

**WAC 284-43-3050 Explanation of right to review.** A carrier must clearly communicate in writing the right to request a review of an adverse benefit determination.

(1) At a minimum, the notice must be sent at the following times:

(a) Upon request;

(b) As part of the notice of adverse benefit determination;

(c) To new enrollees at the time of enrollment; and

(d) Annually thereafter to enrollees, group administrators, and subcontractors of the carrier.

(e) The notice requirement is satisfied if the description of the internal and external review process is included in or attached to the summary health plan descriptions, policy, certificate, membership booklet, outline of coverage or other evidence of coverage provided to participants, beneficiaries, or enrollees.

(2) Each carrier and health plan must ensure that its network providers receive a written explanation of the manner in which adverse benefit determinations may be reviewed on both an expedited and nonexpedited basis.

(3) Any written explanation of the review process must include information about the availability of Washington's designated ombudsman's office, the services it offers, and contact information. A carrier's notice must also specifically direct appellants to the office of the insurance commissioner's consumer protection division for assistance with questions and complaints.

(4) The review process must be accessible to persons who are limited-English speakers, who have literacy problems, or who have physical or mental disabilities that impede their ability to request review or participate in the review process.

(a) Carriers must conform to federal (~~requirements~~) rules and guidance in effect on January 1, 2017, to provide notice of the process in a culturally and linguistically appropriate manner to those seeking review.

(b) In counties where ten percent or more of the population is literate in a specific non-English language, carriers must include in notices a prominently displayed statement in the relevant language or languages, explaining that oral assistance and a written notice in the non-English language are available upon request. Carriers may rely on the most recent data published by the U.S. Department of Health and Human Services Office of Minority Health to determine which counties and which languages require such notices.

(c) This requirement is satisfied if the National Commission on Quality Assurance certifies the carrier is in compliance with this standard as part of the accreditation process.

(5) Each carrier must consistently assist appellants with understanding the review process. Carriers may not use and health plans may not contain procedures or practices that the commissioner determines discourage an appellant from any type of adverse benefit determination review.

(6) If a carrier reverses its initial adverse benefit determination, which it may at any time during the review process, the carrier or health plan must provide appellant with written or electronic notification of the decision immediately, but in no event more than two business days of making the decision.

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

**WAC 284-43-5060 General prescription drug benefit requirements.**

A health carrier must not offer, renew, or issue a health benefit plan providing a prescription drug benefit, which the commissioner determines results or can reasonably be expected to result in an unreasonable restriction on the treatment of patients. A carrier may restrict prescription drug coverage based on contract or plan terms and conditions that otherwise limit coverage, such as ((a preexisting condition waiting period, or)) medical necessity.

(1) A carrier must ensure that a prescription drug benefit covers Federal Drug Administration approved prescribed drugs, medications or drug therapies that are the sole prescription drug available for a covered medical condition.

(2) A prescription drug benefit that only covers generic drugs constitutes an unreasonable restriction on the treatment of patients.

(3) A prescription drug benefit or formulary must not exclude coverage for a nonformulary drug or medication if the only formulary drug available for an enrollee's covered condition is one that the enrollee cannot tolerate or that is not clinically efficacious for the enrollee.

(4) Nothing in this chapter is intended to limit or deter the use of "Dispense as Written" prescriptions, subject to the terms and conditions of the health plan.

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

**WAC 284-43-5400 Purpose and scope.** For plan years beginning on or after January 1, 2014, each nongrandfathered health benefit plan offered, issued, or renewed to small employers or individuals, both inside and outside the Washington health benefit exchange, must provide coverage for a package of essential health benefits, pursuant to RCW 48.43.715. WAC 284-43-5400 through 284-43-5820 explains the regulatory standards defining this coverage, and establishes supplementation of the base-benchmark plan consistent with ((PPACA)) section 9, chapter 33, Laws of 2019 and RCW 48.43.715, and the parameters of the state EHB-benchmark plan.

(1) WAC 284-43-5400 through 284-43-5820 do not apply to a health benefit plan that provides excepted benefits as described in section 2722 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-21), nor to a health benefit plan that qualifies as a grandfathered health plan as defined in RCW 48.43.005.

(2) WAC 284-43-5400 through 284-43-5820 do not require provider reimbursement at the same levels negotiated by the base-benchmark plan's issuer for their plan.

(3) WAC 284-43-5400 through 284-43-5820 do not require a health benefit plan to exclude the services or treatments from coverage that are excluded in the base-benchmark plan.

