The Honorable Robert S. Lasnik

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON AT SEATTLE

ANDREA SCHMITT; ELIZABETH MOHUNDRO; and O.L. by and through her parents, J.L. and K.L., each on their own behalf, and on behalf of similarly situated individuals, Plaintiffs, v. KAISER FOUNDATION HEALTH PLAN OF WASHINGTON; KAISER FOUNDATION HEALTH PLAN OF WASHINGTON OPTIONS, INC.; KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST; and KAISER FOUNDATION HEALTH PLAN, INC., Defendants.	CASE NO. 2:17-cv-01611-RSL DECLARATION OF JESSICA HAMP

I, Jessica Hamp, declare under the penalty of perjury under the laws of the United States of America, the following:

1. I am the Director of Operations, Benefits Administration for Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, (collectively, "Kaiser"). I make this declaration based on personal knowledge and a review of the regularly maintained business records at Kaiser. I am competent to testify.

2. Health benefits in insured health plans in Washington are carefully regulated by the Washington Office of the Insurance Commissioner (OIC). Not only does the state mandate the specific benefits which must be offered, but it also reviews and approves (or disapproves) premiums rates, as well as the forms that are used to describe coverages,

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which is the benefit design. No health insurer can sell a plan that has not been approved by our state's regulator. Every time a plan is renewed, it must be submitted for approval.

3. The most important factor for Kaiser in designing health benefits is compliance with applicable laws. While Kaiser has multiple resources that ensure our plans are in compliance with the law, the most important compliance determination is the one done by our regulator, the OIC, which we rely on as authoritative. As a general practice, Kaiser reviews guidance published by the OIC, as well as final rulemaking, to inform benefit plan design.

4. The OIC reviews and approves plans based, in part, on its "Analyst Checklist." A true copy of the Checklist for 2022 is attached as **Exhibit A** (Kaiser 002111-2255). The OIC also issues guidance, including providing responses to comments during rule making, as well as formal guidance.

5. The Checklist specifically requires the OIC to review for "unfair and discriminatory practices" including health plan benefit design which discriminates against individuals because of their present or predicted disability. (Kaiser p. 002241).

6. The OIC specifically reviewed Kaiser's insured plans for discrimination in benefit design (including those that contain the Exclusion[1] at issue in this case), including for 2022, and approved them as non-discriminatory.

7. The OIC also specifically examined the Exclusion for plan year 2016, and approved it with language changes for clarification. A true copy of the OIC comments and response is attached as **Exhibit B** (CONFIDENTIAL Kaiser pp. 1981-1983).

8. A hallmark of the Affordable Care Act was the balance between "affordability" and comprehensive coverage. To make this balance, the Affordable Care Act outlined the categories of "Essential Health Benefits" (applicable to individual and small group insured health plans) that must be covered. For states like Washington that operate their own Exchange, the state decides what are the "Essential Health Benefits." It also regulates the premiums that can be charged for those Essential Health Benefits. The Office of the Insurance Commissioner issued regulations describing what is and what is not required to be covered as Essential Health Benefits. Because Essential Health Benefits cannot be designed in ways that discriminate against individuals because of disability, we also relied on the OIC's definition of EHB to ensure our benefit design was not discriminatory.

9. During the OIC's rulemaking relating to the state's 2017 update for Essential Health Benefits, the OIC issued responses to comments specifically addressing whether the exclusion of non-cochlear hearing aids was disability discrimination under non-discrimination law. The OIC determined it was not. A true copy of the OIC's concise explanatory statement is attached as **Exhibit C**. (Kaiser 4446-47; 4390-4429).

[1] This refers to the exclusion portion of the hearing benefit in Kaiser's base benefit plan. The hearing benefit covers cochlear implants, Bone Anchored Hearing Aids, and hearing examinations relating to hearing loss and excludes hearing care, routine hearing exams and certain types of hearing aids and related services ("Exclusion").

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10. Kaiser also offers insured health plans that are sold on the Washington Health Benefit Exchange (WAHBE or the Exchange). The Exchange, created as part of the Affordable Care Act, is the marketplace that the state of Washington established where health insurance can be offered to individuals and families and must include the mandated Essential Health Benefits. In addition to approval by the OIC, plans must also meet additional WAHBE criteria, in order to be certified by WAHBE and to be available for sale on the Exchange. Plans approved and certified for sale on the Exchange are described as "qualified health plans."

11. One of the criteria that is reviewed and must be met each year in order to be a qualified health plan certified for the Exchange is compliance with federal and state non-discrimination rules. A true copy of the Guidance for Participation of Health Plans in the Washington Health Benefit Exchange for 2022 is attached as **Exhibit D** (Kaiser 3973-4009). The non-discrimination provision is on page 12.

12. Kaiser's plans have routinely been certified as qualified health plans by WAHBE as compliant with state and federal law, including non-discrimination law. The Washington Health Benefit Exchange Board certified, for example, the Kaiser Foundation Health Plan of Washington Individual & Family 2022 Flex Gold plan. That plan contained the Exclusion. A true copy of the WAHBE Board's Resolution and the referenced Gold Flex Plan, is attached as **Exhibit E** (Kaiser 002299-2301; 3816-3875).

13. We also undertook our own review to ensure our benefit designs, including the Exclusion, were compliant with non-discrimination laws. A true copy of documents relating to such review are attached as **Exhibit F**. (CONFIDENTIAL Kaiser pp. 3594-97; 4010-19; 3582; 4354-57; 4374). We have made changes to benefit design to ensure compliance with non-discrimination rules, including elimination of age limits on benefits and adopting expanded language relating to gender health services.

14. Kaiser has offered hearing aid coverage for all large group plans for many years. Kaiser also covers hearing aids in its Medicare Advantage plans. The base benefit plan, designed to be the most affordable plan offering major medical benefits, contains the Exclusion. Kaiser considered whether to add coverage for hearing aids, along with adult optical hardware (glasses), as an enhanced benefit in its individual and small group base benefit plan. That consideration followed shortly after the OIC had determined that the exclusion of hearing aids in individual and small group policies was not disability discrimination. The analysis of whether to provide this optional coverage followed the same process that we use to evaluate benefits generally: what does our regulator say; evaluation of local market; cost; and stakeholder input. Those are the reasons that coverage for hearing aids was not offered in the base benefit plan—not discrimination against the disabled.

15. Kaiser would have been an outlier in the Washington health benefits market if hearing aid coverage was offered in the base benefits plan. As an outlier, it would require members to pay higher premium (making the product more expensive compared to our competitors) and would subject Kaiser to adverse selection compared to our competitors. That is, people

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who want the service would disproportionately enroll in the plan which can dramatically skew the ability to determine cost. Since the new 2024 hearing aid mandate applies to *all* Washington large group health insurers, these concerns no longer apply.

16. Hearing aids and optical hardware (eyeglasses) are not considered durable medical equipment by Kaiser or in the health insurance industry generally. The reason why Kaiser uses hearing aid (and adult vision coverage) riders to cover hearing aids is because there is not a benefit to which coverage otherwise would apply if the Exclusion were removed.

I declare under penalty and perjury under the laws of the United States that the foregoing is true and correct.

EXECUTED this ___ day of 6/16/2023, 2023, at Seattle, Washington.

DocuSigned by:
Jessica Hamp
BFB8609436D1406...

Jessica Hamp

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CERTIFICATE OF SERVICE

I, Luci Brock, affirm and state that I am employed by Karr Tuttle Campbell in King County, in the State of Washington. I am over the age of 18 and not a party to this action. My business address is: 701 Fifth Avenue, Suite 3300, Seattle, Washington 98104. On this day, I caused a true and correct copy of the foregoing document to be filed with the Court and served on the parties listed below in the manner indicated.

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☒ CM/ECF via court's website

I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct, to the best of my knowledge.

Executed on this 20th day of June, 2023, at Seattle, Washington.

s/ Luci Brock
Luci Brock
Legal Assistant

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Exhibit A

OFFICE of the INSURANCE COMMISSIONER
WASHINGTON STATE

ANALYST CHECKLIST

HCSC – SMALL GROUP MAJOR MEDICAL PLANS

Issuer: _____

SERFF Tracker ID: _____

Network Name: _____
Sub-networks: _____
Provider Network Type (Single or Tiered*): _____
Effective Date: _____
Network Line of Business (dental, medical, medical and vision, vision):
_____

* TIERED as described in WAC 284-170-330

GENERAL REVIEW REQUIREMENTS

Authority to Review Contract – RCW 48.44.040, RCW 48.43.715
WAC 284-43-5622, WAC 284-43-5642, WAC 284-43-5720, WAC 284-43-5800

