency immediately available; or

(ii) Where the individual with limited-English proficiency specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide such assistance, and reliance on that adult for such assistance is appropriate under the circumstances.

(c) Rely on a minor child to interpret or facilitate communication, except in an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with limited-English proficiency immediately available; or

(d) Rely on staff other than qualified bilingual/multilingual staff to communicate directly with individuals with limited-English proficiency.

(6) **Video remote interpreting services.** An issuer that provides a qualified interpreter for an individual with limited-English proficiency through video remote interpreting services shall provide:

(a) Real-time, full-motion video and audio over a dedicated high-speed, wide-bandwidth video connection or wireless connection that delivers high-quality video images that do not produce lags, choppy, blurry, or grainy images, or irregular pauses in communication;

(b) A sharply delineated image that is large enough to display the interpreter's face and the participating individual's face regardless of the individual's body position;

(c) A clear, audible transmission of voices; and

(d) Adequate training to users of the technology and other involved individuals so that they may quickly and efficiently set up and operate the video remote interpreting.

(7) **Acceptance of language assistance services is not required.** Nothing in this section shall be construed to require an individual with limited-English proficiency to accept language assistance services.

NEW SECTION

WAC 284-43-5965 Effective communication for people with disabilities. An issuer offering a plan shall:

(1) Take appropriate steps to ensure that communications with individuals with disabilities are as effective as communications with others with respect to benefits and services, in accordance with the standards found at 28 C.F.R. 35.160 through 35.164. Where the regulatory provisions referenced in this section use the term "public entity," the term "issuer" shall apply in its place.

(2) Provide appropriate auxiliary aids and services to persons with impaired sensory, manual, or speaking skills, where necessary to afford such persons an equal opportunity to benefit from the service in question.

(3) Ensure that their benefits and services provided through electronic and information technology, including telehealth, are accessible to individuals with disabilities, unless doing so would result in undue financial and administrative burdens or a fundamental alteration in the nature of the health programs or activities. When undue financial and administrative burdens or a fundamental alteration exist, the issuer shall provide information in a format other than an electronic format that would not result in such undue financial and administrative burdens or a fundamental alteration but would ensure, to the maximum extent possible, that individuals with disabilities receive the benefits or services of the plan that are provided through electronic and information technology.

(4) Ensure that their health programs and activities provided through websites comply with the requirements of Title II of the ADA.

(5) Make reasonable modifications to policies, practices, or procedures when such modifications are necessary to avoid discrimination on the basis of disability, unless the issuer can demonstrate that making the modifications would fundamentally alter the nature of the health program or activity. Reasonable modifications must be interpreted consistent with the term as set forth in the ADA Title II regulation at 28 C.F.R. Sec. 35.230(b)(7).

NEW SECTION

WAC 284-43-5970 Equal program access on the basis of sex. An issuer offering a plan, and the issuer's officials, employees, agents, or representatives shall:

(1) Provide individuals equal access with respect to the plan including, but not limited to, plan administration, member communication, medical protocols or criteria for medical necessity or other aspects of plan operations without discrimination on the basis of sex; and

(2) Treat individuals consistent with their gender identity and sexual orientation, except that an issuer may not deny or limit health services that are ordinarily or exclusively available to individuals of one sex, to a transgender, nonbinary, intersex or gender nonconforming individual based on the fact that the individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily or exclusively available.

NEW SECTION

WAC 284-43-5975 Designation of responsible employee and adoption of grievance procedures. (1) Each issuer shall designate at least one employee to coordinate its efforts to comply with and carry out its responsibilities under RCW 48.43.0128 and WAC 284-43-5935 through 284-43-5980, including the investigation of any grievance communicated to it alleging noncompliance with RCW 48.43.0128 or WAC 284-43-5935 through 284-43-5980 or alleging any action that would be prohibited by RCW 48.43.0128 or WAC 284-43-5935 through 284-43-5980.

(2) Each issuer shall adopt grievance procedures that incorporate appropriate due process standards and that provide for the prompt and equitable resolution of grievances alleging any action that would be prohibited by RCW 48.43.0128 or WAC 284-43-5935 through 284-43-5980. An issuer whose grievance procedures comply with 45 C.F.R. 92.7 as in effect on January 1, 2017, will be deemed compliant with this subsection.