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

**WAC 284-43-5602 Essential health benefits package benchmark reference plan.** A nongrandfathered individual or small group health benefit plan offered, issued, amended or renewed on or after January 1, 2017, must, at a minimum, include coverage for essential health benefits. "Essential health benefits" means all of the following:

(1) The benefits and services covered by health care service contractor Regence BlueShield as the *Regence Direct Gold* + small group plan, policy form number WW0114CCONMSD and certificate form number WW0114BPPO1SD, offered during the first quarter of 2014. The SERFF form filing number is RGWA-128968362.

(2) The services and items covered by a health benefit plan that are within the categories identified in (~~Section 1302(b) of PPACA~~) sections 1 and 9, chapter 33, Laws of 2019 including, but not limited to:

- (a) Ambulatory patient services;
- (b) Emergency services;
- (c) Hospitalization;
- (d) Maternity and newborn care;
- (e) Mental health and substance use disorder services, including behavioral health treatment;
- (f) Prescription drugs;
- (g) Rehabilitative and habilitative services and devices;
- (h) Laboratory services;
- (i) Preventive and wellness services and chronic disease management;
- (j) Pediatric services, including oral and vision care; and
- (k) Other services as supplemented by the commissioner or required by the secretary of the U.S. Department of Health and Human Services.

(3) Mandated benefits pursuant to Title 48 RCW enacted before December 31, 2011.

(4) This section applies to health plans that have an effective date of January 1, 2017, or later.

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

**WAC 284-43-5622 Plan design.** (1) A nongrandfathered individual or small group health benefit plan offered, issued, or renewed, on or after January 1, 2017, must provide coverage that is substantially equal to the EHB-benchmark plan, as described in WAC 284-43-5642, 284-43-5702, and 284-43-5782.

(a) For plans offered, issued, or renewed for a plan or policy year beginning on or after January 1, 2017, an issuer must offer the EHB-benchmark plan without substituting benefits for the benefits specifically identified in the EHB-benchmark plan.

(b) "Substantially equal" means that:

(i) The scope and level of benefits offered within each essential health benefit category supports a determination by the commissioner that the benefit is a meaningful health benefit;

(ii) The aggregate actuarial value of the benefits across all essential health benefit categories does not vary more than a de minimis amount from the aggregate actuarial value of the EHB-benchmark base plan; and

(iii) Within each essential health benefit category, the actuarial value of the category must not vary more than a de minimis amount from the actuarial value of the category for the EHB-benchmark plan.

(2) An issuer must classify covered services to an essential health benefits category consistent with WAC 284-43-5642, 284-43-5702, and 284-43-5782 for purposes of determining actuarial value. An issuer may not use classification of services to an essential health benefits category for purposes of determining actuarial value as the basis for denying coverage under a health benefit plan.

(3) The base-benchmark plan does not specifically list all types of services, settings and supplies that can be classified to each essential health benefits category. The base-benchmark plan design does not specifically list each covered service, supply or treatment. Coverage for benefits not specifically identified as covered or excluded is determined based on medical necessity. An issuer may use this plan design, provided that each of the essential health benefit categories is specifically covered in a manner substantially equal to the EHB-benchmark plan.

(4) An issuer is not required to exclude services that are specifically excluded by the base-benchmark plan. If an issuer elects to cover a benefit excluded in the base-benchmark plan, the issuer must not include the benefit in its essential health benefits package for purposes of determining actuarial value. A health benefit plan must not exclude a benefit that is specifically included in the base-benchmark plan.

(5) An issuer must not apply visit limitations or limit the scope of the benefit category based on the type of provider delivering the service, other than requiring that the service must be within the provider's scope of license for purposes of coverage. This obligation does not require an issuer to contract with any willing provider, nor is an issuer restricted from establishing reasonable requirements for credentialing of and access to providers within its network.

(6) Telemedicine or telehealth services are considered a method of accessing services, and are not a separate benefit for purposes of the essential health benefits package. Issuers must provide essential health benefits consistent with the requirements of (~~((add RCW citation for SSB 5175 when it becomes available))~~) RCW 48.43.735.

(7) Consistent with state and federal law, a health benefit plan must not contain an exclusion that unreasonably restricts access to medically necessary services for populations with special needs including, but not limited to, a chronic condition caused by illness or injury, either acquired or congenital.

(8) Benefits under each category set forth in WAC 284-43-5642, 284-43-5702, or 284-43-5782 must be covered for both pediatric and adult populations unless:

(a) A benefit is specifically limited to a particular age group in the base-benchmark plan and such limitation is consistent with state and federal law; or

(b) The category of essential health benefits is specifically stated to be applicable only to the pediatric population, such as pediatric oral services.