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Alternative to Hospitalization	Requirement to Cover Home Care in Lieu of Hospitalization	WAC 284-44-500(1)	As an alternative to hospitalization or institutionalization and with the intent to cover placement of the enrollee in the most appropriate, cost-effective setting, plan must include substitution of home health care in lieu of hospitalization or other institutional care, furnished by home health, hospice and home care agencies licensed under chapter 70.127 RCW, at equal or lesser cost.		
		WAC 284-44-500(2)	• Such expenses may include coverage for durable medical equipment which permits the insured to stay at home, care provided in Alzheimer's centers, adult family homes, assisted living facilities, congregate care facilities, adult day health care, home health, hospice and home care, or similar alternative care arrangements		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Alternative to Hospitalization (Cont'd)	Requirement to Cover Home Care in Lieu of Hospitalization (Cont'd)		which provide necessary care in less restrictive or less expensive environments.		
		WAC 284-44-500(3)	• Such substitution must be made only with the consent of the insured and on the recommendation of the insured's attending physician or licensed provider that such services will adequately meet the insured patient's needs. The decision to substitute less expensive or less intensive services shall be determined based on the medical needs of the individual enrollee.		
		WAC 284-44-500(4)	• HCSC may require that home health agencies or similar alternative care providers have written treatment plans which are approved by the enrollee's attending physician or other licensed provider.		
		WAC 284-44-500(5)	• Coverage may be limited to no less than the maximum benefits which would be payable for hospital or other institutional expenses under the contract, and may include all deductibles and coinsurances which would be payable by the insured under the hospital or other institutional expense coverage of the insured's contract.		
Ambulatory Patient Services (EHB)	General Ambulatory Patient Services Requirements	42 USC §18021 (a)(1)(B); 42 USC 18022 (b)(1)(A)	Plan must cover "ambulatory patient services" substantially equal to the base-benchmark plan. In determining AV, 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. WAC 284-43-5642(1).		
		WAC 284-43-5642(1)(a)(i)	Plan must cover the following, which are specifically covered by the base-benchmark plan, and classify them as ambulatory patient services: • Home and outpatient dialysis services;		
		WAC 284-43-5642(1)(a)(ii)	• Hospice and home health care, including skilled nursing care as an alternative to hospitalization consistent with state law.		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Ambulatory Patient Services(EHB) (Cont'd)	General Ambulatory Patient Services Requirements (Cont'd)	WAC 284-43-5642(1)(a)(iii)	• Provider office visits and treatments, and associated supplies and services, including therapeutic injections and related supplies;		
		WAC 284-43-5642(1)(a)(iv)	• Urgent care center visits, including provider services, facility costs and supplies;		
		WAC 284-43-5642(1)(a)(v)	• Ambulatory surgical center professional services, including anesthesiology, professional surgical services, surgical supplies and facility costs;		
		WAC 284-43-5642(1)(a)(vi)	• Diagnostic procedures including colonoscopies, cardiovascular testing, pulmonary function studies and neurology/neuromuscular procedures; and		
		WAC 284-43-5642(1)(a)(vii)	• Provider contraceptive services and supplies including, but not limited to, vasectomy, tubal ligation and insertion or extraction of FDA-approved contraceptive devices.		
		WAC 284-43-5642(1)(b)(iii); 42 USC §18021 (a)(1)(B); 42 USC 18022(b)(1)(I)	• Plan must cover oral surgery related to trauma and injury. 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;		
	Optional Services	WAC 284-43-5642 (1)(b)(i)	Plan may, but is not required to, cover: • Infertility treatment and reversal of voluntary sterilization;		
		(ii)	• Routine foot care for those that are not diabetic;		
		WAC 284-43-5642(1)(b)(iii)	• Dental services following injury to sound natural teeth. (Must cover services listed above in required services.)		
		(iv)	• Private duty nursing for hospice care and home health care;		
		WAC 284-43-5642(1)(b)(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;		
		WAC 284-43-5642(1)(b)(vii)	• Hearing care, routine hearing examinations, programs or treatment for hearing loss including, but not limited to, externally worn or		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Ambulatory Patient Services (EHB) (Cont'd)			surgically implanted hearing aids, and the surgery and services necessary to implant them. 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 EHB category; and		
		284-43-5642 (1)(b)(viii)	• Obesity or weight reduction or control other than covered nutritional counseling. (Must cover services listed above as required services.)		
	Allowable Limitations	WAC 284-43-5642(1)(c)(i)	The base-benchmark plan's visit limitations on services in the ambulatory patient services category include: • Ten spinal manipulation services per calendar year without referral;		
		(ii)	• Twelve acupuncture services per calendar year without referral;		
		WAC 284-43-5642(1)(c)(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.		
	State-Required Ambulatory Services Benefits	WAC 284-43-5642(1)(d)(i)	Plan must include the following State benefit requirements classified to the ambulatory patient services category: • Chiropractic care;		
		(1)(d)(ii)	• TMJ disorder treatment;		
		RCW 48.44.315	• Diabetes-related care and supplies WAC 284-43-5642(1)(d)(iii)		
Appeals Procedures	Internal Appeals / Review of Adverse Benefit Decisions Under **Both**	42 U.S.C. §300gg-19 (a); 45 C.F.R. §147.136(b)	Does the plan have a fully operational, comprehensive process for review of appeals / adverse benefit determinations? RCW 48.43.530(1); WAC 284-43-3030(1)		
		WAC 284-43-4020(1)	• The issuer's process for review of adverse benefit determinations must meet accepted national certification standards such as those used by the National Committee for		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Appeals Procedures (Cont'd)	Grand-fathered and Non-Grand-fathered Plans		Quality Assurance, except as otherwise required under Chapter 284-43 WAC.		
		RCW 48.43.530 (8)	Does the contract provide a clear explanation of the appeal / review of adverse benefit determination process? WAC 284-43-3050; WAC 284-43-4020(2)(a)		
		RCW 48.43.530(9)	The process must be accessible to enrollees who are limited English speakers, who have literacy problems, or who have physical or mental disabilities that impede their ability to file an appeal or review of adverse benefit determination. WAC 284-43-3050(4); WAC 284-43-4020(2)(b)		
		RCW 48.43.530(3)	Each carrier and health plan must provide written notice to an enrollee or the enrollee's designated representative, and the enrollee's provider, of its decision to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits, including the admission to or continued stay in a health care facility. Such notice must be sent directly to a protected individual receiving care when accessing sensitive health care services or when a protected individual has requested confidential communication pursuant to RCW 48.43.505(5)		
		RCW 48.43.530(4) (a)and (b)	An issuer must process as an appeal / review of adverse benefit determination an enrollee's written or oral request that the issuer reconsider its decision to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits, including the admission to, or continued stay in, a health care facility.		
		RCW 48.43.530(4)(c)	• The issuer may not require that an enrollee file a complaint or grievance prior to seeking an appeal or review of an adverse benefit determination.		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Appeals Procedures (Cont'd)	Internal Appeals Under Grand-fathered Health Plans	RCW 48.43.530(7)	Does the contract notify the enrollee that, when the enrollee requests reconsideration of a decision to modify, reduce, or terminate an otherwise covered health service that the enrollee is receiving through the health plan, based upon a finding that the health service, or level of health service, is no longer medically necessary or appropriate, the issuer must continue to provide that health service until the appeal / review of adverse benefit determination is resolved?		
		RCW 48.43.530(5)(b)	The issuer must assist the enrollee with the appeal process. WAC 284-43-4020(2)(d)		
		RCW 48.43.530(5)(d)	The issuer must cooperate with any representative authorized in writing by the enrollee. WAC 284-43-4020(2)(e)		
		RCW 48.43.530(5)(e)	The issuer must consider all information submitted by the enrollee or representative. WAC 284-43-4020(2)(f); WAC 284-43-4040(5)		
		RCW 48.43.530(5)(f)	The issuer must investigate and resolve all appeals / requests for review of adverse benefit determination. WAC 284-43-4020(2)(g)		
		RCW 48.43.530(4)(a)	The review of a decision to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits, including admission to, or continued stay in, a health care facility, is called and processed as an "Appeal".		
		WAC 284-43-4020(2)(c)	The issuer must: • respond to oral and written appeals in a timely and thorough manner; • notify the enrollee that an appeal has been received.		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Appeals Procedures (Cont'd)	Internal Appeals under Grand-fathered Health Plans (cont'd)	WAC 284-43-4020(2)(h)	Provide information on the enrollee's right to obtain second opinions.		
		WAC 284-43-4040(1)	An enrollee or the enrollee's representative, including the treating provider (regardless of whether the provider is contracted with the issuer) acting on behalf of the enrollee may appeal an adverse determination in writing. • The issuer must reconsider the adverse determination and notify the enrollee of its decision within fourteen days of receipt of the appeal. • Issuer can extend time to complete the appeal up to a max of 30 days if it notifies the enrollee an extension is necessary; Issuer can delay the decision beyond thirty days ONLY with the informed, written consent of the enrollee.		
		RCW 48.43.535(7)(a); WAC 284-43-4040(2)	Issuer must expedite either a written or oral appeal whenever delay would jeopardize the enrollee's life or materially jeopardize the enrollee's health. • Must issue its decision no later than seventy-two hours after receipt of the appeal. • If the treating health care provider determines that delay could jeopardize the enrollee's health or ability to regain maximum function, the issuer must presume the need for expeditious review, including the need for expedited determination in any independent review.		
		WAC 284-43-4040(4)	Appeals of adverse determinations shall be evaluated by health care providers who were not involved in the initial decision and who have appropriate expertise in the field of medicine that encompasses the enrollee's condition or disease.		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Appeals Procedures (Cont'd)	Internal Appeals Under Grand-fathered Health Plans (cont'd)	WAC 284-43-4040(6)	The carrier shall issue to affected parties and to any provider acting on behalf of the enrollee a written notification of the adverse determination that includes the actual reasons for the determination, the instructions for obtaining an appeal of the carrier's decision, a written statement of the clinical rationale for the decision, and instructions for obtaining the clinical review criteria used to make the determination.		
	Internal Reviews of Adverse Benefit Determi-nations under Non-Grand-fathered Health Plans	WAC 284-43-3110	Carrier's process for review of an adverse benefit determination must include an opportunity for internal review.		
		29 C.F.R. §2560.503-1(m)(4); RCW 48.43.530(4)(b)	The review of a decision to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits, including admission to, or continued stay in, a health care facility, is processed as a "review of an adverse benefit determination" as defined in RCW 48.43.005(2).		
		45 C.F.R. §147.136 (a)(2)(i)	A denial or rescission of coverage is subject to review of adverse benefit determination, whether or not the rescission has an adverse effect on any particular benefit at the time. RCW 48.43.530(11); WAC 284-43-3110(8)		
		WAC 284-43-3030(4)	The issuer must accept a request for internal review of adverse benefit determination if it is received within 180 days of the enrollee's receipt of the determination.		
		RCW 48.43.530(5)(a)	In order to process an adverse benefit determination, the issuer must: Provide written notice of receipt to the enrollee within 72 hours after a request for review of the adverse benefit decision is received;		
		RCW 48.43.530(5)(g);	Provide written notice of its resolution to the enrollee and, with the permission of the enrollee, to the enrollee's providers. WAC 284-43-3030(4)		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Appeals Procedures (Cont'd)	Internal Reviews of Adverse Benefit Determi-nations under Non-Grand-fathered Health Plans (Cont'd)	WAC 284-43-3110(1)	• The issuer must notify the appellant of the review decision within fourteen days of receipt of the request for review, unless the adverse benefit determination involves an experimental or investigational treatment.		
		WAC 284-43-3110(2)	• For good cause, an issuer may extend the time it takes to make a review determination by up to sixteen additional days without the appellant's written consent, but must notify appellant of the extension and the reason for the extension. • The issuer may request further extension of its response time only if the appellant consents to a specific request for a further extension, the consent is reduced to writing, and includes a specific agreed-upon date for determination. In its request for the appellant's consent, the issuer must explain that waiver of the response time is not compulsory.		
		WAC 284-43-3110(3)	• The issuer must provide the appellant with any new or additional evidence or rationale considered, whether relied upon, generated by, or at the direction of the issuer in connection with the claim. This must be provided free of charge to the appellant and sufficiently in advance of the date the notice of final internal review must be provided. • If the appellant requests an extension in order to respond to any new or additional rationale or evidence, the issuer must extend the determination date for a reasonable amount of time, which may not be less than two days.		
		WAC 284-43-3110(4)	• The review process must provide the appellant with the opportunity to submit information, documents, written comments, records, evidence, and testimony, including those obtained through a second opinion.		
			• The appellant must have the right to review the issuer's file and		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Appeals Procedures (Cont'd)	Internal Reviews of Adverse Benefit Determi-nations Under Non-Grandfathered Health Plans (cont'd)		obtain a free copy of all documents, records, and information relevant to any claim that is the subject of the determination being appealed.		
		WAC 284-43-3110(5)	• The internal review process must include the requirement that the issuer affirmatively review and investigate the appealed determination, and consider all information submitted by the appellant prior to issuing a determination.		
		WAC 284-43-3110(6)	• Review of adverse determinations must be performed by health care providers or staff who were not involved in the initial decision, and who are not subordinates of the persons involved in the initial decision. If the determination involves, even in part, medical judgment, the reviewer must be or must consult with a health care professional who has appropriate training and experience in the field of medicine encompassing the appellant's condition or disease and make a determination that is within the clinical standard of care for an appellant's disease or condition.		
		WAC 284-43-3110(7)	The internal review process for group health plans may require two levels of internal review prior to bringing a civil action.		
		WAC 284-43-3050(3)	Does the contract include information about the availability of Washington's designated ombudsman's office, the services it offers, and contact information? Does the contract specifically direct appellants to the OIC's consumer protection division for assistance with questions and complaints?		
		WAC 284-43-3050(4)(a)	• Does the contract's notice of the process for review of adverse benefit decisions conform to federal requirements to provide this notice in a culturally and linguistically appropriate manner to those seeking review?		
		WAC 284-43-3050(4)(b)	• In counties where ten percent or more of the population is		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Appeals Procedures (Cont'd)	Internal Reviews of Adverse Benefit Determi-nations Under Non-Grand-fathered Health Plans (cont'd)		literate in a specific non-English language, issuers 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.		
		WAC 284-43-3050(4)(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.		
		WAC 284-43-3050(5)	Contract may not contain procedures or practices that discourage an appellant from any type of adverse benefit determination review.		
		WAC 284-43-3050(6)	Issuer may reverse its initial adverse benefit determination at any time during the review process. In that case, issuer must provide written or electronic notification immediately, but in no event more than two business days of making the decision.		
		WAC 284-43-3090(1)	An issuer can provide documents related to adverse benefit determinations and review of adverse benefit determinations electronically, but ONLY IF:		
		WAC 284-43-3090(2)(a)	• The enrollee affirmatively consents, in electronic or nonelectronic form, to receiving documents through electronic media and has not withdrawn such consent.		
		WAC 284-43-3090(2)(b)	• If the documents are to be furnished electronically, the appellant must have affirmatively consented or confirmed consent electronically, in a manner that reasonably demonstrates his ability to access the electronically-provided information, and must have provided an address for receipt of electronically furnished documents;		
		WAC 284-43-3090(2)(c)	• Prior to consenting, the enrollee must be provided, in electronic or nonelectronic form, a clear and conspicuous statement		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Appeals Procedures (Cont'd)	Internal Reviews of Adverse Benefit Determinations Under Non-Grandfathered Health Plans (cont'd)		indicating:		
		WAC 284-43-3090(2)(c)(i)	○ The types of documents to which the consent would apply;		
		WAC 284-43-3090(2)(c)(ii)	○ That consent can be withdrawn at any time without charge;		
		WAC 284-43-3090(2)(c)(iii)	○ The procedures for withdrawing consent and for updating the individual's electronic address for receipt of electronically furnished documents or other information;		
		WAC 284-43-3090(2)(c)(iv)	○ The right to request and obtain a paper version of an electronically furnished document, including whether the paper version will be provided free of charge; and		
		WAC 284-43-3090(2)(c)(v)	○ Any hardware and software requirements for accessing and retaining the documents.		
		WAC 284-43-3090(3)	After consent, if a change in hardware or software requirements to access or retain electronic documents creates a material risk that an enrollee will be unable to access or retain such documents, the issuer must provide information about the new requirements and the opportunity to withdraw consent without consequences. The issuer must request and receive a new consent to electronically provided documents, following such a hardware or software requirement change.		
		WAC 284-43-3090(1)(c) and (d)	With respect to documents regarding adverse benefit determinations and review of such determinations, an issuer furnishing such documents electronically is deemed to satisfy the notice and disclosure requirements if: • at the time a document is furnished electronically, the issuer provides notice (in electronic or nonelectronic form) that apprises the recipient of:		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Appeals Procedures (Cont'd)	Internal Reviews of Adverse Determi-nations under Non-Grand-fathered Plans (Cont'd)		• the significance of the document when it is not otherwise reasonably evident as transmitted (e.g., "the attached document describes the internal review process used by your plan"); and • The recipient's right to request and obtain a paper version of such document; AND The issuer furnishes the appellant or their representative with a paper version of the electronically furnished documents if requested.		
	Expedited Internal Reviews of Adverse Benefit Determi-nations Under Non-Grand-Fathered Plans	RCW 48.43.530(5)(c)	The Issuer must provide an expedited review process at any point in the review process IF: (WAC 284-43-3170(1))		
		WAC 284-43-3170(1)(a)	• The appellant is currently receiving or is prescribed treatment or benefits that would end due to the adverse benefit determination; OR		
		WAC 284-43-3170(1)(b)	• The ordering provider for the appellant believes that following the normal process response timelines could seriously jeopardize the enrollee's life, health, or ability to regain maximum function, or would subject the appellant to severe and intolerable pain; OR		
		WAC 284-43-3170(1)(c)	• The determination is related to an issue related to admission, availability of care, continued stay, or emergency health care services where the appellant has not been discharged from the emergency room or transport service.		
		WAC 284-43-3170(5)	If the treating health care provider determines that a delay could jeopardize the enrollee's health or ability to regain maximum function, the issuer must presume the need for expedited review, and treat the review request as such, including the need for an expedited determination of an external review under RCW 48.43.535.		
		WAC 284-43-3170(2)	Appellant is not entitled to expedited review if the treatment has already been delivered and the review involves payment for the		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Appeals Procedures (Cont'd)	Expedited Internal Reviews of Adverse Benefit Determi-nations Under Non-Grand-Fathered Plans (cont'd)		delivered treatment, if the situation is not urgent, or if the situation does not involve the delivery of services for an existing condition, illness, or disease.		
		WAC 284-43-3170(3)	An expedited review may be filed by an appellant, the appellant's authorized representative, or the appellant's provider orally, or in writing.		
		RCW 48.43.530(5)(c); WAC 284-43-3170(4)	The issuer must respond as expeditiously as possible to an expedited review request, preferably within twenty-four hours, but in no case longer than seventy-two hours. The decision regarding an expedited appeal must be made within seventy-two hours of the date the request for review is received.		
		WAC 284-43-3170(4)(a)	• The issuer's response to an expedited review request may be delivered orally, and must be reduced to and issued in writing not later than 72 hours after the date of the decision. Regardless of who makes the issuer's determination, the time frame for providing a response to an expedited review request begins when the issuer first receives the request.		
		WAC 284-43-3170(4)(b)	• If the issuer requires additional information to determine whether the service being reviewed is covered, the issuer must request such information as soon as possible after receiving the request for expedited review.		
		WAC 284-43-3170(6)	An issuer may require exhaustion of the internal appeal process before appellant may request external review in urgent care situations that justify expedited review.		
		WAC 284-43-3170(7)	Expedited review must be conducted by appropriate clinician(s) in the same or similar specialty as would typically manage the case being reviewed. The clinician(s) must not have been involved in making the initial adverse determination.		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Appeals Procedures (Cont'd)	Independent Review of Appeals ("IRO") for **Both** Grand-fathered and Non-Grand-fathered Plans	42 U.S.C. §300gg-19(b); RCW 48.43.535(2)	An enrollee may seek review by a certified independent review organization of an issuer's decision to deny, modify, reduce, or terminate coverage of or payment for a health care service, or of any adverse determination made by a carrier under RCW 48.49.020, 48.49.030, or 42 U.S.C. Secs. 300gg-111 or 300gg-112, after exhausting the issuer's internal appeals / review of adverse benefit decision process and receiving a decision that is unfavorable to the enrollee.		
		RCW 48.43.535(2); WAC 284-43-3130(1)	• Enrollee may also seek review by a certified independent review organization after the carrier has exceeded the timelines provided in RCW 48.43.530, without good cause and without reaching a decision.		
		WAC 284-43A-140(1)	Appellants must be provided the right to external review of adverse benefit determinations based on medical necessity, appropriateness, health care setting, level of care, or that the requested service or supply is not efficacious or otherwise unjustified under evidence-based medical criteria. • Issuer may not establish a minimum dollar amount requirement for an appellant to seek external independent review.		
		WAC 284-43A-140(4)(b)	• IRO review must be provided without imposing any cost to the appellant or their provider.		
		WAC 284-43A-140(2)	Issuers must use the rotational registry system of certified independent review organizations (IROs) established by OIC, and may not make an assignment to an IRO out of sequence for any reason other than the existence of a conflict of interest, as set forth in WAC 284-43A-050.		
		WAC 284-43A-140(4)(a)	• Issuers must make available to the enrollee and to any provider acting on behalf of the enrollee all materials provided to the IRO.		
		WAC	• Issuers must provide IROs with all relevant clinical review criteria used by the issuer and other relevant medical, scientific, and		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Appeals Procedures (Cont'd)	Independent Review of appeals ("IRO") for **both** Grand-fathered and Non-Grand-fathered plans (Cont'd)	284-43A-140(4)(c)	cost-effectiveness evidence, the attending or ordering provider's recommendations, and a copy of the terms and conditions of coverage under the relevant health plan.		
		RCW 48.43.535(5); WAC 284-43A-140(4)(d)	• Within one day of selecting the IRO, the issuer must notify the appellant of the name of the IRO and its contact information. • The notice must explain that the IRO will accept additional information in writing from the appellant for up to five business days after it receives the assignment, which the IRO must consider when conducting its review.		
		RCW 48.43.535(7)(a)	An enrollee or carrier may request an expedited external review if the issuer's decision to deny, modify, reduce, or terminate coverage or payment for a health care service: • concerns an admission, availability of care, continued stay, or health care service for which the claimant received emergency services but has not been discharged from a facility; or • involves a medical condition for which the standard external review time frame would seriously jeopardize the life or health of the enrollee or jeopardize the enrollee's ability to regain maximum function. The independent review organization must make its determination to uphold or reverse the issuer's decision, and notify the enrollee and the issuer of its determination as expeditiously as possible but within not more than seventy-two hours after the receipt of the request for expedited external review.		
		RCW 48.43.535(7)(a)	If the notice is not in writing, the independent review organization must provide written confirmation of the decision within forty-eight hours after the date of the notice of the decision.		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Appeals Procedures (Cont'd)	Independent Review of Appeals ("IRO") for **Both** Grand-fathered and Non-Grand-fathered Plans (cont'd)	RCW 48.43.535(9)	When an enrollee requests independent review of an issuer's decision to modify, reduce, or terminate an otherwise covered health service that an enrollee is receiving at the time the request for review is submitted and the issuer's decision is based upon a finding that the health service, or level of health service, is no longer medically necessary or appropriate, the issuer must continue to provide the health service if requested by the enrollee until a determination is made. • If the determination affirms the issuer's decision, the enrollee may be responsible for the cost of the continued health service. Note: Washington has demonstrated that it meets parallel process to federal external review standards, so a plan does not have to separately follow federal law. See chart: www.cms.gov/cciio/resources/files/external_appeals.html.		
		WAC 284-43A-140(5)	An issuer may waive a requirement that internal appeals must be exhausted before an appellant may proceed to independent review of an adverse determination.		
		RCW 48.43.535(6); WAC 284-43A-140(6)	Upon receipt of this information provided by the appellant to the IRO, an issuer may reverse its final internal adverse determination. If it does so, it must immediately notify the IRO and the appellant.		
	Independent Review of Adverse Benefit Determi-nations ("IRO") for Non-Grand-	WAC 284-43-3150(5)	Appellant must be given up to 180 days following receipt of written notification of the internal review determination to file a request for external review. If external review is not requested, the internal review decision is final and binding.		
		WAC 284-43-3130(2)	Issuer may challenge external review requested due to failure to adhere to requirements (either to the IRO or to a court) on the basis that the issuer's violations are *de minimis*, and do not prejudice the appellant.		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
	fathered Plans				
Appeals Procedures (Cont'd)	Independent Review of Adverse Benefit Determi-nations ("IRO") for Non-Grand-fathered Plans (cont'd)	WAC 284-43-3130(2)(a)	• Exception applies only if the IRO or court determines that the issuer has demonstrated that the violation was for good cause or was due to matters beyond its control, and that the violation occurred in the context of an ongoing, good faith exchange of information between the issuer and appellant.		
		WAC 284-43-3130(2)(b)	• Exception is not available, and the challenge may not be sustained, if the violation is part of a pattern or practice of violations by the carrier or health plan.		
		WAC 284-43-3130(3)	Appellant may request a written explanation of the violation from the carrier and the carrier must provide such explanation within ten calendar days, including a specific description of its basis, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted.		
		WAC 284-43-3130(4)	If the challenge is successful and the IRO or court determines that the internal review process is not exhausted, the issuer must provide the appellant with notice that they may resubmit and pursue the internal appeal within a reasonable time, not to exceed ten days, of receiving the IRO's determination, or entry of the court's final order.		
	Concurrent Expedited Review of Adverse Benefit Determin-ations for Non-Grand-	WAC 284-43-3190(1)	Issuer must offer the right to request concurrent expedited internal and external review of adverse benefit determinations. • "Concurrent expedited review" means initiation of both the internal and external expedited review simultaneously. This is review of either utilization review decisions or treatment decisions during a patient's stay or course of treatment in an inpatient or outpatient health care setting so that the final adverse benefit determination is reached as expeditiously as possible.		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Appeals Procedures (Cont'd)	Fathered Plans	WAC 284-43-3190(2)	When concurrent expedited review is requested, issuer may not make the determinations consecutively. The requisite timelines must be applied concurrently.		
		WAC 284-43-3190(3)	Issuer may deny a request for concurrent expedited review only if the conditions for expedited review are not met. Issuer may not require exhaustion of internal review if an appellant requests concurrent expedited review.		
Applications		45 CFR 147.104(a)	The federal statutory guaranteed issue requirement and implementing rule do not distinguish between exchange and non-exchange products and do not except plans from the requirement that all products approved for sale in the individual market must be made available to any individual who applies for any of those products inside or outside the exchange. Therefore you must submit an application for products offered both inside and outside the exchange.		
	Fraud Statement	RCW 48.135.080	All outside market applications must contain a statement similar to the following: "It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits." This includes applications for plans normally sold on the exchange which are purchased directly from the issuer.		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Clinical Trials	Requirements for Coverage	WAC 284-43-5420	• Plan must not restrict coverage of routine patient costs for enrollees who participate in a clinical trial.		
		WAC 284-43-5420	○ "Routine costs" means items and services that are consistent with and typically covered by the plan for an enrollee who is not enrolled in a clinical trial.		
		WAC 284-43-5420	• Plan may apply limitations and requirements related to use of network services.		
		WAC 284-43-5420(1)	• Plan may require enrollees to meet eligibility requirements of the clinical trial protocol, including medical and scientific information establishing that the enrollee meets the requirements, unless the enrollee is referred to the clinical trial by an in-network provider.		
		WAC 284-43-5420(2)	• Plan must cover the cost of prescription medication used for direct clinical management of the enrollee, unless the trial is for the investigation of the medication or the medication is typically provided free by the research sponsors for anyone in the trial.		
		WAC 284-43-5420(3)(a)	• Exceptions: The requirement does not apply to: ○ A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;		
		WAC 284-43-5420(3)(b)	○ Items and services provided solely to satisfy data collection and analysis needs;		
		WAC 284-43-5420(3)(c) and (d)	○ Items and services that are not used in the direct clinical management of the enrollee; or ○ The investigational item, device, or service itself.		
		WAC 284-43-5420(4) WAC 284-43-5420(4)(a)	• "Clinical trial" means a phase I, II, III, or IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, funded or approved by: ○ One of the National Institutes of Health (NIH);		
		WAC 284-43-5420(4)(b)	○ An NIH cooperative group or center which is a formal network of facilities that collaborate on research projects and have an		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Clinical Trials (Cont'd)	Requirements For Coverage (cont'd)		established NIH-approved peer review program including, but not limited to, the NCI Clinical Cooperative Group and the NCI Community Clinical Oncology Program;		
		WAC 284-43-5420(4)(c)	○ The federal Departments of Veterans Affairs or Defense;		
		WAC 284-43-5420(4)(d)	○ An institutional review board of an institution in this state that has a multiple project assurance contract approval by the Office of Protection for the Research Risks of the NIH; or		
		WAC 284-43-5420(4)(e)	○ A qualified research entity that meets the criteria for NIH Center Support Grant eligibility.		
		WAC 284-43-5420 (4)(e)	• "Life threatening condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.		
Colorectal Cancer Screening	Requirement for Coverage	RCW 48.43.043(1)	Plan must provide coverage for colorectal cancer exams and lab tests consistent with the A and B recommendations of the USPSTF or the CDC. Coverage must be provided:		
		RCW 48.43.043 (1)(a)	• For any of the colorectal screening exams and tests in the selected recommendations, at a frequency identified therein, as deemed appropriate by the patient's physician after consultation with the patient; and To an enrollee who is:		
		RCW 48.43.043 (1)(b)(i); WAC 284-43-5642(9)(b)(ii)(A)	• At least forty-five years old; or		
		RCW 48.43.043 (1)(b)(ii)	• Less than fifty years old and at high risk or very high risk for colorectal cancer according to such guidelines or recommendations.		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Colorectal Cancer Screening (Cont'd)	Burdensome Requirements Prohibited	RCW 48.43.043(2)	• Plan design must not require patients and providers to meet burdensome criteria or overcome significant obstacles to secure such coverage. Enrollee may not be required to pay an additional deductible or coinsurance for testing greater than a deductible or coinsurance for similar benefits. If the plan does not cover a similar benefit, a deductible or coinsurance may not be set that materially diminishes the value of the colorectal cancer benefit required.		
	If No In-Network Provider Available	RCW 48.43.043 (3)(a)	Issuer is not required to provide for referral to an out-of-network provider, unless the carrier does not have an in-network provider that is appropriate, available and accessible to administer the screening exam.		
		RCW 48.43.043 (3)(b); WAC 284-170-200(5)	• If issuer has no appropriate in-network provider, then out-of-network screening exam services and resulting treatment, if any, must be provided at no additional cost to the enrollee beyond what he/she would pay for in-network services.		
Congenital Anomolies	Requirement for Coverage	RCW 48.44.212(1)	If plan provides coverage for dependent children of the enrollee, must provide coverage for newborn infants of the enrollee from and after the moment of birth. Coverage must include, but not be limited to, coverage for congenital anomalies of such infant children from the moment of birth.		
		RCW 48.44.212(2)	If payment of an additional premium is required to provide coverage for a child, the contract may require that notification of birth of a newly born child and payment of the required premium must be furnished to the issuer. The notification period must be no less than sixty days from the date of birth.		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Contract Standards Required	Rate and Form Filing Instructions	WAC 284-44A-040	• Filing must comply with The SERFF Industry Manual, and Washington State SERFF Health and Disability Form Filing General Instructions. • Rates must be filed concurrently with forms.		
		Fittro v. Lincoln Nat'l Life Ins. Co., 111 Wn.2d 46; 757 P.2d 1374 (1988)	• If there is a conflict in language between the contract and the certificate, the certificate governs. Forms may contain no language that conflicts with this principle.		
	Examination/ Disapproval	RCW 48.44.020(2)(a)	• The filing must not: • Contain or incorporate by reference any inconsistent, ambiguous, or misleading clauses, or exceptions or conditions which unreasonably or deceptively affect the risk purported to be assumed in the general coverage of the agreement;		
		RCW 48.44.020(2)(b)	• Contain any title, heading, or other indication which is misleading;		
		(2)(d)	• Contain unreasonable restrictions on the treatment of patients;		
		(2)(e)	• violate any provision of Chapter 48.44 RCW;		
		(2)(f)	• fail to conform to minimum provisions or standards required by OIC regulation;		
		RCW 48.44.020(4)	• Contain any provision inconsistent with the hold harmless protections of RCW 48.44.020(4)(b) – "No participating provider, insurance producer, trustee, or assignee may maintain any action against an enrolled participant to collect sums owed by the health care service contractor."		
		RCW 48.44.020(3)	• The benefits provided by the contract must be reasonable in relation to the amount charged for the contract.		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Contract Standards Required (Cont'd)	Examination / Disapproval (cont'd)	WAC 284-44-030(1)	• The style, arrangement and over-all appearance of the contract must give no undue prominence to any portion of the text. Every printed portion of the text of all forms must be plainly printed in type of a style in general use. Size must be uniform and not less than eight-point with a lower-case unspaced alphabet length not less than one hundred and twenty-point. "Text" includes all printed matter except the name and address of the HCSC, name or title of the policy, a brief description if any, and captions and subcaptions.		
		WAC 284-44-030(2)	• Exceptions, reductions, and limitations must be set forth in the contract either included with the benefit provisions to which they apply, or under an appropriate caption, except that if an exception, reduction, or limitation specifically applies only to a particular benefit, it must be included with the benefit to which it applies.		
		WAC 284-44-030(3)	• Each form, including riders and endorsements, shall be identified by a form number in the lower left hand corner of the first page thereof.		
		WAC 284-44-030(4)	• Contract must not purport to make any portion of the HCSC's charter, rules, constitution, articles of incorporation, or bylaws a part of the contract if the effect of such provision would be to incorporate into the contract exceptions, reductions, limitations or additional charges not otherwise set forth in the contract, unless such portion is set forth in full in the contract, or is attached thereto.		
	Injury Due to Intoxication or Narcotics	RCW 48.44.305	The plan cannot exclude services solely because the injury is sustained as a result of the insured being intoxicated or under the influence of a narcotic.		
	Prohibited Limitations	WAC 284-43-5440(1)	• Contract must specifically explain any uniformly applied limitation on the scope, visit number, or duration of a benefit, and state whether the uniform limitation is subject to adjustment based on the specific treatment requirements of the patient.		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Contract Standards (Cont'd)	Prohibited Limitations (Cont'd)	WAC 284-44-040(1)	• Contract must not unreasonably limit benefits to a specified period of time. (e.g., cannot have a provision that services for a particular condition will be covered only for one year without regard to the amount of the benefits paid or provided.)		
		WAC 284-43-5622(7)	• Contract 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.		
		WAC 284-43-5622(9)(a)(b)	• Plan must not create a risk of biased selection based on health status. • The benefits within an EHB category must not be so limited that the coverage for the category is not a meaningful benefit.		
		RCW 48.43.065(2)(b)(i), (ii) and (iii); RCW 48.43.725	A health carrier that excludes, under state or federal law,any benefit required or mandated by this title or rules adopted by the commissioner from any health plan or student health plan shall: • Provide written notice to enrollees, which benefits the plan does not cover; listing services that the carrier refuses to cover for reason of conscience or religion; and • Alternate ways in which enrollees may access excluded benefit information in an timely manner; and • Clearly and legibly include this information in any of its marketing materials that include a list of benefits covered under the plan.		
	Right to Legal or Arbitration Proceedings	WAC 284-44-040(3)	In the case of controversy arising out of the contract, a subscriber must not be denied the right to have the controversy determined by legal or arbitration proceedings.		
	Unreasonable Payment Delays	WAC 284-44-040(7)	Contract must not contain any provision that unreasonably restricts or delays the payment of benefits payable under the contract. Delays are		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Contract Standards (Cont'd)			not justified because the expenses incurred, or the services received, resulted from an act or omission of a third party.		
	No Retrospective Denials	RCW 48.43.525(1)	• Plan must 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.		
		RCW 48.44.465	• When an authorized plan representative approves a claim for an individual prescription, the plan may not later reject that claim.		
	Small Group Cost-Sharing	WAC 284-43-5800 (2)	• Small group health benefit plan that includes the essential health benefits package may not impose annual cost-sharing or deductibles that exceed the maximum annual amounts that apply to high deductible plans linked to health savings accounts, as set forth in the most recent version of IRS Publication 969, pursuant to Section 106(c)(2) of the Internal Revenue Code of 1986, and Section 1302(c)(2) of PPACA.		
	Reasonable Medical Management	WAC 284-43-5800(3)	• Plan may include reasonable medical management to control costs, including promoting the use of appropriate, high value preventive services, providers and settings. • Plan must permit waiver of an otherwise applicable copayment for a service that is tied to one setting but not the preferred high-value setting, if the enrollee's provider determines that it would be medically inappropriate to have the service provided in the lower-value setting. Issuer may still apply applicable in-network requirements.		
	Contracting for Outside Services	RCW 48.43.085	• The issuer may not prohibit enrollees from freely contracting to obtain any health care services outside the plan on any terms the enrollees choose.		
	No Annual or Lifetime Dollar Limits	WAC 284-43-5622(10)	• An issuer must not impose annual or lifetime dollar limits on an essential health benefit, other than those specifically permitted under WAC 284-43-5642, 284-43, 5702, and 284-43-5782.		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Contract Standards (Cont'd)	Discretionary Clauses Prohibited	WAC 284-44-040(3)	• Contract must not purport to give the HCSC or any designee authority to make a decision on the contract, or coverage or claims thereunder, which is final and binding on the enrollee.		
		WAC 284-44-015(1)	• Contract may not contain a "discretionary clause" that purports to reserve discretion to a carrier or its designees to interpret the contract or decide eligibility for benefits, or requires deference to such interpretations or decisions.		
		WAC 284-44-015(1)(a)	• That the carrier's interpretation of the terms of the contract is binding;		
		WAC 284-44-015(1)(b)	• That the carrier's decision regarding eligibility or continued receipt of benefits is binding;		
		WAC 284-44-015(1)(c)	• That the carrier's decision to deny, modify, reduce or terminate payment, coverage, authorization, or provision of health care service or benefits, is binding;		
		WAC 284-44-015(1)(d)	• That there is no appeal or judicial remedy from a denial of a claim;		
		WAC 284-44-015(1)(e)	• That deference must be given to the carrier's interpretation of the contract or claim decision; and		
		WAC 284-44-015(1)(f)	• That the standard of review of a carrier's interpretation of the contract or claim decision is other than a de novo review.		
		WAC 284-44-015(2)	• Contract may include provisions that inform enrollees that, as part of its routine operations, the carrier applies the terms of its contracts for making decisions, including determinations regarding eligibility, receipt of benefits and claims, or explaining its policies, procedures, and processes.		
	Spouse includes state registered	RCW 48.43.904	Washington state-registered domestic partners must be extended the same rights under insurance contracts as spouses. All terms and benefits of the plan must be provided equally to spouses and state-registered domestic partners. For plans issued in Washington, the		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Contract Standards (Cont'd)	domestic partner		amount of benefits payable, or any term, rate, condition, or type of coverage may not be restricted, modified, excluded, increased, or reduced on the basis of the sex, marital status, or sexual orientation. This includes any benefits under COBRA, USERRA, and FMLA.		
	Mis-representation of Essential Health Benefits	WAC 284-43-5820	A health benefit plan issuer must not indicate or imply that a health benefit plan covers essential health benefits unless the plan, policy, or contract covers the essential health benefits in compliance with WAC 284-43-5400 through 284-43-5800. This requirement applies to any health benefit plan offered on or off the Washington health benefit exchange.		
Coordination of Benefits	Disclosure of Coordination	WAC 284-51-200(3) WAC 284-51-200(1) WAC 284-51-200(2)	**Please note which COB Model is used and proceed to the required COB elements.** Each certificate of coverage under a contract that provides for COB must contain a description of the COB provisions. • Does the contract use the model COB provisions in WAC 284-51-255 Appendix A? **OR** • Does the contract use the Consumer Explanatory Booklet in WAC 284-51-260 Appendix B?	**Model A**	**Model B**
	General	WAC 284-51-200(3)	• Plan need not use the specific words and format provided in WAC 284-51-255 and the plain language explanation in WAC 284-51-260. Changes may be made to fit the language and style of the rest of the contract or to reflect differences among plans that provide services, that pay benefits for expenses incurred, and that indemnify, provided they do not conflict with the requirements of Chapter 284-51 WAC.		
		WAC 284-51-200(4) (4)(a)	• Plan cannot have a COB provision that permits it to reduce its benefits on the basis that: o Another plan exists and the enrollee did not enroll in that plan;		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Coordination of Benefits (Cont'd)	General (cont'd)	(4)(b)	○ A person could have been covered under another plan; or		
		(4)(c)	○ A person could have elected an option under another plan that pays a higher level of benefits than what he elected.		
		WAC 284-51-200(5)	• Plan may not provide that its benefits are "always excess" or "always secondary" except as permitted in Chapter 284-51 WAC.		
		WAC 284-51-200(6)	No plan may use a COB provision, or any other provision that allows it to reduce its benefits with respect to any other coverage its insured may have that does not meet the definition of plan as defined in WAC 284-51-195(12).		
		RCW 48.21.200	• A carrier may not administer COB in a way that reduces total benefits payable below an amount equal to 100% of total allowable expenses. (Note: by its terms, this statute applies to HMOs)		
		WAC 284-51-230(1)	• Any secondary plan must pay an amount which, together with the payment made by the primary plan, cannot be less than the same allowable expense as the secondary plan would have paid if it was the primary plan. In no event will a secondary plan be required to pay an amount in excess of its maximum benefit plus accrued savings.		
		WAC 284-51-195(1)	• When Medicare, Part A, Part B, Part C, or Part D is primary, Medicare's allowable amount is the allowable expense.		
	Time Limit	WAC 284-51-215(1)	Plan must not unreasonably delay payment of a claim due to a COB provision. Any time limit established by a secondary plan in excess of 30 days is unreasonable.		
	Definition of "Plan" for COB Purposes	WAC 284-51-195(12)	• "Plan" means coverage with which coordination is allowed. Separate parts of a plan provided through alternative contracts intended to be part of a coordinated package of benefits are considered one plan. There is no COB among the separate parts of the plan.		
		WAC	• If a plan coordinates benefits, its contract must state the types of coverage that will be considered in applying COB. Whether the		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Coordination of Benefits (Cont'd)	Definition of "Plan" for COB Purposes	284-51-195(12)(a)	contract uses the term "plan" or some other term such as "program," the contractual definition may be no broader than this definition.		
		WAC 284-51-195(12)(b)(i)	• "Plan" includes: ○ Group or individual contracts or blanket disability contracts;		
		WAC 284-51-195(12)(b)(ii)	○ Closed panel plans or other forms of group or individual coverage;		
		WAC 284-51-195(12)(b)(iii)	○ The medical care components of long-term care contracts, such as skilled nursing care; and		
		WAC 284-51-195(12)(b)(iv)	○ Medicare or other governmental benefits, as permitted by law. That part of the definition of plan may be limited to the hospital, medical and surgical benefits of the governmental program.		
		WAC 284-51-195(12)(c)(i)	• "Plan" does not include: ○ Hospital indemnity or fixed payment coverage benefits or other fixed indemnity or payment coverage;		
		(ii)	○ Accident only coverage;		
		(iii)	○ Specified disease or specified accident coverage;		
		(iv)	○ Limited benefit health coverage, as defined in WAC 284-50-370;		
		(v)	○ School accident and similar coverages that cover students for accidents only, including athletic injuries, either on a twenty-four-hour basis or on a "to and from school" basis;		
		(vi)	○ Benefits provided in long-term care insurance policies for nonmedical services, e.g., personal care, adult day care, homemaker services, assistance with ADLs, respite care and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;		
		(vii)	○ Medicare supplement policies;		
		(viii)	○ A state plan under Medicaid;		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Coordination of Benefits (Cont'd)	Definition of "Plan" for COB Purposes (cont'd)	(ix)	○ A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan;		
		(x)	○ Automobile insurance policies required by statute to provide medical benefits;		
		(xi)	○ Benefits provided as part of a direct agreement with a direct patient-provider primary care practice as defined at section 3, chapter 267, Laws of 2007.		
	Contract Description of COB	WAC 284-51-200(7)	• If a person has met the requirements for coverage under the primary plan, a closed panel plan in secondary position must pay benefits as if the covered person had met the requirements of the closed panel plan. COB may occur during the claim determination period even where there are no savings in the closed panel plan.		
		WAC 284-51-195(5)	• "Closed panel plan" means a plan that provides benefits in the form of services primarily through providers employed by the plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.		
		WAC 284-51-195(1)	• The definition of "allowable expense" should be clear that when coordinating benefits, any secondary plans must pay an amount which, together with the payment made by the primary plan, cannot be less than the allowable expense the secondary plan would have paid if it was primary. A secondary plan must not be required to pay an amount in excess of its maximum benefit plus accrued savings.		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Coordination of Benefits (Cont'd)	Rules for Coordination of Benefits	WAC 284-51-205(1); WAC 284-51-205(1)(a)	Contract may not contain any provisions that are inconsistent with or less favorable than these COB rules: • The primary plan must provide benefits as if the secondary plan did not exist. A plan may only take into consideration benefits provided by another plan when it is secondary to that other plan.		
		WAC 284-51-205 (1)(b)	• If the primary plan is a closed panel plan and the secondary plan is not, the secondary plan must provide benefits as if it were primary when an enrollee uses a nonpanel provider, except for emergency services or authorized referrals provided by the primary plan.		
		WAC 284-51-205 (1)(c)	• When multiple contracts providing coordinated coverage are treated as a single plan per WAC 284-51-195, the COB rules apply only to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one issuer pays or provides benefits under the plan, the issuer designated as primary within the plan is responsible for the plan's compliance with Chapter 284-51 WAC.		