NEW SECTION

WAC 284-43-5980 Notice requirement. (1) An issuer offering a plan shall take appropriate initial and continuing steps to notify enrollees, applicants, and members of the public of the following:

(a) The issuer does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation in its benefits and services;

(b) The issuer provides appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate formats, free of charge and in a timely manner, when such aids and services are necessary to ensure an equal opportunity to participate to individuals with disabilities;

(c) The issuer provides language assistance services, including translated documents and oral interpretation, free of charge and in a timely manner, when such services are necessary to provide meaningful access to individuals with limited-English proficiency;

(d) How to obtain the aids and services in (b) and (c) of this subsection;

(e) An identification of, and contact information for, the employee responsible for compliance with RCW 48.43.0128 and WAC 284-43-5935 through 284-43-5980;

(f) How to file a grievance with the issuer related to the issuer's compliance with RCW 48.43.0128 and WAC 284-43-5935 through 284-43-5980; and

(g) How to file a complaint with the commissioner related to the issuer's compliance with RCW 48.43.0128 and WAC 284-43-5935 through this section or with the federal Department of Health and Human Services, Office of Civil Rights related to the issuer's compliance with 42 U.S.C. Sec. 18119 (Sec. 1557 of the Affordable Care Act).

(2) An issuer offering a plan shall:

(a) As described in subsection (7) of this section, post a notice that conveys the information in subsection (1)(a) through (g) of this section; and

(b) As described in subsection (8) of this section, if applicable, post a nondiscrimination statement that conveys the information in subsection (1)(a) of this section.

(3) To satisfy the requirements of this section, issuers may use the sample notices published at 81 Fed. Reg. 31472 through 31473 (May 18, 2016) that convey:

(a) The information in subsection (1)(a) through (g) of this section; and

(b) The information in subsection (1)(a) of this section.

For use beginning January 1, 2022, the notice referenced in (a) of this subsection must be modified to identify the office of the insurance commissioner as the designated entity to file a complaint regarding compliance with RCW 48.43.0128 and WAC 284-43-5935 through 284-43-5980 and the federal Department of Health and Human Services, Office of Civil Rights as the designated entity to file a complaint regarding compliance related to the issuer's compliance with 42 U.S.C. Sec. 18119 (Sec. 1557 of the Affordable Care Act). Until that date, issuers may continue to use the sample notice published at 81 Fed. Reg. 31472 through 31473 (May 18, 2016).

(4) Except to the extent provided otherwise in subsection (5) of this section, each issuer shall:

(a) As described in subsection (7)(a) of this section, post taglines in at least the top fifteen languages spoken by individuals with limited-English proficiency in Washington state; and

(b) As described in subsection (8)(b) of this section, if applicable, post taglines in at least the top two languages spoken by individuals with limited-English proficiency in Washington state.

(5) Plans deemed by the commissioner to have a short-term limited purpose or duration that are offered in Washington state must come into compliance with the language assistance notice and tagline requirements in this section on or before April 1, 2021.

(6) To satisfy the requirements of this section, issuers may use taglines provided by the federal Department of Health and Human Services pursuant to 45 C.F.R. 92.8, as in effect on January 1, 2017.

(7)(a) Each issuer shall post the notice required by subsection (1) of this section and the taglines required by subsection (4)(a) of this section in a conspicuously visible font size:

(i) In significant publications and significant communications targeted to enrollees, applicants, and members of the public, except for significant publications and significant communications that are small-sized, such as postcards and tri-fold brochures;

(ii) In conspicuous physical locations where the issuer interacts with the public; and

(iii) In a conspicuous location on the issuer's website accessible from the home page of the issuer's website.

(b) An issuer may also post the notice and taglines in additional publications and communications.

(8) Each issuer shall post, in a conspicuously visible font size, in significant publications and significant communications that are small-sized, such as postcards and tri-fold brochures:

(a) The nondiscrimination statement required by subsection (1)(a) of this section; and

(b) The taglines required by subsection (4)(b) of this section.

(9) An issuer may combine the content of the notice required in subsection (1) of this section with the content of other notices if the combined notice clearly informs individuals of their rights under RCW 48.43.0128 and WAC 284-43-5935 through 284-43-5980 and 42 U.S.C. Sec. 18119 (Sec. 1557 of the Affordable Care Act).