(9) A health benefit plan must not be offered if the commissioner determines that:

(a) It creates a risk of biased selection based on health status;  
(b) The benefits within an essential health benefit category are limited so that the coverage for the category is not a meaningful health benefit; or

(c) The benefit has a discriminatory effect in practice, outcome or purpose in relation to age, present or predicted disability, and expected length of life, degree of medical dependency, quality of life or other health conditions, race, gender, national origin, sexual orientation and gender identity or in the application of Section 511 of Public Law 110-343 (the federal Mental Health Parity and Addiction Equity Act of 2008).

(10) An issuer must not impose annual or lifetime dollar limits on an essential health benefit, other than those permitted under WAC 284-43-5642, 284-43-5702, and 284-43-5782.

(11) This section applies to health plans that have an effective date of January 1, 2017, or later.

AMENDATORY SECTION (Amending WSR 16-19-085, filed 9/20/16, effective 10/21/16)

**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; and

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

(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) Hospitalization where mental illness is the primary diagnosis to the extent that it is classified under the mental health and substance use disorder benefits category;

(ii) 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;

(iii) 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.

(iv) Reversal of sterilizations; and

(v) 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, and should not be included in essential health benefit plans:

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

(ii) The base-benchmark plan excludes coverage for sexual reassignment treatment, surgery, or counseling services. Health plans must cover such services consistent with 42 U.S.C. 18116, Section 1557, section 15, chapter 33, Laws of 2019, RCW 48.30.300 and 49.60.040.

(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, but nothing in this section requires an issuer to offer the benefit, consistent with 42 U.S.C. 18023 (b) (a) (A) (i) and 45 C.F.R. 156.115.



(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)*, 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 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 may not include these benefits 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 42 U.S.C. 18116, Section 1557, 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 for women with reproductive capacity;

(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);

(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.

(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 func-

tion 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 per-

sonal 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.

(v) Chronic disease management services, which typically include, but are not limited to, a treatment plan with regular monitoring, co-

ordination 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 Section 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) This section applies to health plans that have an effective date of January 1, 2017, or later.

NEW SECTION

**WAC 284-43-5910 Prohibition on organ transplant waiting periods.**

An issuer offering an individual, small group or large group health plan may not impose waiting periods for organ transplant services in any health plan.

NEW SECTION

**WAC 284-43-5920 Health plan rescission.**

A health plan cannot be rescinded by an issuer during the coverage period, except for an enrollee who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan or coverage. If the plan is rescinded, the issuer must refund to the enrollee all payments made by or on behalf of the enrollee prior to the rescission date or the expiration date of the health plan.

NEW SECTION

**WAC 284-43-5930 Qualified health plan marketing and benefit design.**

(1) An issuer offering qualified health plans as defined in 42 U.S.C. 18021, and its officials, employees, agents and representatives cannot employ marketing practices or benefit designs with respect to these plans that will have the effect of discouraging the enrollment of individuals with significant health needs.

(2) In implementing this section, issuers may rely upon regulations and guidance issued by the United States Department of Health and Human Services Office of Civil Rights in effect as of January 1, 2017. Actions taken by an issuer that are consistent with such regulations and guidance will be deemed by the commissioner to constitute compliance with section 16, chapter 33, Laws of 2019 and this section.

NEW SECTION

**WAC 284-43-5940 Nondiscrimination in individual and small group health plans.** (1) An issuer offering a nongrandfathered individual or small group health plan may not:

(a) In its benefit design or implementation of its benefit design in such health plans, discriminate 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 such health plans:

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

(iv) Deny or limit coverage, deny or limit coverage of a claim, 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;

(v) Have or implement a categorical coverage exclusion or limitation for all health services related to gender transition; 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 health services related to gender transition if such denial, limitation, or restriction results in discrimination against a transgender individual.

(2) The enumeration of specific forms of discrimination in subsection (1)(b)(ii) through (vi) 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 reasonable medical management techniques.

(4) In implementing this section, issuers may rely upon regulations and guidance issued by the United States Department of Health and Human Services Office of Civil Rights in effect as of January 1, 2017. Actions taken by an issuer that are consistent with such regulations and guidance will be deemed by the commissioner to constitute compliance with section 15, chapter 33, Laws of 2019 and this section.

#### NEW SECTION

**WAC 284-43-5950 Definitions.** For purposes of WAC 284-43-5960 through 284-43-5980, the definitions apply unless the context clearly requires otherwise:

(1) "Individual with a disability" means any individual who has a disability as defined for the purpose of section 504 of the Rehabilitation Act of 1973, 29 U.S.C. 705(20)(B) through (F), as amended.

(2) "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.

(3) "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.

(4) "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.