		WAC 284-51-205 (1)(d)	• If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which secondary plans pay. Each secondary plan must consider the benefits of the primary plan and the benefits of any other plan, which, under the COB rules, has its benefits determined before those of that secondary plan.		
		WAC 284-51-205 (2)(a)	• Except as provided below, a plan that contains noncompliant COB provisions is always the primary plan unless the provisions of both plans state that the complying plan is primary.		
		WAC 284-51-245 (2)(a)	○ A plan with order of benefit determination rules that comply with the WAC rules (complying plan) may coordinate its benefits with a plan that is "excess" or "always secondary", or that uses order of benefit determination rules inconsistent with the WAC rules (noncomplying plan) on the following basis:		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Coordination of Benefits (Cont'd)	Rules for Coordination of Benefits (cont'd)	284-51-245 (2)(a)(i)	▪ If the complying plan is the primary plan, it must provide its benefits first;		
		WAC 284-51-245 (2)(a)(ii)	▪ If the complying plan is the secondary plan under Chapter 284-51 WAC, it must provide its benefits first, but the amount of benefits payable must be determined as if the complying plan were the secondary plan. In this situation, the payment is the limit of the complying plan's liability; and		
		WAC 284-51-245 (2)(a)(iii)	• If the noncomplying plan does not provide the information needed by the complying plan to determine its benefits within forty-five days after the date on the letter making the request, the complying plan may assume the benefits of the noncomplying plan are identical to its own, and pay its benefits accordingly. If, within twenty-four months after payment, the complying plan receives information as to the actual benefits of the noncomplying plan, it must adjust payments accordingly between the plans.		
		WAC 284-51-245 (2)(b)	▪ If the noncomplying plan reduces its benefits so the enrollee receives less in benefits than they would have received had the complying plan provided its benefits as the secondary plan and the noncomplying plan provided its benefits as the primary plan, and governing state law allows the right of subrogation outlined below, then the complying plan may advance to the covered person or on behalf of the covered person an amount equal to the difference.		
		WAC 284-51-245 (2)(c)	▪ Complying plan may not advance more than the complying plan would have paid had it been the primary plan less any amount it previously paid for the same expense. In consideration of the advance, the complying plan is		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Coordination of Benefits (Cont'd)	Rules for Coordination of Benefits (cont'd)		subrogated to all rights of the enrollee against the noncomplying plan. The advance by the complying plan must be without prejudice to any claim it may have against a noncomplying plan in the absence of subrogation.		
		WAC 284-51-205 (2)(b)	• Coverage that is obtained by virtue of membership in a group and designed to supplement a part of a basic package of benefits may provide that the supplementary coverage is excess to any other parts of the plan provided by the contract holder. (e.g., major medical coverages superimposed over base plan hospital and surgical benefits, and insurance coverages written in connection with a closed panel plan to provide out-of-network benefits.)		
		WAC 284-51-205(4)	• **Order of benefit determination.** Each plan determines its order of benefits using the first of the following rules that applies:		
		WAC 284-51-205 (4)(a)(i)	○ Nondependent or dependent. ▪ Subject to the following, the plan that covers the person other than as a dependent (e.g., as an employee, member, subscriber, policyholder or retiree) is the primary plan and the plan that covers the person as a dependent is the secondary plan.		
		WAC 284-51-205 (4)(a)(ii)(A)	▪ If the person is a Medicare beneficiary, and, as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations, Medicare is:		
		WAC 284-51-205 (4)(a)(ii)(A)(I)	• Secondary to the plan covering the person as a dependent; and		
		WAC 284-51-205 (4)(a)(ii)(A)(II)	• Primary to the plan covering the person as other than a dependent (e.g., a retired employee);		
		WAC	Then the order of benefits is reversed so that the plan covering the person as an employee, member, subscriber, policyholder or		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Coordination of Benefits (Cont'd)	Rules for Coordination of Benefits (cont'd)	284-51-205 (4)(a)(ii)(B)	retiree is the secondary plan and the other plan covering the person as a dependent is the primary plan.		
		WAC 284-51-205(4)(b)	○ **Dependent child covered under more than one plan**. Unless there is a court decree stating otherwise, plans covering a dependent child must determine the order of benefits as follows:		
		WAC 284-51-205(4)(b)(i)	▪ For a dependent child whose parents are married or are living together, whether or not they have ever been married:		
		WAC 284-51-205 (4)(b)(i)(A)	• The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or		
		WAC 284-51-205 (4)(b)(i)(B)	• If both parents have the same birthday, the plan that has covered the parent longest is the primary plan.		
		WAC 284-51-205 (4)(b)(ii)	▪ For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:		
		WAC 284-51-205 (4)(b)(ii)(A)	• If a court decree states that one parent is responsible for the dependent child's health care expenses or coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This does not apply to any plan year during which benefits are paid or provided before the plan has actual knowledge of the court decree provision;		
		WAC 284-51-205 (4)(b)(ii)(B)	• If a court decree states one parent is to assume primary financial responsibility for the dependent child but does not mention responsibility for health care expenses, the plan of the parent assuming financial responsibility is primary;		
		WAC	• If a court decree states that both parents are responsible for the dependent child's health care expenses or coverage, the		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Coordination of Benefits (Cont'd)	Rules for Coordination of Benefits (cont'd)	284-51-205 (4)(b)(ii)(C)	provisions above for parents married or living together determine the order of benefits;		
		WAC 284-51-205 (4)(b)(ii)(D)	• If a court decree states that the parents have joint custody without specifying that one parent has financial responsibility or responsibility for the health care expenses or health care coverage of the dependent child, the above provisions for parents married or living together determine the order of benefits; or		
		WAC 284-51-205 (4)(b)(ii)(E)	• If there is no court decree allocating responsibility for the child's health care expenses or coverage, the order of benefits for the child is as follows:		
		(4)(b)(ii)(E)(I)	○ The plan covering the custodial parent, first;		
		(4)(b)(ii)(E)(II)	○ The plan covering the custodial parent's spouse, second;		
		4)(b)(ii)(E)(III)	○ The plan covering the noncustodial parent, third; and then		
		(4)(b)(ii)(E)(IV)	○ The plan covering the noncustodial parent's spouse, last.		
		WAC 284-51-205(4)(b)(iii)	▪ For a dependent child covered under more than one plan of individuals who are not the child's parents, the order of benefits is determined as if they were the parents of the child.		
		(4)(c)	○ **Active employee or retired or laid-off employee.**		
		WAC 284-51-205(4)(c)(i)	▪ The plan that covers a person as an active employee (neither laid off nor retired) or as a dependent of an active employee is the primary plan. The plan covering that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee is the secondary plan.		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Coordination of Benefits (Cont'd)	Rules for Coordination of Benefits (cont'd)	WAC 284-51-205(4)(c)(ii)	▪ If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule does not apply.		
		WAC 284-51-205(4)(c)(iii)	▪ This provision also does not apply if the above provisions regarding nondependents and dependents can determine the order of benefits.		
		WAC 284-51-205(4)(d)	○ **COBRA or state continuation coverage**		
		WAC 284-51-205(4)(d)(i)	▪ If a person has coverage provided under COBRA or under a right of continuation under state or federal law, and is covered under another plan, the plan covering him as an employee, member, subscriber or retiree or covering him as a dependent of one of these, is the primary plan and the plan covering that same person under COBRA or under a right of continuation according to state or other federal law is the secondary plan.		
		WAC 284-51-205(4)(d)(ii)	▪ If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.		
		WAC 284-51-205(4)(d)(iii)	▪ This provision also does not apply if the above provisions regarding nondependents and dependents in (a) of this subsection can determine the order of benefits.		
		(4)(e)	○ **Longer or shorter length of coverage**		
		WAC 284-51-205(4)(e)(i)	▪ If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is the primary plan and the plan that covered the person for the shorter period of time is the secondary plan.		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Coordination of Benefits (Cont'd)	Rules for Coordination of Benefits (cont'd)	WAC 284-51-205(4)(e)(ii)	▪ To determine the length of time a person has been covered under a plan, two successive plans are treated as one if the enrollee was eligible under the second plan within twenty-four hours after coverage under the first plan ended. ▪ The start of a new plan does not include:		
		(4)(e)(iii)(A)	• A change in the amount or scope of a plan's benefits;		
		WAC 284-51-205 (4)(e)(iii)(B)	• A change in the entity that pays, provides or administers the plan's benefits; or		
		WAC 284-51-205 (4)(e)(iii)(C)	• A change from one type of plan to another, such as, from a single employer plan to a multiple employer plan.		
		WAC 284-51-205(4)(e)(iv)	▪ The length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group must be used as the date to determine the length of time his coverage under the present plan has been in force.		
		WAC 284-51-205(4)(f)	▪ If none of the preceding rules determines the order of benefits, the allowable expenses must be shared equally between the plans.		
	Rules for Secondary Plan Payment	WAC 284-51-230(1)	• In determining the amount to be paid by the secondary plan if the plan wishes to coordinate benefits, the secondary plan must pay an amount that, when combined with the amount paid by the primary plan, the total benefits paid by all plans equal one hundred percent of the total allowable expense for that claim. The secondary carrier must not be required to pay an amount in excess of its maximum benefit plus accrued savings. The enrollee must not be responsible		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Coordination of Benefits (Cont'd)	Rules for Secondary Plan Payment (Cont'd)		for a deductible amount greater than the highest of the two deductibles.		
		WAC 284-51-230(3); WAC 284-51-230(3)	○ "Gatekeeper requirements" means any requirement that an otherwise eligible person must fulfill prior to receiving the benefits of a plan. (e.g., use of network providers, prior authorization, primary care physician referrals, or other similar case management requirements.) If a plan by its terms contains gatekeeper requirements, AND a person fails to comply with such requirements, And an alternative procedure is not agreed upon between both plans and the covered person:		
		WAC 284-51-230(2)(a)	○ If the plan is secondary, all secondary gatekeeper requirements will be waived if the gatekeeper requirements of the primary plan have been met.		
		WAC 284-51-230(2)(b)	○ If the primary plan becomes secondary during a course of treatment, the new primary plan must make reasonable provision for continuity of care if one or more treating providers are not in the new primary plan's network.		
		WAC 284-51-230(4)	• When a plan is secondary, it may reduce its benefits so the total benefits provided by all plans during a claim determination period do not exceed one hundred percent of the total allowable expenses. The secondary plan must calculate and record its savings from the amount it would have paid had it been primary, and must use these savings to pay any allowable expenses not otherwise paid, that are incurred by the covered person during the claim determination period, so that one hundred percent of the total allowable expenses incurred are paid during the claim determination period.		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Coordination of Benefits (Cont'd)	Required Provisions: "Facility of Payment"	WAC 284-51-220	SKIP IF USING MODEL A LANGUAGE If the plan provides for COB, it must contain provisions substantially as follows: • "If payments that should have been made under this plan are made by another plan, the issuer has the right, at its discretion, to remit to the other plan the amount it determines appropriate to satisfy the intent of this provision. To the extent of such payments, the issuer is fully discharged from liability under this plan."		
	Required Provisions: "Right of Recovery"	WAC 284-51-225	• SKIP IF USING MODEL A LANGUAGE "The issuer has the right to recover excess payment whenever it has paid allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this provision. The issuer may recover excess payment from any person, other issuer or plan that has received payment."		
	Required Provisions: "Notice to Covered Persons"	WAC 284-51-235	• The plan must include the following statement in the enrollee contract or booklet provided to covered persons: "If you are covered by more than one health benefit plan, and you do not know which is your primary plan, you or your provider should contact any one of the health plans to verify which plan is primary. The health plan you contact is responsible for working with the other plan to determine which is primary and will let you know within thirty calendar days. CAUTION: All health plans have timely claim filing requirements. If you or your provider fail to submit your claim to a secondary health plan within that plan's claim filing time limit, the plan can deny the claim. If you experience delays in the processing of your claim by the primary health plan, you or your provider will need to submit your claim to the secondary health plan within its claim filing time limit to prevent a denial of the claim. To avoid delays in claims processing, if you are covered by more than one plan you should promptly report to your providers and plans any changes in your coverage."		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Coordination of Benefits (Cont'd)	If Plans Cannot Agree Which is Primary	WAC 284-51-245(4)	If the plans cannot agree on the order of benefits within thirty calendar days after they have received the information needed to pay the claim, they must immediately pay the claim in equal shares and determine their relative liabilities following payment. No plan is required to pay more than it would have paid had it been the primary plan.		
Dependent Enrollment Requirements	Newborn Coverage ("Erin Act")	RCW 48.43.115 (3)(f)	Coverage for newborns must be no less than the coverage of the child's mother for no less than three weeks (21 days), even if there are separate hospital admissions.		
	Adoptive Child	RCW 48.01.180 (1)	• A child must be considered a dependent child for coverage purposes upon assumption of a legal obligation for total or partial support of a child in anticipation of adoption. On termination of such legal obligations, the child shall no longer be considered a dependent child for coverage purposes.		
		RCW 48.01.180(2); RCW 48.44.420(1)	• Coverage for dependent children placed for adoption must be provided under the same terms and conditions as apply to natural, dependent children, whether or not the adoption has become final.		
		RCW 48.01.180 (3)	• Contract may not restrict coverage of any dependent child adopted by, or placed for adoption with, an enrollee solely on the basis of a preexisting condition of the child at the time that the child would otherwise become eligible for coverage under the plan if the adoption or placement for adoption occurs while the enrollee is eligible for coverage under the plan.		
		RCW 48.44.420(2)	• If payment of an additional premium is required to provide coverage for the child, the contract may require notification of placement and payment of the required premium. The notification period shall be no less than sixty days from the date of placement.		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Dependent Enrollment Requirements (Cont'd)	Disabled Child Over Age Limit	RCW 48.44.200	If the contract states that coverage of a dependent child will terminate upon attainment of the limiting age for dependent children, the contract must also state that coverage of a dependent child will not be terminated while the child is and continues to be both (1) incapable of self-sustaining employment by reason of developmental or physical disability and (2) chiefly dependent upon the subscriber for support and maintenance. Issuer may require proof of incapacity and dependency within thirty-one days of the child's attainment of the limiting age and subsequently, but not more than annually after the first two years following attainment of the limiting age.		
	Newborn Child Enrollment	RCW 48.44.212(1)	• If plan covers dependent children of the enrollee, it must provide coverage for newborn infants of the enrollee from and after the moment of birth. Must include coverage for congenital anomalies of such infant children from the moment of birth.		
		RCW 48.44.212(2)	• If payment of an additional premium is required to provide coverage for a child, the contract may require that notification of birth of a newly born child and payment of the required premium must be furnished to the contractor. The notification period shall be no less than sixty days from the date of birth.		
	Dependents Under Age 26	RCW 48.44.215	Each group plan that covers dependents must have language allowing the member to cover dependents under the age of 26.		
Diabetes	Coverage Requirements	RCW 48.44.315 (2)(a); WAC 284-43-5642(1)(d)(iii); WAC 284-43-5642(6)(a)(ii);	• Contract must provide appropriate and medically necessary equipment and supplies, as prescribed by a health care provider, for all subscribers diagnosed "Insulin using", "Non-insulin using", and "elevated blood glucose induced by pregnancy. This must include: o insulin, syringes, injection aids, blood glucose monitors, test strips (for blood glucose monitors, visual blood sugar reading, and urine testing); insulin pumps and accessories to the pumps, insulin		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Diabetes (Cont'd)	Coverage Requirements (cont'd)	WAC 284-43-5642(7)(f)(ii)	infusion devices, prescriptive oral agents for controlling blood sugar levels, foot care appliances for prevention of complications associated with diabetes, and glucagon emergency kits.		
		RCW 48.43.780(1)	Health plans providing prescription drug coverage of insulin drugs for the treatment of diabetes must cap the total amount that an enrollee is required to pay for a covered insulin drug at an amount not to exceed **thirty-five dollars** per thirty-day supply of the drug. ○ Prescription insulin drugs must be covered without being subject to a deductible, and any cost sharing paid by an enrollee must be applied toward the enrollee's deductible obligation.		
		RCW 48.43.780(2)	• If the federal internal revenue service removes insulin from the list of preventive care services which can be covered by a qualifying health plan for a health savings account before the deductible is satisfied, the carrier must establish the plan's cost sharing for the coverage of prescription insulin for diabetes at the minimum level necessary to preserve the enrollee's ability to claim tax exempt contributions from his or her health savings account under internal revenue service laws and regulations.		
		RCW 48.44.315(2)(b); WAC 284-43-5642(1)(d)(iii)	• Contract must provide: ○ outpatient self-management training and education, including medical nutrition therapy, as ordered by the health care provider. Diabetes outpatient self-management training and education may be provided only by providers with expertise in diabetes. ○ HCSC may restrict patients to seeing only health care providers who have signed participating provider agreements with the HCSC or an insuring entity under contract with the HCSC.		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Diabetes (Cont'd)	Coverage Requirements (cont'd)	RCW 48.44.315(3)	Benefits may be subject to customary cost sharing for all other similar services or supplies within the policy. Except as provided in RCW 48.43.780, coverage required under this section may be subject to customary cost-sharing provisions established for all other similar services or supplies within a policy.		
		48.44.315(5)	• Services must be covered when deemed medically necessary.		
		WAC 284-43-5642(1)(b)(ii)	• Plan must provide routine foot care for diabetic persons.		
Disclosures	List of Disclosure Items	RCW 48.43.510(3)	• Issuer must provide to all enrollees and prospective enrollees a list of available disclosure items, including:		
		WAC 284-43-5130(4)	○ Instructions on how to access and request copies in paper and electronic forms, and ○ Web site links to the entire health plan disclosure information.		
	Required Offer	RCW 48.43.510(1)(g); WAC 284-43-5130(2) WAC 284-435130(3)	• Plan must clearly and prominently display an offer to provide the information listed below before purchase or selection. ○ Information must be provided upon request (either by paper or electronic, whichever is requested). Must be prominently displayed and accessible on the issuer's website. ○ Each disclosure must be written in a manner that is easily understood by the average plan participant.		
		RCW 48.43.510 (1)(a)	○ listing of covered benefits, including RX benefits, if any, ▪ copy of the current formulary, if any is used ▪ definitions of terms such as generic versus brand name, and ▪ policies regarding coverage of drugs, such as how they become approved or taken off the formulary, and how consumers may be involved in decisions about benefits;		
		RCW 48.43.510 (1)(b)	○ listing of exclusions, reductions, and limitations to covered benefits, and any definition of medical necessity or other		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Disclosures (Cont'd)	Required Offer (cont'd)		coverage criteria upon which they may be based;		
		48.43.510 (1)(c)	○ statement of the carrier's policies for protecting the confidentiality of health information;		
		48.43.510 (1)(d)	○ statement of the cost of premiums and any enrollee cost-sharing requirements;		
		48.43.510 (1)(e)	○ summary explanation of the carrier's review of adverse benefit determinations and grievance processes;		
		48.43.510 (1)(f)	○ statement regarding the availability of a point-of-service option, if any, and how the option operates; and		
		48.43.510 (1)(g);	○ convenient means of obtaining lists of participating primary care and specialty care providers, including disclosure of network arrangements that restrict access to providers within any plan network.		
		RCW 48.43.510(2)(a)	• Upon the request of any person, including a current enrollee, prospective enrollee a carrier must provide written information regarding any health care plan it offers, that includes the following written information: ○ Any documents, instruments, or other information referred to in the medical coverage agreement;		
		RCW 48.43.510(2)(b)	○ A full description of the procedures to be followed by an enrollee for consulting a provider other than the primary care provider and whether any entity must authorize the referral;		
		RCW 48.43.510(2)(c)	○ Procedures, if any, that an enrollee must first follow for obtaining prior authorization for health care services;		
		RCW 48.43.510(2)(d)	○ A written description of any reimbursement or payment arrangements between the issuer and providers, including capitation provisions, fee-for-service provisions, and health care delivery efficiency provisions;		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Disclosures (Cont'd)	Required Offer (cont'd)	RCW 48.43.510(2)(e)	○ Descriptions and justifications for provider compensation programs, including any incentives or penalties that are intended to encourage providers to withhold services or minimize or avoid referrals to specialists;		
		RCW 48.43.510(2)(f)	○ An annual accounting of all payments made by the carrier which have been counted against any payment limitations, visit limitations, or other overall limitations on a person's coverage under a plan; and		
		RCW 48.43.510 (2)(h)	○ Accreditation status with one or more national managed care accreditation organizations, and whether the carrier tracks its health care effectiveness performance using the health employer data information set (HEDIS), whether it publicly reports its HEDIS data, and how people can access its HEDIS data.		
		WAC 284-43-7100(1)	• Contract must inform enrollees of their rights to free information, including: ○ Access to and copies of all information relevant to a claim.		
		WAC 284-43-7100(3)	○ The reason for any adverse benefit decision for MH/SUD benefits must be provided with the notification of the adverse benefit decision.		
		WAC 284-43-7100(2)	○ The criteria, processes, strategies, evidentiary standards and other factors used to ▪ Make medical necessity determinations of MH/SUD benefits and ▪ Apply an NQTL to medical/surgical and MH/SUD benefits under the plan.		
		WAC 284-170-200(8)	▪ Issuer must disclose that limitations or restrictions on access to participating providers and facilities may arise from the health service referral and authorization practices of the issuer. The description of referral and authorization practices		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Disclosures (Cont'd)			may be included in the summary of benefits and explanation of coverage.		
	Description of Provider Tiering	WAC 284-170-330(2)	• If the plan providers or facilities are placed in tiers, and this network design results in cost differentials for enrollees, the issuer must disclose to enrollees at the time of enrollment the cost difference and the basis for the issuer's placement of providers or facilities in one tier or another.		
		WAC 284-170-330(3)	• The lowest cost-sharing tier of a tiered network must provide enrollees with adequate access and choice among health care providers and facilities for essential health benefits as set forth in 284-43-5642; 284-43-5702 and 284-43-5782		
		WAC 284-170-330(6)	An issuer's provider and facility ranking program, and the criteria used to assign providers and facilities to different tiers, must not be described in plan documents so as to deceive consumers as to issuer rating practices and their effect on available benefits. When a tiered network is used, issuer must provide detailed information on its web site and if requested, make available in paper form information about the tiered network including, but not limited to:		
		WAC 284-170-330(6)(a)	• The providers and facilities participating in the tiered network;		
		WAC 284-170-330(6)(b)	• The selection criteria, if any, used to place the providers and facilities, but not including the results of applying those selection criteria to a particular provider or facility;		
		WAC 284-170-330(6)(c)	• The potential for providers and facilities to move from one tier to another at any time; and		
		WAC 284-170-330(6)(d)	• The tier in which each participating provider or facility is assigned.		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Disclosures (Cont'd)	Health Care Benefit Managers	WAC 284-180-325(1)	• If the plan utilizes Health Care Benefit Managers, a website link to the list of the Health Care Benefit Managers must be included in the plan for enrollees to access.		
	Prescription Drug Emergency Fills	WAC 284-170-470	If a carrier requires cost-sharing for enrollees receiving an emergency fill as defined in WAC 284-170-470, then issuers must disclose that information to enrollees within their policy forms. A clear statement explaining that members may be eligible to receive an emergency fill for prescription drugs under the circumstances described in WAC 284-170-470 must be disclosed. This disclosure must include the process that members use to obtain an emergency fill, and cost-sharing requirements, if any, for an emergency fill. The applicable WAC also does not limit the fill to one per prescription medication per calendar year. – WAC 284-43-5110(5), WAC 284-43-5170 (1)(c), and WAC 284-170-470(8)(c).		
Eligibility	Preexisting Conditions	RCW 48.43.015 42 U.S.C. §300gg-3(a)	• Plan may not reject an individual for an individual health benefit plan based upon preexisting conditions of the individual. • Plan may not deny, exclude, or otherwise limit coverage for an individual's preexisting health conditions. • Plan may not include a waiting period for benefits or enrollment due to a preexisting condition.		
		42 U.S.C. §300gg-3(1)(B)	Plan may not impose any preexisting condition exclusion on the basis of genetic information. 45 CFR 148.180 (d)(1); 45 CFR §147.108(a).		
		42 U.S.C. §300gg-7	• Issuer cannot apply any waiting period longer than 90 days. *Resources*: ACA FAQ Part XVI		
		42 U.S.C. §300gg-3(b)(1)(A)	• Plan must correctly define "Preexisting Condition". o The term "preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Eligibility (Cont'd)	Preexisting Conditions (cont'd)		the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.		
		42 U.S.C. §300gg-3(b)(1)(B)	○ Genetic information may not be treated as a preexisting condition in the absence of a diagnosis of the condition related to the information.		
	Organ Transplant Waiting Period	42 USC §300gg-3(a); WAC 284-43-5642(3)(c)(i)	The plan may not include a waiting period for organ transplant benefits because such a waiting period excludes, for the waiting period, benefits specifically relating to conditions requiring transplants.		
	Special Enrollment Periods – Federal Law	42 U.S.C. §300gg-1(b)(1);	• Plan can use open enrollment periods but must offer Special Enrollment where required. 45 CFR 147.104(b)(3).		
		45 C.F.R. §146.117 (a)(3)(i)	• Plan must offer enrollment to eligible persons regardless of open enrollment requirements ("special enrollment"), in the following situations:		
		42 U.S.C. §300gg-3(f)(1)	○ Employee loses other coverage ▪ If the employee didn't enroll during open enrollment because they had other coverage.		
		42 U.S.C. §300gg-3(f)(1)(A); 45 CFR § 146.117 (a)(2)(ii)(B)	○ Dependent loses coverage ▪ During open enrollment, the dependent had other coverage. ▪ Allow both dependent and employee to enroll, but not any other dependents unless they also have their own special enrollment qualifying event.		
		42 U.S.C. §300gg-3	○ Employee or any dependent loses other coverage (other than for nonpayment or fraud) due to:		
		(f)(1)(c)(ii)	▪ Divorce or legal separation ▪ Death of an employee under whose coverage they were a dependent		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Eligibility (Cont'd)	Special Enrollment – Federal Law (cont'd)		▪ Termination or reduction in the number of hours worked ▪ Discontinuation of employer contributions; or		
		(f)(1)(c)(i)	▪ Exhaustion of COBRA continuation coverage		
	Special Enrollment – on or off the Exchange	WAC 284-43-1060(2)	Issuer must make a special enrollment period of not less than sixty days available to any person who experiences one of the following qualifying events:		
		WAC 284-43-1020(2)(a)	• Loss of minimum essential benefits, including loss of employer sponsored insurance coverage, or of the coverage of a person under whose policy they were enrolled, unless the loss is based on the individual's voluntary termination of employer sponsored coverage, the misrepresentation of a material fact affecting coverage or for fraud related to the terminated health coverage;		
		WAC 284-43-1020(2)(b)	• The loss of eligibility for Medicaid or a public program providing health benefits;		
		1020(2)(c)	• Dissolution of marriage or termination of a domestic partnership;		
		WAC 284-43-1020(2)(d)	• Permanent change in residence, work, or living situation, whether or not within the choice of the individual, where the health plan under which they were covered does not provide coverage in the new service area;		
		WAC 284-43-1020(2)(e)	• Birth, adoption or placement for adoption. For newborns, coverage must be effective from the moment of birth; for those adopted or placed for adoption, coverage must be effective from the date of adoption or placement for adoption, whichever occurs first;		
		WAC 284-43-1020(2)(f)	• Plan no longer offers any benefits to the class of similarly situated individuals that includes the individual;		
		WAC 284-43-1020(2)(g)	• Loss of individual or group coverage purchased on the health benefit exchange due to an error on the part of the exchange, the issuer or the U.S. Department of Health and Human Services;		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Eligibility (Cont'd)		WAC 284-43-1020(2)(h)	• Marriage or entering into a domestic partnership, including eligibility as a dependent of an individual marrying or entering into a domestic partnership.		
	Special Enrollment – Qualified Health Plans	WAC 284-43-1040(1) WAC 284-43-1040(2) WAC 284-43-1040(2)(a)	Issuers of small group qualified health plans must comply with the additional special enrollment period requirements set forth in 45 C.F.R. 155.420 (b)(2) and 45 C.F.R. 155.725. • In addition to meeting the requirements set forth in WAC 284-43-1020, issuers must include in qualified health plan contract forms and required disclosure documents an explanation of special enrollment rights if one of the following triggering events occurs: • In addition to the requirements for adopted, placed for adoption, and newborn children, the same special enrollment right accrues for foster children and children placed in foster care;		
		WAC 284-43-1040(2)(b)	• Applicant demonstrates to the Exchange that the qualified health plan in which they are enrolled violated a material provision of the coverage contract in relation to the individual;		
		WAC 284-43-1040(2)(c)	• Applicant lost prior coverage due to errors by the Exchange staff or the U.S. Department of Health and Human Services;		
		WAC 284-43-1040(2)(d) WAC 284-43-1040(2)(e)	• In addition to the special enrollment event in WAC 284-43-1020 (2)(d), a change in the individual's residence as the result of a permanent move results in new eligibility for previously unavailable qualified health plans; • For qualified individuals who are an Indian, as defined by Section 4 of the Indian Health Care Improvement Act, enrollment in a qualified health plan or change from one qualified health plan to another must be permitted one time per month, without requiring an additional special enrollment triggering event.		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Eligibility (Cont'd)	Duration, Notice, and Effective Dates	WAC 284-43-1060(2)	Special enrollment periods must not be shorter than sixty days from the date of the qualifying event.		
		WAC 284-43-1060(3)	The effective date of coverage for those enrolling in a small group plan through a special enrollment period is the first date of the next month after the application for coverage is received, unless one of the following exceptions applies:		
		WAC 284-43-1060(3)(a)	• For special enrollment of newborn, adopted or placed for adoption children, the date of birth, date of adoption or date of placement for adoption becomes the first effective date of coverage;		
		WAC 284-43-1060(3)(b)	• For applicants enrolling after the fifteenth of the month, the issuer must begin coverage not later than the first date of the second month after the application is received, unless the applicant is enrolling due to marriage or the commencement of a domestic partnership. An issuer may establish an earlier effective date at their discretion. An issuer may establish an earlier effective date at their discretion;		
		WAC 284-43-1060(3)(c)	• For applicants enrolling because of marriage or the commencement of a domestic partnership, when notice of the marriage or domestic partnership is received within sixty days of the marriage or commencement of the domestic partnership, either as spouse, domestic partner or as a dependent child, coverage must begin no later than the first date of the month immediately following the date of marriage or domestic partnership.		
		WAC 284-43-1060(4)	• An issuer must not refuse to enroll an applicant who applies within sixty days of the qualifying event, if the applicant would be eligible had the application been received during open enrollment.		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Emergency Medical Services (EHB)	Required Emergency Services	42 USC §18021 (a)(1)(B); 42 USC 18022(b)(1)(B)	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. WAC 284-43-5642(2).		
		WAC 284-43-5642(2)(a)	Plan must include the following services which are specifically covered by the base-benchmark plan and classify them as emergency services:		
		WAC 284-43-5642(2)(a)(i)	• Ambulance transportation to an emergency room and treatment provided as part of the ambulance service;		
		WAC 284-43-5642(2)(a)(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;		
		WAC 284-43-5642(2)(a)(iii)	• Prescription medications associated with an emergency medical condition, including those purchased in a foreign country.		
		WAC 284-43-5642(2) (b and c)	• Plan may not specifically exclude any services classified to the emergency medical services category or establish visit limitations on services in the emergency medical services category.		
		RCW 48.43.093; WAC 284-43-5642(2)(d); WAC 284-44-040(5)	• Plan must include the services necessary to screen and stabilize a covered person, classified to the emergency medical services category. • If plan restricts treatment to services by in-network providers, must include a reasonable provision to allow emergency treatment consistent with the scope of the benefits regularly provided by the contract.		
		WAC 284-170-370	• Enrollees must have access to emergency services twenty-four hours per day, seven days per week.		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Emergency Medical Services (EHB)	Definitions and coverage requirements	42 U.S.C. §300gg-19a (b) (2)(B); RCW 48.43.005(16) (a)(i)	Plan's definition of "Emergency services" must be consistent with RCW 48.43.005(16), which states: • "Emergency Services" means a medical screening examination, as required under section 1867 of the social security act (42 U.S.C. 1395dd), that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate that emergency medical condition;		
		RCW 48.43.005(16) (a)(ii)	• Medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the social security act (42 U.S.C. 1395dd) to stabilize the patient. Stabilize, with respect to an emergency medical condition, has the meaning given in section 1867(e)(3) of the social security act (42 U.S.C. 1395dd(e)(3); and		
		(a)(iii)	• Covered services provided by staff or facilities of a hospital after the enrollee is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit during which screening and stabilization services have been furnished. Poststabilization services relate to medical, mental health, or substance use disorder treatment necessary in the short term to avoid 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, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part; or		
		(b)(I)	• A screening examination that is within the capability of a behavioral health emergency services provider including ancillary services routinely available to the behavioral health emergency services provider to evaluate that emergency medical condition;		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Emergency Services (EHB) (Cont'd)	Definitions and coverage requirements (Cont'd)	(b)(ii)	• Examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the behavioral health emergency services provider, as are required under section 1867 of the social security act (42 U.S.C. Sec. 1395dd) or as would be required under such section if such section applied to behavioral health emergency services providers, to stabilize the patient. Stabilize, with respect to an emergency medical condition, has the meaning given in section 1867(e)(3) of the social security act (42 19 U.S.C. Sec. 1395dd(e)(3)); and		
		(b)(iii)	• Covered behavioral health services provided by staff or facilities of a behavioral health emergency services provider after the enrollee is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit during which screening and stabilization services have been furnished. Poststabilization services relate to mental health or substance use disorder treatment necessary in the short term to avoid 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, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.		
		42 U.S.C. §300gg-19a(b)(2)(A); RCW 48.43.005 (15); WAC 284-43-0160(8)	Plan's definition of "Emergency medical condition" must be consistent with RCW 48.43.005(15), or WAC 284-43-0160(8) which states: "Emergency medical condition" means a medical, mental health, or substance use disorder condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain or emotional distress, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical, mental health, or substance use disorder treatment attention to result in a condition (a) placing the health of the individual, or with		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Emergency Services (EHB) (Cont'd)	Definitions and coverage requirements (Cont'd)		respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part.		
		RCW 48.43.005(46)	• "Nonemergency health care services performed by nonparticipating providers at certain participating facilities" means covered items or services other than emergency services with respect to a visit at a participating health care facility, as provided in section 2799A-1(b) of the public health service act (42 U.S.C. Sec. 300gg-111(b)), 45 C.F.R. Sec. 149.30, and 45 C.F.R. Sec. 149.120.		
		RCW 48.43.005 (48)	"Behavioral health emergency services provider" means emergency services provided in the following settings:		
		RCW 48.43.005 (48)(a)	• A crisis stabilization unit as defined in RCW 71.05.020;		
		RCW 48.43.005 (48)(b)	• An evaluation and treatment facility that can provide directly, or by direct arrangement with other public or private agencies, emergency evaluation and treatment, outpatient care, and timely and appropriate inpatient care to persons suffering from a mental disorder, and which is licensed or certified as such by the department of health;		
		RCW 48.43.005 (48)(c)	• An agency certified by the department of health under chapter 31 71.24 RCW to provide outpatient crisis services;		
		RCW 48.43.005 (48)(d)	• A triage facility as defined in RCW 71.05.020;		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Emergency Services (EHB) (Cont'd)	Definitions and coverage requirements (Cont'd)	RCW 48.43.005 (48) (e)	• An agency certified by the department of health under chapter 71.24 RCW to provide medically managed or medically monitored withdrawal management services; or		
		RCW 48.43.005 (48)(f)	• A mobile rapid response crisis team as defined in RCW 71.24.025 that is contracted with a behavioral health administrative services organization operating under RCW 71.24.045 to provide crisis response services in the behavioral health administrative services organization's service area.		
		RCW 48.43.093 (1)(a)	• Plan must cover emergency services provided to a covered person if a prudent layperson acting reasonably would have believed that an emergency medical condition existed.		
		45 CFR 147.138 (b)(2)(i); RW 48.43.093(1)(c)	• The contract must not require prior authorization of emergency services if a prudent layperson acting reasonably would have believed that an emergency medical condition existed.		
		RCW 48.43.093(1)(a); 42 U.S.C. §300gg-19a(b)(1)(B-C)	• The plan must cover emergency services provided by a nonparticipating hospital emergency department or behavioral health emergency services provider, without prior authorization of emergency services.		
		RCW 48.43.093(1)(b);	• A health carrier shall cover emergency services without limiting what constitutes an emergency medical condition solely on the basis of diagnosis codes. Any determination of whether the prudent layperson standard has been met must be based on all pertinent documentation and be focused on the presenting symptoms and not solely on the final diagnosis.		
		RCW 48.43.093 (2)	• Coverage of emergency services may be subject to applicable in-network copayments, coinsurance, and deductibles, as provided in chapter 48.49 RCW.		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Emergency Services (EHB) (Cont'd)	Definitions and coverage requirements (Cont'd)	RCW 48.49.020 (3)(a)	• Must hold an enrollee harmless from balance billing when emergency services are provided by an out-of-network hospital		
		42 U.S.C. Sec. 300gg-111(b); RCW 48.49.020(1) and (1)(a)	• A nonparticipating provider or facility may not balance bill for the following health care services: • emergency services are provided by nonparticipating provider or facility;		
		RCW 48.49.020 (1)(b)	• Nonemergency health care services performed by nonparticipting providers at certain participating facilities; or		
		RCW 48.49.020 (1)(c)	• Air Ambulance Services		
		RCW 48.49.020 (2)(b)	• A health care provider, health care facility, or air ambulance service provider may not request or require a patient at any time, for any procedure, service, or supply, to sign or otherwise execute by oral, written, or electronic means, any document that would attempt to avoid, waive, or alter any provision of RCW 48.49.020 and 48.49.030 or sections 2799A-1 et seq. of the public health service act (P.L. 116-260)		
		RCW 48.43.093(3)(a)	• Issuer may require notification of stabilization or inpatient admission within the time frame specified in its contract with the hospital or behavioral health emergency services provider or as soon thereafter as medically possible but no less than twenty-four hours; or		
		RCW 48.43.093 (3)(b)	• Issuer may require a hospital or emergency behavioral health emergency services provider to make a documented good faith effort to notify the covered person's health carrier within 48 hours of stabilization, or by the end of the business day		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Emergency Services (EHB) (Cont'd)	Definitions and coverage requirements (Cont'd)		following the day the stabilization occurs, whichever is later, if the covered person needs to be stabilized. If a health carrier requires such notification, the health carrier shall provide access to an authorized representative seven days a week to receive notifications.		
		RCW 48.43.093(4)	◦ Unless provided otherwise in this section, care that is a direct result of the emergency must be obtained in accordance with the plan's usual terms and conditions of coverage.		
	Balance Billing Notice	RCW 48.49.060(1); WAC 284-43B-050	Issuers must provide notice to consumers of their rights concerning balance billing under RCW 48.49 and 42 U.S.C. Secs. 300gg-111 and 5 300gg-112 • The notice must include contact information for the office of the insurance commissioner so consumers may make contact if they believe they have received a balance bill in violation of RCW 48.49.		
		RCW 48.49.090(1)	A carrier must update its website and provider directory no later than thirty days after the addition or termination of a facility or provider.		
		RCW 48.49.090(2)	A carrier must provide an enrollee with:		
		(2)(a)	◦ A clear description of the health plan's out-of-network health benefits;		
		(2)(b)	◦ The Notice of Consumer Rights developed under RCW 48.49.060;		
		(2)(c)	◦ Notification that if the enrollee receives services from an out-of-network provider, facility, or behavioral health emergency services provider, under circumstances other than those described in RCW 48.49.020, the enrollee will have the financial responsibility applicable to services provided outside the health plan's network in excess of applicable cost-sharing amounts and that the enrollee may be responsible for any costs in excess of those allowed by the health plan;		
		(2)(d)	◦ Information on how to use the carrier's member transparency		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Emergency Services (EHB) (Cont'd)	Balance Billing Notice (Cont'd)		tools under RCW 48.43.007		
		(2)(e)	• Upon request, information regarding whether a health care provider is in-network or out-of-network, and whether there are in network providers available to provide emergency medicine, anesthesiology, pathology, radiology, neonatology, surgery, hospitalist, intensivist and diagnostic services, including radiology and laboratory services at specified in-network hospitals or ambulatory surgical facilities; and		
		(2)(f)	• Upon request, an estimated range of the out-of-pocket costs for an out-of-network benefit.		
Every Category of Provider	Requirements	42 U.S.C. §300gg-5(a) *See* ACA FAQ Part XV	• Plan and Issuer must not discriminate with respect to participation under the plan against any provider acting within the scope of that provider's license or certification under applicable State law. (Reimbursement rates may vary based on quality or performance measures.)		
		RCW 48.43.045 (1)(a)(i);	• Every category of provider must be permitted to provide covered services, if the treatment is within the scope of the provider's licensure.		
		WAC 284-170-200(1)	• Each health plan's defined service area must have a comprehensive range of primary, specialty, institutional, and ancillary services available without unreasonable delay to all enrollees and that emergency services are accessible twenty-four hours per day, seven days per week without unreasonable delay.		
		RCW 48.43.515(1); WAC 284-170-200(2)	• Each enrollee must have adequate choice among health care providers, including those providers which must be included in the network under WAC 284-170-270, and for qualified health plans and qualified stand-alone dental plans under WAC 284-170-310.		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Every Category of Provider (Cont'd)		WAC 284-170-270(1)	Issuers must not exclude any category of providers licensed by the State of Washington who provide health care services or care within the scope of their practice for services covered as essential health benefits.		
	American Indians/ Alaska Natives	WAC 284-170-200(9)	Issuer must maintain arrangements that ensure that American Indians/Alaska Natives who are enrollees have access to covered medical and behavioral health services provided by Indian health care providers.		
	Allowable Limits Allowable Limits (cont'd)	RCW 48.43.045 (1)(a)(ii) WAC 284-170-270(2-3)	• Providers can be required to conform with carrier standards for cost - Containment, administrative procedures, and provision of cost-effective, clinically effective services. • Issuers may place reasonable limits on specific services rendered by specific categories of providers based on relevant information or evidence of the type usually considered and relied upon in making determinations of cost-effectiveness or clinical efficacy. However, health plans must not contain unreasonable limits.		
		WAC 284-170-270(4)	• Plans may use restricted networks.		
		WAC 284-170-270(4)(a)	• Plans that use "gatekeepers" or "Medical Homes" for access to specialists may use them for access to specified categories of providers.		
	No Separate Benefit	WAC 284-170 270(5)	Issuers may not offer coverage for services by certain categories of providers solely as a separately-priced optional benefit (e.g., chiropractic care; acupuncture).		
	Services by RNs, ARNPs and Podiatrists	RCW 48.44.225; 48.44.290; 48.44.300; 48.44.299	• Contract must cover services performed by a Registered Nurse, Advanced Registered Nurse Practitioner, or podiatrist if: • the service is within the scope of the provider's license, and • The contract would have covered the service if it had been performed by a physician licensed under Chapter 18.71 RCW.		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Every Category of Provider (Cont'd)	Services by RNs, ARNPs and Podiatrists (Cont'd)	WAC 284-44-045(1)	• Contract must contain the following provision, or substantial equivalent: "Benefits under this contract will not be denied for any health care service performed by a registered nurse licensed to practice under chapter 18.88 RCW, if first, the service performed was within the lawful scope of such nurse's license, and second, this contract would have provided benefits if such service had been performed by a doctor of medicine licensed to practice under chapter 18.71 RCW."		
		WAC 284-44-045(4)	• The contract may not contain a provision which places restrictions or limitations on benefits for services by nurses or any class of doctors which are not also placed on benefits for services by other doctors. E.g., plan may not limit the number of office calls made to a RN to fewer than the limit for office calls made to a MD.		
	Coverage of Chiropractic care	RCW 48.43.190; RCW 48.44.310; WAC 284-170-360(4)	• Plan must cover chiropractic care on the same basis as other care. • Benefits cannot be denied on the basis that a service is not performed by a physician licensed under Chapter 18.57 or 18.71 RCW. • Must provide direct access to a chiropractor without a referral for covered chiropractic benefits, but can restrict this to in-network chiropractors.		
	Denturist if Dental Covered	RCW 48.44.500; RCW 48.43.180	• If plan offers dental coverage, Denturist must be able to provide services within the scope of their license if the plan would provide the same benefits performed by a dentist.		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Experimental or Investigational Treatment	Definition Required	WAC 284-44-043(1)	• If the contract includes exclusion, reduction or limitation for services that are experimental or investigational, contract must include a definition of Experimental and Investigational services.		
		WAC 284-44-043(2)	○ The definition must include an identification of the authority or authorities which will make a determination of which services will be considered to be experimental or investigational.		
	Contract Must State Criteria for Determination	WAC 284-44-043(2)	• If the HCSC or an affiliated entity is the authority making the determination, it must state the criteria it will utilize to make the determination. This requirement may be satisfied by using one or more of the following statements, or other similar statements:		
		WAC 284-44-043(2)(a)	○ "In determining whether services are experimental or investigational, the plan will consider whether the services are in general use in the medical community in the state of Washington, whether the services are under continued scientific testing and research, whether the services show a demonstrable benefit for a particular illness or disease, and whether they are proven to be safe and efficacious."		
		WAC 284-44-043 (2)(b)	○ "In determining whether services are experimental or investigational, the plan will consider whether the services result in greater benefits for a particular illness or disease than other generally available services, and do not pose a significant risk to health or safety of the patient."		
	Support for Criteria Must be Available	WAC 284-44-043 (2)(b)	○ The supporting documentation upon which the criteria are established must be made available for inspection upon written request in all instances and may not be withheld as proprietary.		
	Time Limits for Denial	WAC 284-44-043(3) WAC 284-43-3110(1)	• Whether the claim or request for preauthorization is made in writing or through other claim presentation or preauthorization procedures set out in the contract, any denial because of an experimental or investigational exclusion or limitation, must be done in writing within		