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

WAC 284-43-7000 Scope and intent—Parity in mental health and substance use disorder benefits. This subchapter applies to ((~~all~~)):

(1) Health plans;

(2) Plans deemed by the commissioner to have a short-term limited purpose or duration;

(3) Plans deemed by the commissioner to be student-only health plans that are guaranteed renewable while the covered person is enrolled as a regular, full-time undergraduate student at an accredited higher education institution; and

(4) Issuers.

The purpose of this ((~~rule~~)) subchapter is to consolidate existing state mental health and ((~~chemical dependency~~)) substance use disorder regulation with federal mental health and substance use disorder parity requirements into state regulation. This rule also provides health plans, plans deemed by the commissioner to have a short-term limited purpose or duration, or to be student-only health plans that are guaranteed renewable while the covered person is enrolled as a regular, full-time undergraduate student at an accredited higher education institution and issuers with the method of demonstrating compliance with these requirements. A plan or issuer's obligation to comply with these requirements is nondelegable; a plan or issuer is obligated to ensure compliance with WAC 284-43-7000 through 284-43-7120, even if they use a third-party vendor or subcontracting arrangement. A plan or issuer is not exempt from any of these requirements because it relied upon a third-party vendor or subcontracting arrangement for ad-

ministration of any aspect of its mental health or substance use disorder benefits or services.

AMENDATORY SECTION (Amending WSR 16-14-106, filed 7/6/16, effective 8/6/16)

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~~)) substance use disorder treatment provided by a treatment program certified by the department of ((~~social and health services~~)) health as meeting standards adopted under chapter ((~~70.96A~~)) 71.24 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 medical, mental health or substance use disorder condition manifesting itself by acute symptoms of sufficient severity, including severe emotional or physical distress or a combination of severe emotional and physical distress, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical ((~~or~~)), mental health or substance use disorder treatment attention to result in a condition placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

Essential health benefits (EHBs). EHBs have the same definition as found in WAC 284-43-5600 or 284-43-5602, as appropriate. The definition of EHBs includes mental health and substance use disorder serv-

ices, including behavioral health treatment. For EHBs, including mental health and substance use disorder benefits, federal and state law prohibit limitations ((~~or~~)) on age, condition, lifetime and annual dollar amounts.

Financial requirements means cost sharing measures such as deductibles, copayments, coinsurance, and out-of-pocket maximums. Financial requirements do not include aggregate lifetime or annual dollar limits.

Health carrier or issuer has the same meaning as RCW 48.43.005(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 and substance use disorder conditions, as defined under the terms of the plan or health insurance coverage and in accordance with applicable federal and state law. Any condition defined by the plan or coverage as being ((~~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~~)), as published by the American Psychiatric Association.

Nonquantitative treatment limitations (NQTL) means processes, strategies, or evidentiary standards, or other factors that are not expressed numerically, but otherwise limit the scope or duration of benefits for treatment. NQTLs include, but are not limited to:

(a) Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;

(b) Formulary design for prescription drugs;

(c) For plans with multiple network tiers (such as preferred providers and participating providers), network tier design;

(d) Standards for provider admission to participate in a network, including reimbursement rates;

(e) Plan methods for determining usual, customary, and reasonable charges;

(f) Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols);

(g) Exclusions based on failure to complete a course of treatment; and

(h) Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage.

Plan means a health plan, a short-term limited duration medical plan or a student-only health plan.

Predominant level: If a type of financial requirement or quantitative treatment limitation applies to substantially all medical surgical benefits in a classification, the predominant level is the level that applies to more than one-half of the medical/surgical benefits in that classification subject to the financial requirement or quantitative treatment limitation.

Quantitative parity analysis means a mathematical test by which plans and issuers determine what level of a financial requirement or quantitative treatment limitation, if any, is the most restrictive level that could be imposed on mental health or substance use disorder benefits within a classification.

Quantitative treatment limitations means types of objectively quantifiable treatment limitations such as frequency of treatments, number of visits, days of coverage, days in a waiting period or other similar limits on the scope or duration of treatment.

Short-term limited duration medical plan means a plan deemed by the commissioner to have a short-term limited purpose or duration.

Student-only health plan means a health plan that is guaranteed renewable while the covered person is enrolled as a regular, full-time undergraduate student at an accredited higher education institution.

Substance use disorder ((~~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)~~)) means a substance-related or addictive disorder listed in the most current version of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* published by the American Psychiatric Association.