(5) "Taglines" means short statements written in at least the top fifteen non-English languages in Washington state that indicate the availability of language assistance services free of charge.

#### NEW SECTION

**WAC 284-43-5960 Access for individuals with limited-English proficiency.** (1) Each issuer shall take reasonable steps to provide meaningful access to each individual with limited-English proficiency enrolled in their individual or small group health plans.

(2) In evaluating whether an issuer has met its obligation under subsection (1) of this section, the commissioner shall:

(a) Evaluate, and give substantial weight to, the nature and importance of the health plan 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 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.

(4) Subject to subsection (2) of this section:

(a) An issuer shall offer a qualified interpreter to an individual with limited-English proficiency who is enrolled in an individual or small group health plan 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 for an enrollee in an individual or small group health plan.

(5) An issuer shall not, with respect to enrollees in an individual or small group health plan:

(a) Require an individual with limited-English proficiency to provide his or her 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) An issuer that provides a qualified interpreter for an individual with limited-English proficiency who is an enrollee in an individual or small group health plan 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) Nothing in this section shall be construed to require an individual with limited-English proficiency to accept language assistance services.

(8) In implementing this section, issuers may rely upon regulations and any guidance issued by the United States Department of Health and Human Services Office of Civil Rights in effect as of January 1, 2017. Actions taken by an issuer that are consistent with such regulations and guidance will be deemed by the commissioner to constitute compliance with section 15, chapter 33, Laws of 2019 and this section.

NEW SECTION

**WAC 284-43-5970 Notice requirements.** (1) Each issuer offering a nongrandfathered individual or small group health plan shall take appropriate initial and continuing steps to notify enrollees in such health plans of the following:

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

(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 described in this section and in WAC 284-43-5960;

(e) An identification of, and contact information for, the responsible employee designated pursuant to WAC 284-43-5980;

(f) The availability of the grievance procedure and how to file a grievance, pursuant to WAC 284-43-5980; and

(g) How to file a discrimination complaint with the commissioner.

(2) Each issuer offering a nongrandfathered health plan in the individual or small group markets shall, with respect to such health plans:

(a) As described in subsection (4) of this section, post a notice that conveys the information in subsection (4) of this section; and

(b) As described in subsection (5) of this section, if applicable, post a nondiscrimination statement that conveys the information in subsection (1) of this section.

(3) Each issuer offering a nongrandfathered health plan in the individual or small group markets shall, with respect to such health plans:

(a) As described in subsection (4) 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 (5) of this section, if applicable, post taglines in at least the top two languages spoken by individuals with limited-English proficiency in Washington state.

(4) Each issuer offering a nongrandfathered health plan in the individual or small group markets shall, with respect to such health plans, post the notice required by subsection (1) of this section and the taglines required by subsection (3) of this section in a conspicuously-visible font size:

(a) 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;

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

(c) In a conspicuous location on the issuer's web site accessible from the home page of the issuer's web site.

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

(6) Each issuer offering a nongrandfathered health plan in the individual or small group markets shall, with respect to such health plans 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 (2) of this section; and

(b) The taglines required by subsection (3) of this section.

(7) Each issuer offering a nongrandfathered health plan in the individual or small group markets may, with respect to such health plans, 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 section 15, chapter 33, Laws of 2019 and WAC 284-43-5930 through 284-43-5970.

(8) In implementing this section, issuers may rely upon regulations and guidance issued by the United States Department of Health and Human Services Office of Civil Rights in effect as of January 1, 2017. Actions taken by an issuer that are consistent with such regulations and guidance will be deemed by the commissioner to constitute compliance with section 15, chapter 33, Laws of 2019 and this section.

#### NEW SECTION

**WAC 284-43-5980 Designation of responsible employee and adoption of grievance procedures.** (1) Each issuer offering a nongrandfathered health plan in the individual or small group markets shall designate at least one employee to coordinate its efforts to comply with and carry out its responsibilities under sections 15 and 16, chapter 33, Laws of 2019 and WAC 284-43-5930 through 284-43-5970, including the investigation of any grievance communicated to it alleging noncompliance with these provisions or alleging any action that would be prohibited by these provisions.

(2) Each issuer offering a nongrandfathered health plan in the individual or small group markets 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 sections 15 and 16, chapter 33, Laws of 2019 and WAC 284-43-5930 through 284-43-5970.

(3) In implementing this section, issuers may rely upon regulations and guidance issued by the United States Department of Health and Human Services Office of Civil Rights in effect as of January 1, 2017. Actions taken by an issuer that are consistent with such regulations and guidance will be deemed by the commissioner to constitute compliance with sections 15 and 16, chapter 33, Laws of 2019 and this section.