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Experimental or Investigational Treatment (Cont'd)			twenty working days of receipt of a fully documented request. The issuer may extend the review period beyond twenty days only with the informed written consent of the enrollee.		
Grievance Procedures	Definition	RCW 48.43.005 (24); WAC 284-43-0160(14); WAC 284-43-4500	• "Grievance" means a written complaint submitted by or on behalf of an enrollee regarding service delivery issues other than denial of payment for, or nonprovision of, medical services, including dissatisfaction with medical care, waiting time for medical services, provider or staff attitude or demeanor, or dissatisfaction with service provided by the health carrier.		
		RCW 48.43.530(8)	• Contract must provide a clear explanation of the grievance process.		
	Requirements	RCW 48.43.530(9)	○ Process must be accessible to enrollees who are limited English speakers, who have literacy problems, or who have physical or mental disabilities that impede their ability to file a grievance.		
		RCW 48.43.530 (4)(c)	○ Issuer may not require enrollee to file a complaint or grievance prior to seeking appeal of a decision or review of an adverse benefit determination.		
		WAC 284-43-4520(3)	○ Grievances are not adverse benefit determinations and do not establish the right to internal or external review of an issuer's resolution of the grievance.		
Guaranteed Issue and Continuity of Coverage	Issuer Must Accept All Residents in Service Area	45 CFR §147.104(a); RCW 48.43.035(1); RCW 48.44.220	Issuer must accept for enrollment any state resident within the group to whom the plan is offered and within the carrier's service area and provide or assure the provision of all covered services regardless of age, sex, family structure, ethnicity, race, religion, national origin, health condition, geographic location, employment status socioeconomic		