Substance use disorder benefits means benefits with respect to items or services for substance use disorders, as defined under the terms of the plan or health insurance coverage and in accordance with applicable federal and state law. Substance use disorder benefits must include payment for reasonable charges for medically necessary treatment and supporting service rendered to an enrollee either within an approved treatment program or by a health care professional that meets the requirements 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 284-43-7040 (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 16-14-106, filed 7/6/16, effective 8/6/16)

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~~)) calculated for each type of financial requirement or treatment limitation within a coverage unit for each classification of services.

(5) Medical/surgical benefits and mental health or substance use disorder benefits cannot be categorized as being offered outside of these six classifications and therefore not subject to the parity analysis.

(a) A ((~~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 284-43-7040 and 284-43-7060 must be performed ((~~within each subclassification~~)) for each type of financial requirement or quantitative treatment limitation within a coverage unit for each subclassification of services.

(7) **Prohibited subclassifications:** All subclassifications other than the permitted subclassification listed in subsection (6) of this section are specifically prohibited. For example, a plan is prohibited from basing a subclassification on generalists and specialists.

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

WAC 284-43-7040 Measuring ((~~health~~)) plan benefits—Financial requirements and quantitative treatment limitations. (1) Classification of benefits must be measured as follows:

(a) By type and level of financial requirement or treatment limitation.

(i) A financial requirement or treatment limitation type includes deductibles, copayments, coinsurance, and out-of-pocket maximums. Types of quantitative treatment limitations include annual, episode, and lifetime day and visit limits.

(ii) A financial requirement or treatment limitation level includes the amount of the financial requirement or treatment limitation type. For example, different levels of coinsurance include twenty percent and thirty percent; different levels of a copayment include fifteen dollars and twenty dollars; different levels of a deductible include two hundred fifty dollars and five hundred dollars; and different levels of an episode limit include twenty-one inpatient days per episode and thirty inpatient days per episode.

(b) A ((~~health~~)) plan or issuer may not apply any financial requirement or quantitative treatment limitation to mental health/substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or quantitative treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification. Whether a financial requirement or treatment limitation is a predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in a classification is determined separately for each type of financial requirement or treatment limitation.

(c) The determination of the portion of medical/surgical benefits in a classification of benefits subject to a financial requirement or quantitative treatment limitation (or subject to any level of a financial requirement or quantitative treatment limitation) is based on the dollar amount of all plan payments for medical/surgical benefits in the classification expected to be paid under the ((~~health~~)) plan for the plan year.

(i) The dollar amount of plan payments is based on the amount the plan allows (before enrollee cost sharing) rather than the amount the plan pays (after enrollee cost sharing) because payment based on the allowed amount covers the full scope of the benefits being provided.

(ii) A reasonable actuarial method must be used to determine the dollar amount expected to be paid under a plan for medical/surgical benefits subject to a financial requirement or quantitative treatment limitation.

(d) Clarifications for certain threshold requirements when performing "substantially all" and "predominant" tests.

(i) For any deductible, the dollar amount of plan payments includes all plan payments with respect to claims that would be subject to the deductible if it had not been satisfied.

(ii) For any out-of-pocket maximum, the dollar amount of plan payments includes all plan payments associated with out-of-pocket payments that are taken into account towards the out-of-pocket maximum as well as all plan payments associated with out-of-pocket payments that would have been made towards the out-of-pocket maximum if it had not been satisfied.

(iii) Similar rules apply for any other thresholds at which the rate of plan payment changes.

(2) Application to different coverage units. If a ((~~health~~)) plan or insurer applies different levels of a financial requirement or quantitative treatment limitation to different coverage units in a classification of medical/surgical benefits, the "predominant" level that applies to "substantially all" medical/surgical benefits in the classification is determined separately for each coverage unit.

(a) Determining "substantially all": A type of financial requirement or quantitative treatment limitation is considered to apply to substantially all medical/surgical benefits in a classification of benefits if it applies to at least two-thirds of all medical/surgical benefits in that classification.

(i) Benefits subject to a zero level for a type of financial requirement are treated as benefits not subject to that type of financial requirement. Benefits with no quantitative treatment limitations are treated as benefits not subject to that type of quantitative treatment limitation.

(ii) If a type of financial requirement or quantitative treatment limitation does not apply to at least two-thirds of all medical/surgical benefits in a classification, the financial requirement or quantitative treatment limitation of that type cannot be applied to mental health or substance use disorder benefits in that classification.