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Grievance Procedures (Cont'd)			status, the presence of any disability, other condition or situation, or actual or perceived status regarding HIV or Hepatitis C.		
		45 CFR 147.104(b)(1)(i)	Issuer must offer to any employer or qualified group inthe state all products approved for sale in that market at any time in the year.		
	Contract Must Contain Guarantee of Continuity	42 USC §300gg-2(a); 45 C.F.R. §147.106 (a); RCW 48.43.035(2)	Plan must contain or incorporate by endorsement a guarantee of the continuity of coverage of the plan. • A plan is "renewed" when it is continued beyond the earliest date upon which, at the carrier's sole option, the plan could have been terminated for other than nonpayment of premium.		
	When Plan May be Nonrenewed	42 USC 300gg-2(b)(1); RCW 48.43.035 (3)(a)	• Plan may still be canceled or nonrenewed for: o Nonpayment of premium;		
		RCW 48.43.035(3)(b)	o Violation of published policies of the carrier approved by the commissioner;		
		RCW 48.43.035 (3)(c)	o Covered persons entitled to become eligible for Medicare benefits by reason of age who fail to apply for a Medicare supplement plan or Medicare cost, risk, or other plan offered by the issuer pursuant to federal laws and regulations;		
		RCW 48.43.035 (3)(d)	o Covered persons who fail to pay any deductible or copayment amount owed to the carrier and not the provider of health care services;		
		(3)(e)	o Covered persons committing fraudulent acts as to the issuer;		
		(3)(f)	o Covered persons who materially breach the health plan; or		
		48.43.035 (3)(g)	o Change or implementation of federal or state laws that no longer permit the continued offering of such coverage.		
	Guaranteed Renewability Not Required When	42 USC 300gg-2(c)	• Guaranteed renewability is not required in all situations. See RCW 48.43.035(4)		