(b) Determining "predominant":

(i) If a type of financial requirement or quantitative treatment limitation applies to at least two-thirds of all medical/surgical benefits in a classification as determined under (a) of this subsection, the level of the financial requirement or quantitative treatment limitation that applies to more than one-half of medical/surgical benefits in that classification subject to the financial requirement or quantitative treatment limitation is the predominant level of that type in a classification of benefits.

(ii) If a type of financial requirement or quantitative treatment limitation applies to at least two-thirds of all medical/surgical benefits in a classification and there is no single level that applies to more than one-half of medical/surgical benefits in the classification subject to the financial requirement or quantitative treatment limitation, the ((~~health~~)) plan or issuer must combine levels until the com-

bination of levels applies to more than one-half of medical/surgical benefits subject to the financial requirement or quantitative treatment limitation in the classification.

(iii) The least restrictive level within the combination is considered the predominant level of that type in the classification. (For this purpose, a ((~~health~~)) plan must combine the most restrictive levels first, with each less restrictive level added to the combination until the combination applies to more than one-half of the benefits subject to the financial requirement or treatment limitation.)

(3) Cumulative financial requirements and cumulative quantitative treatment limitations.

(a) A ((~~health~~)) plan or issuer may not apply cumulative financial requirements (such as deductibles and out-of-pocket maximums) or cumulative quantitative treatment limitations (such as annual or lifetime day or visit limits) for mental health or substance use disorder benefits in a classification that accumulate separately from any cumulative requirement or limitation established for medical/surgical benefits in the same classification.

(b) Cumulative requirements and limitation must also satisfy the quantitative parity analysis.

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

WAC 284-43-7060 Measuring ((~~health~~)) plan benefits—Nonquantitative treatment limitations. (1) A ((~~health~~)) plan or issuer may not impose an NQTL with respect to mental health or substance use disorder in any classification unless, under the terms of the ((~~health~~)) plan as written and in operation, any processes, strategies, evidentiary standards or other factors used in applying the NQTL to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the same classification.

(2) All ((~~health~~)) plan standards, such as in-and-out-of-network geographic limitations, limitations on inpatient services for situations where the ((~~participant~~)) enrollee is a threat to self or others, exclusions for court-ordered and involuntary holds, experimental treatment limitations, service coding, exclusions for services provided by clinical social workers, and network adequacy, while not specifically enumerated in the illustrative list of NQTLs must be applied in a manner that complies with this subsection.

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

WAC 284-43-7080 Prohibited exclusions. (1) Benefits for actual treatment and services rendered may not be denied solely because a course of treatment was interrupted or was not completed.

(2) If a service is prescribed for a mental health condition and is medically necessary, it may not be denied solely on the basis that it is part of a category of services or benefits that is excluded by the terms of the contract.

(3) Benefits for mental health services and substance use disorder may not be limited or denied based solely on age or condition.

(4) Nothing in this section relieves a ((~~health~~)) plan or an issuer from its obligations to pay for a court ordered substance use disorder benefit or mental health benefit when it is medically necessary.

AMENDATORY SECTION (Amending WSR 16-14-106, filed 7/6/16, effective 8/6/16)

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~~))

(a) Plans and issuers must provide disclosures consistent with WAC 284-43-4040, ((~~284-43-3070~~)) 284-43-3170, 284-43-3110, and 284-43-2000((~~, within a reasonable time~~)). For any other disclosures related to an individual's claim, the plan or issuer must provide disclosures within thirty days.

(b) When a claim relates to a protected individual, as defined in RCW 48.43.005, the health carrier must comply with RCW 48.43.505.

(2) ((~~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~~)) enrollee, beneficiary, or contracting provider upon request, within a reasonable time in compliance with WAC 284-43-2000, and in a manner that provides reasonable access to the requestor. This requirement includes information on the processes, strategies, evidentiary standards, and other factors used to apply an NQTL with respect to medical/surgical and mental health or substance use disorder benefits under the ((~~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. When an adverse benefit decision relates to a protected individual, as defined in RCW 48.43.005, the health carrier must comply with RCW 48.43.505.

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

(5) If a ((~~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 16-14-106, filed 7/6/16, effective 8/6/16)

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 284-43-7040.

(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.