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Hospitalization (EHB)	Required Hospitaliz-ation Services	42 USC §18021 (a)(1)(B); 42 USC 18022 (b)(1)(C); WAC 284-43-5642(3)	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.		
	Required Services (Cont'd)	WAC 284-43-5642(3)(a)	Plan must include the following services and classify them as hospitalization services:		
		WAC 284-43-5642(3)(a)(i)	• Hospital visits, facility costs, provider and staff services and treatments delivered during an inpatient hospital stay, including inpatient pharmacy services;		
		WAC 284-43-5642(3)(a)(ii)	• Skilled nursing facility costs, including professional services and pharmacy services and prescriptions filled in the skilled nursing facility pharmacy;		
		WAC 284-43-5642(3)(a)(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;		
		(3)(a)(iv)	• Dialysis services delivered in a hospital;		
		WAC 284-43-5642(3)(a)(v)	• Artificial organ transplants based on an issuer's medical guidelines and manufacturer recommendations; and		
		WAC 284-43-5642(3)(a)(vi)	• Respite care services delivered on an inpatient basis in a hospital or skilled nursing facility.		
	Optional Hospitalization Services	WAC 284-43-5642(3)(b)	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:		

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Hospitalization (EHB) (Cont'd)		WAC 284-43-5642(3)(b)(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;		
		WAC 284-43-5642(3)(b)(ii); RCW 48.44.330	• 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;		
		WAC 284-43-5642(3)(b)(iii)(A)	• The following types of surgery: • Bariatric surgery and supplies;		
		WAC 284-43-5642(3)(b)(iii)(B)	• Orthognathic surgery and supplies unless due to temporomandibular joint disorder or injury, sleep apnea or congenital anomaly.		
		(3)(b)(iv)	• Reversal of sterilizations; and		
		WAC 284-43-5642(3)(b)(v)	• Surgical procedures to correct refractive errors, astigmatism or reversals or revisions of surgical procedures which alter the refractive character of the eye.		
	Prohibited Limitations on Benefits	WAC 284-43-5642(3)(c)(i)	• Plan may not include a waiting period for transplant services.		
		42 U.S.C. 18116, §1557	• Plan may not exclude coverage for sexual reassignment treatment, surgery or counseling services. See, also: RCW 48.30.300; RCW 49.60.040; WAC 284-43-5642(3)(c)(ii)		
	Allowable Limitations on benefits	WAC 284-43-5642(3)(d)(i)	Plan may include the following limitations on services in the hospitalization category: • Sixty inpatient days per calendar year for illness, injury or physical disability in a skilled nursing facility;		
		WAC 284-43-5642(3)(d)(ii)	• Thirty inpatient rehabilitation service days per calendar year. For purposes of determining actuarial value, this benefit may be		

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			classified to the hospitalization category or to the rehabilitation services category, but not to both.		
Hospitalization (EHB) (Cont'd)	State Benefit Requirements Classified to the Hospitalization Category	RCW 48.43.185; WAC 284-43-5642(3)(e)(i)	State benefit requirements classified to the hospitalization category are: • 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 48.44.330(1)	• Reconstructive breast surgery resulting from a mastectomy that resulted from disease, illness or injury; WAC 284-43-5642(3)(e)(ii)		
		RCW 48.44.330(2)	• Coverage for all stages of one reconstructive breast reduction on the nondiseased breast to make it equal in size with the diseased breast after definitive reconstructive surgery on the diseased breast has been performed.		
		RCW 48.44.460;	• Coverage for treatment of temporomandibular joint disorder (WAC 284-43-5642(3)(e)(iii)); and		
		RCW 48.43.125	**IF** a plan covers care in a long term care facility following hospitalization, carrier must allow enrollee to return to the same long term care facility after hospitalization, as long as the following criteria are met (WAC 284-43-5642(3)(e)(iv)):		
		RCW 48.43.125 (1)(a)	• The person's primary care physician determines that the medical care needs of the person can be met at the requested facility;		
		RCW 48.43.125 (1)(b)	• The requested facility has all applicable licenses and certifications, and is not under a stop placement order that prevents the person's readmission;		
		RCW 48.43.125 (1)(c)	• The requested facility agrees to accept payment from the carrier for covered services at the rate paid to similar facilities that otherwise contract with the carrier to provide such services; and		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Hospitalization (EHB) (Cont'd)		RCW 48.43.125 (1)(d)	• The requested facility, with regard to the following, agrees to abide by the standards, terms, and conditions required by the carrier of similar facilities with which the carrier otherwise contracts: (i) Utilization review, quality assurance, and peer review; and (ii) management and administrative procedures, including data and financial reporting that may be required by the carrier.		
Laboratory Services (EHB)	Required Laboratory Services	42 USC §18021 (a)(1)(B); 42 USC 18022 (b)(1)(H); WAC 284-43-5642(8)	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.		
		WAC 284-43-5642(8)(a)(i)	Plan must include the following services, which are specifically covered by the base-benchmark plan, and classify them as laboratory services. • Laboratory services, supplies and tests, including genetic testing;		
		WAC 284-43-5642(8)(a)(ii)	• Radiology services, including X ray, MRI, CAT scan, PET scan, and ultrasound imaging; and		
		WAC 284-43-5642(8)(a)(iii)	• Blood, blood products, and blood storage, including the services and supplies of a blood bank.		
	Optional Laboratory Services	WAC 284-43-5642(8)(b)	Plan may, but is not required to, include 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.		

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Maternity and Newborn Services (EHB)	Requirement to cover Maternity and Newborn Services	WAC 284-43-5642(4); 42 USC §18021 (a)(1)(B); 42 USC 18022 (b)(1)(D)	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.		
		WAC 284-43-5642(4)(a)(i)	Plan must cover the following services which are specifically covered by the base-benchmark plan and classify them as maternity and newborn services: • In utero treatment for the fetus;		
		WAC 284-43-5642(4)(a)(ii)	• Vaginal or cesarean childbirth delivery in a hospital or birthing center, including facility fees;		
		WAC 284-43-5642(4)(a)(iii)	• Nursery services and supplies for newborns, including newly adopted children;		
		(4)(a)(iv)	• Infertility diagnosis;		
		(4)(a)(v)	• Prenatal and postnatal care and services, including screening;		
		WAC 284-43-5642(4)(a)(vi)	• Complications of pregnancy such as, but not limited to, fetal distress, gestational diabetes, and toxemia; and		
		RCW 48.43.073; WAC 284-43-5642(4)(a)(vii)	• Termination of pregnancy. Termination of pregnancy must be covered, and may be included in an issuer's essential health benefits package, but some groups and issuers are exempt from this requirement, consistent with 42 U.S.C. 18023 (b)(a)(A)(i); 45 C.F.R. 156.115; RCW 48.43.065, and RCW 48.43.073(5).		
		RCW 48.42.100(2)	• Health care practitioners that provide women's health care services must include, but need not be limited to: • Any generally recognized medical specialty of practitioners licensed under chapter 18.57 or 18.71 RCW who provides women's health care services; practitioners licensed under		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Maternity and Newborn Services (EHB)	Required Maternity and Newborn Services		chapters 18.57A and 18.71A RCW when providing women's health care services; • midwives licensed under chapter 18.50 RCW; and • advanced registered nurse practitioner specialists in women's health and midwifery under chapter 18.79 RCW.		
		RCW 48.42.100(3); WAC 284-170-350(1)(a)	• Women's health care services must include, but need not be limited to: Maternity care; reproductive health services, gynecological care, contraceptive services, testing and treatment for sexually transmitted diseases, pregnancy termination, breast feeding, complications of pregnancy, general examination, preventive care as medically appropriate and medically appropriate follow-up visits for these services; and any appropriate health care service for other health problems, discovered and treated during the course of a visit to a women's health care practitioner for a women's health care service, which is within the practitioner's scope of practice.		
	Optional Maternity and Newborn Services	WAC 284-43-5642(4)(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.		
	Allowable Limitations	WAC 284-43-5642(4)(c)	Plan may limit coverage of home birth by a midwife or nurse midwife to low risk pregnancy only.		
	Required termination of pregnancy coverage	RCW 48.43.073(1)	• Health plans issued or renewed on or after January 1, 2019, that provide coverage for maternity care or services, must also provide a covered person with substantially equivalent coverage to permit the abortion of a pregnancy.		
		RCW 48.43.073 (2)(b)(i)	• Coverage for the abortion of a pregnancy may be subject to terms and conditions generally applicable to the		

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Maternity and Newborn Services (EHB) (Cont'd)			health plan's coverage of maternity care or services, including applicable cost sharing.		
		RCW 48.43.073 (2)(b)(ii)	• A Health plan is not required to cover abortions that: • Are unlawful under RCW 9.02.120		
		RCW 48.43.065(2)(b)(i), (ii) and (iii); RCW 48.43.725	The provisions of this section are not intended to result in an enrollee being denied timely access to any service included in the basic health plan services. Each health carrier shall: • Provide written notice to enrollees, which benefits the plan does not cover; listing services that the carrier refuses to cover for reason of conscience or religion; and • Alternate ways in which enrollees may access excluded benefit information in an timely manner; and • Clearly and legibly include this information in any of its marketing materials that include a list of benefits covered under the plan.		
	Women's Direct Access	48.42.100(4) and (5)(a); WAC 284-170-350(3)(a)	• Female enrollees must have direct access to timely and appropriate covered women's health care services from the type of health care practitioner of their choice for appropriate covered women's health care services without the necessity of prior referral from another type of health care practitioner.		
		RCW 48.42.100(4) and (5)(c); WAC 284-170-350(3)(b)	• Plan may restrict women's direct access to in-network providers, but must not limit access to a subset of participating women's health care practitioners within the network. Such an impermissible limitation might arise when a primary care provider's group practice receives a capitation payment for comprehensive care to an enrollee and then represents to the enrollee that only those gynecologists in the primary care provider's clinic are available for direct access.		

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Maternity and Newborn Services (EHB) (Cont'd)	Women's Direct Access (Cont'd)	WAC 284-170-350(1)(b)	• Plan must not exclude or limit access to covered women's health care services offered by a particular type of women's health care provider, practitioner, or facility in a manner that would unreasonably restrict access to that type of provider, practitioner, or facility or covered service. For example, plan must not require all child birth to occur in a hospital attended by a physician, thus preventing a woman from choosing between and using the birthing services of an advanced registered nurse practitioner, a certified midwife, or a licensed midwife.		
		RCW 48.42.100	▪ Plan must cover medically necessary supplies for a home birth. WAC 284-170-350(2).		
		WAC 284-170-350(1 and 2)	• Plan must not require notification or prior authorization for women's health care practitioners, providers, and facilities unless such requirements are imposed upon other providers offering similar types of service. E.g.,, plan must not require a directly accessed women's health care practitioner to notify the plan within seven days of providing direct women's health care services if a primary care provider would not also be required to provide seven-day notice for the same or similar service.		
		WAC 284-170-350(2) WAC 284-170-350(1)(b)	• Plan must not deny coverage for medically appropriate laboratory, imaging, or diagnostic services, or prescriptions for pharmaceutical or medical supplies, ordered by a directly accessed women's health care practitioner within the practitioner's scope of practice, if such services would be covered when provided by another type of health care practitioner. • Plan must not require authorization by another type of health care practitioner for these services. For example, if plan would cover a prescription written by the primary care provider, the issuer must cover that prescription if written by the directly accessed women's health care practitioner.		

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Maternity and Newborn Services (EHB) (Cont'd)		WAC 284-170-350(4)	• Contract must include a written explanation of a woman's right to directly access covered women's health care services, including information regarding any limitations to direct access, including, but not limited to: • Limited direct access based on a benefit plan's closed network of practitioners, if appropriate; and • The issuer's right to limit coverage to medically necessary and appropriate women's health care services.		
		WAC 284-170-350(5)	• Plan may not impose cost-sharing for directly accessed women's health care services, that is not required for access to primary care providers.		
	State Benefit Requirements for Maternity And Newborn Services	WAC 284-43-5642(4)(d)(i)	• Maternity services must include diagnosis of pregnancy, prenatal care, delivery, care for complications of pregnancy, physician services, and hospital services		
		RCW 48.43.115 (3)(f); 284-43-5642(4)(d)(ii)	• Must provide newborn coverage that is not less than the postnatal coverage for the mother, for no less than three weeks, even if there are separate admissions; and		
		WAC 284-43-5642(4)(d)(iii)	• Prenatal diagnosis of congenital disorders by screening/diagnostic procedures if medically necessary.		
		RCW 48.43.115 (3)(a)	• Plan must permit the attending provider, in consultation with the mother, to make decisions on the length of inpatient stay. These decisions must be based on accepted medical practice.		
		RCW 48.43.115 (3)(b)	• Plan may not deny covered, eligible services for inpatient, postdelivery care to a mother and her newly born child after a vaginal delivery or a cesarean section delivery that is ordered by the attending provider in consultation with the mother.		
		RCW 48.43.115 (3)(c)	• At the time of discharge, determination of the type and location of follow-up care must be made by the attending provider in consultation with the mother rather than by contract or agreement		

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Maternity and Newborn Services (EHB) (Cont'd)			between the hospital and the insurer. These decisions must be based on accepted medical practice.		
		RCW 48.43.115 (3)(d)	• Plan may not deny covered, eligible services for follow-up care, including in-person care, as ordered by the attending provider in consultation with the mother. Coverage for providers of follow-up services must include, but need not be limited to, attending providers, home health agencies licensed under chapter 70.127 RCW, and registered nurses licensed under chapter 18.79 RCW.		
		RCW 48.43.115 (3)(e)	• This section does not require attending providers to authorize care they believe to be medically unnecessary.		

	Length of Stay	RCW 48.43.115 (3) and (5) ("Erin Act"); 42 USC 300gg-51	• The plan must provide notice that the health care provider in consultation with the mother will determine the care and length of hospital stay.
			  • If length of stay guideline is stated it must be no less than: 48-hour normal birth/96 caesarian section birth.
			  • The plan cannot restrict follow-up care when ordered by the attending provider in consultation with the mother. ("Newborns' and Mothers' Health Protection Act of 1996")		

	Dependent Daughter Coverage	WAC 284-43-5622(1); WAC 284-43-5602	• Plan must include maternity coverage and newborn delivery for dependent daughters on the same basis as the EHB-benchmark plan.		

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Medical Necessity	Requirements of Medical Necessity Determination Process	WAC 284-43-5440(2)(a)	• Contract must specifically explain issuer's medical necessity determination process.		
		WAC 284-43-5440(2)(b)	• Process must: o be conducted fairly, and with transparency to enrollees and providers, at a minimum when an enrollee or their representative appeals or seeks review of an adverse benefit determination;		
		WAC 284-43-5440(2)(c)	o Include consideration of services that are a logical next step in reasonable care if they are appropriate for the patient;		
		WAC 284-43-5440(2)(d)	o Identify the information needed in the decision-making process and incorporate appropriate outcomes within a developmental framework;		
		WAC 284-43-5440(2)(e)	o Ensure that when the interpretation of the medical purpose of interventions is part of the medical necessity decision making, the interpretation standard can be explained in writing to an enrollee and providers, and is broad enough to address any of the services encompassed in the ten essential health benefits categories of care;		
		WAC 284-43-5440(2)(f)	o Comply with inclusion of the ten essential health benefits categories;		
		WAC 284-43-5440(2)(g)	o Not discriminate based on age, present or predicted disability, expected length of life, degree of medical dependency, quality of life or other health conditions, race, gender, national origin, sexual orientation and gender identity;		
		WAC 284-43-5440(2)(h)	o Include consideration of the treating provider's clinical judgment and recommendations regarding the medical purpose of the requested service, and the extent to which the service is likely to produce incremental health benefits for the enrollee;		

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Medical Necessity (Cont'd)	Requirements of Medical Necessity Determination Process (cont'd)	WAC 284-43-5440(2)(i)	○ Identify by role who will participate in the issuer's medical necessity decision-making process; and		
		WAC 284-43-5440(2)(j)	○ Ensure that where medically appropriate, and consistent with the health benefit plan's contract terms, an enrollee is not unreasonably restricted as to the site of service delivery.		
		WAC 284-43-5440(3)	• Medical necessity determination process may include, but is not limited to, evaluation of the effectiveness and benefit of a service for the individual patient based on scientific evidence considerations, up-to-date and consistent professional standards of care, convincing expert opinion and a comparison to alternative interventions, including no interventions. Cost effectiveness may be one of but not the sole criteria for determining medical necessity.		
		WAC 284-43-5440(4)	• Within thirty days of receiving a request, an issuer must furnish its medical necessity criteria for any or all essential health benefit categories to an enrollee or provider.		
Mental Health and Substance Use Disorder ("MH / SUD") Services, including Behavioral Health Treatment (EHB)	Requirement for Mental Health / Substance Use Disorder Coverage	42 USC §18021 (a)(1)(B); 42 USC 18022(b)(1)(E); WAC 284-43-5642(5)	Plan must cover "mental health and substance use disorder services, including behavioral health treatment" substantially equal to the base-benchmark plan. For determining a plan's actuarial value, an issuer must classify as mental health and substance use disorder services, including behavioral health treatment, 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.		

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Mental Health and Substance Use Disorder Services, (EHB) (Cont'd))	Required Services	WAC 284-43-5642(5)(a)(i)	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: • Inpatient, residential, and outpatient mental health and substance use disorder treatment, including diagnosis, partial hospital programs or inpatient services;		
		WAC 284-43-5642(5)(a)(ii)	• Chemical dependency detoxification;		
		(5)(a)(iii)	• Behavioral treatment for a DSM category diagnosis;		
		WAC 284-43-5642(5)(a)(iv)	• Services provided by a licensed behavioral health provider for a covered diagnosis in a skilled nursing facility;		
		WAC 284-43-5642(5)(a)(v)	• Prescription medication including medications prescribed during an inpatient and residential course of treatment;		
		WAC 284-43-5642(5)(a)(vi)	• Acupuncture treatment visits without application of the visit limitation requirements, when provided for chemical dependency.		
		WAC 284-43-5642(5)(b)(ii); Benchmark Plan	• Plan must cover treatment for mental health treatment for the following "V code" diagnoses in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders (DSM):* • 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,		
		42 U.S.C. 18116: ACA §1557	• gender dysphoria consistent with 42 U.S.C. 18116, Section 1557, RCW 48.30.300, 49.60.040 and WAC 284-43-5642(5)(b)(ii)		

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Mental Health and Substance Use Disorder Services, (EHB) (Cont'd)	Required Services (Cont'd)	WAC 284-43-5642(5)(b)(iii); Benchmark Plan	• Court-ordered mental health treatment which is medically necessary.		
	Optional Mental Health and Substance Use Disorder Services	WAC 284-43-5642(5)(b)	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:		
		WAC 284-43-5642(5)(b)(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;		
		WAC 284-43-5642(5)(b)(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		
		WAC 284-43-5642(5)(b)(iii)	• Court-ordered mental health treatment which is not medically necessary.		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Mental Health and Substance Use Disorder Services, (EHB) (Cont'd)	Prohibited Limitations on MH / SUD Services	WAC 284-43-5642(5)(c); 42 U.S.C. § 300gg-26;	• Plan must 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. 42 USC §300gg-26 is the Paul Wellstone and Pete Domenici Mental Health and Addiction Equity Act of 2008 ("MHPAEA")		
		RCW 48.44.341 (2)(a)	The copayment or coinsurance for mental health services may be no more than the copayment or coinsurance for medical and surgical services otherwise provided under the contract.		
			▪ Preventive services are excluded from this comparison.		
			○ If the plan has a maximum out-of-pocket limit or stop loss, it must be for medical, surgical, and mental health - it cannot have a separate MOOP or stop loss for mental health.		
			○ If the plan has any deductible, it must be for medical, surgical, and mental health – it cannot have a separate deductible for mental health.		
			○ Treatment limitations or any other financial requirements on coverage for mental health services are only allowed if the same limitations or requirements are imposed on coverage for medical and surgical services; and		
		RCW 48.44.341 (2)(b)	○ Prescription drugs intended to treat any of the disorders covered to the same extent, and under the same terms and conditions, as other prescription drugs covered under the plan		
		RCW 48.44.341 (4)	• Nothing in this section shall be construed to prevent the management of mental health services if a comparable benefit management requirement is applicable to medical and surgical services.		
		42 USC §300gg-26; WAC 284-43-5642(5)(f)	• Plan must cover mental health services and substance use disorder treatment that is delivered in parity with medical surgical benefits,		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Mental Health and Substance Use Disorder Services, (EHB) (Cont'd)			consistent with state and federal law. This includes any scope and duration limits imposed on these benefits.		
	Allowable Limitations	WAC 284-43-5642(5)(d)	Plan may limit court-ordered mental health treatment to only when medically necessary.		
	State Benefit Requirements Classified to the MH/SUD Category	RCW 48.44.341	• Plan must provide mental health services. WAC 284-43-5642(5)(e)(i)		
		RCW 48.44.240; 48.44.245	• Plan must provide chemical dependency detoxification services. See, also, WAC 284-43-5642(5)(e)(ii)		
		RCW 48.44.342	• Plan must provide services delivered pursuant to involuntary commitment proceedings. WAC 284-43-5642(5)(e)(iii)		
	Definitions	RCW 48.44.341(1)	• Plan must define "Mental Health Services" as: ""Medically necessary outpatient and inpatient services provided to treat mental disorders covered by the diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental disorders, published by the American psychiatric association, consistent with the purposes of chapter 6, Laws of 2005, with the exception of the following categories, codes, and services: (a) Substance related disorders; (b) life transition problems, currently referred to as "V" codes, and diagnostic codes 302 through 302.9 as found in the diagnostic and statistical manual of mental disorders, 4th edition, published by the American psychiatric association; (c) skilled nursing facility services, home health care, residential treatment, and custodial care; and (d) court ordered treatment unless the health care service contractor's medical director or designee determines the treatment to be medically necessary.court ordered treatment unless the insurer's medical director or designee determines the treatment to be medically necessary."		
		RCW 48.44.245;	• Does the plan define Substance Use Disorder consistent with RCW 48.44.245 and WAC 284-43-7010?		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Mental Health and Substance Use Disorder Services, (EHB) (Cont'd))	Definitions (Cont'd)	WAC 284-43-7010	"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. 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."		
	Mental Health Parity	42 USC 300gg-26	• Plan may not apply any financial requirement or treatment limitation to MH/SUD benefits that is more restrictive than those applied to medical/surgical benefits.		
		RCW 48.44.341 (2)(c)(i)	○ The copayment or coinsurance for mental health services may be no more than the copayment or coinsurance for medical and surgical services otherwise provided under the health benefit plan. ○ Preventive services are excluded from this comparison. ○ If the plan has a maximum out-of-pocket limit or stop loss, it must be for medical, surgical, and mental health - it cannot have a separate MOOP or stop loss for mental health. ○ If the plan has any deductible, it must be for medical, surgical, and mental health – it cannot have a separate deductible for mental health.		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Mental Health and Substance Use Disorder Services, (EHB) (Cont'd)	Mental Health Parity (Cont'd)	RCW 48.44.341 (2)(c)(ii)	○ Prescription drugs intended to treat any MH/SUD disorder must be covered to the same extent, and under the same terms and conditions, as other covered prescription drugs.		
		RCW 48.44.342	• No preauthorization is required for mental health treatment rendered by a state hospital if the enrollee or covered dependent is involuntarily committed.		
		RCW 48.44.341(3)	• Health benefit plans may not reduce the number of mental health outpatient visits or mental health inpatient days below the level in effect on July 1, 2002.		
		WAC 284-43-7020(1) WAC 284-43-7020(2) and (6)(a)(i and ii)	• Plan must cover MH/SUD benefits in every classification in which medical/surgical benefits are provided. ○ 6 Classifications: Inpatient, in-network; inpatient, out-of-network; outpatient, in-network; outpatient, out-of-network; emergency care; and prescription drugs. Outpatient services may be subclassified into office visits and all other outpatient items and services.		
		WAC 284-43-7020(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 MH/SUD benefits. An issuer must assign covered intermediate MH/SUD 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		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Mental Health and Substance Use Disorder Services, (EHB) (Cont'd)	Mental Health Parity (Cont'd)		partial hospitalization must be considered outpatient benefits as well.		
		WAC 284-43-7020(5)(a)	• 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 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.		
		WAC 284-43-7010; 284-43-7020(4)	• Parity analysis must be done for each classification and applies to all treatment limitations (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). Look at:		
		WAC 284-43-7010; 284-43-7040	○ Quantitative treatment limitations: expressed numerically (such as fifty outpatient visits per year) ▪ Includes annual, episode, and lifetime day and visit limits.		
		WAC 284-43-7010	○ Nonquantitative treatment limitations ("NQTL"): processes, strategies, or evidentiary standards, or other factors that are not expressed numerically, but otherwise limit the scope or duration of benefits for treatment. Includes, but not limited to: ▪ Limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative; ▪ Formulary design; ▪ Network tiering Design, if networks are tiered; ▪ Methods for determining usual, customary, and reasonable charges;		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Mental Health and Substance Use Disorder Services (EHB) (Cont'd)	Mental Health Parity (Cont'd)		▪ Use of fail-first policies or step therapy protocols; ▪ Restrictions based on geographic location, facility type, provider specialty, and other ▪ Criteria that limit scope or duration of benefits ▪ A permanent exclusion of all benefits for a particular condition or disorder is not a NQTL; may be allowable if not otherwise prohibited		
		WAC 284-43-7060(2)	○ Plan standards: in-and-out-of-network geographic limitations, limitations on inpatient services for situations where the participant is a threat to self or others, exclusions for court-ordered and involuntary holds, experimental treatment limitations, service coding, exclusions for services provided by clinical social workers, and network adequacy.		
		WAC 284-43-7020(5)(b)	• If a health plan or issuer classifies providers into tiers, and varies cost-sharing based on the different tiers, no financial requirement or treatment limitation on MH/SUD benefits may be more restrictive than what applies to substantially all medical/surgical benefits in that tier.		
		WAC 284-43-7060(1)	• No NQTL may be imposed on MH/SUD in any classification unless any processes, strategies, evidentiary standards or other factors used to apply the NQTL to MH/SUD benefits are in parity with those used to apply it to medical/surgical benefits in the same classification.		
	Prohibited Exclusions	WAC 284-43-7080(1)	• Benefits for actual treatment and services rendered may not be denied solely because a course of treatment was interrupted or was not completed.		
		WAC 284-43-7080(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.		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Mental Health and Substance Use Disorder Services (EHB) (Cont'd)	Prohibited Exclusions (Cont'd)	WAC 284-43-7080(3)	• Benefits for MH/SUD may not be limited or denied based solely on age or condition.		
		WAC 284-43-7080(4)	When a treatment or service is gender affirming treatment, as defined in RCW 48.43.0128, a health carrier may not:		
		WAC 284-43-7080(4)(a)	• 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 if that treatment is:		
		(i)	• Prescribed to an individual because of, related to, or consistent with a person's gender expression or identity, as defined in RCW 49.60.040;		
		(ii)	• Medically necessary; and		
		(iii)	• Prescribed in accordance with accepted standards of care; or		
		WAC 284-43-7080(4)(b)	• Apply blanket exclusions; or		
		WAC 284-43-7080(4)(c)	• When prescribed as medically necessary, exclude facial gender affirming treatment (such as tracheal shaves), hair removal procedures, and other care (such as mastectomies, breast reductions, breast implants, or any combination of gender affirming procedures, including revisions to prior treatment) as cosmetic services.		
		WAC 284-43-7080(5)	• Medically necessary benefits for MH/SUD treatment may not be denied solely because they were court ordered.		
	Withdrawal Coverage Requirements	RCW 48.43.761 (2)(a)(i)	A health plan must: • Provide coverage for no less than two business days, excluding weekends and holidays, in a behavioral health agency that provides inpatient or residential substance use disorder treatment prior to conducting a utilization review; and		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Mental Health and Substance Use Disorder Services (EHB) (Cont'd)	Withdrawal Coverage Requirements (Cont'd)	RCW 48.43.761 (2)(a)(ii)	• Provide coverage for no less than three days in a behavioral health agency that provides withdrawal management services prior to conducting a utilization review.		
		RCW 48.43.761(2)(b)	A health plan may not require an enrollee to obtain prior authorization for the services as a condition for payment of services prior to the times specified.		
			• Once the times specified have passed, the health plan may initiate utilization management review procedures if the behavioral health agency continues to provide services or is in the process of arranging for a seamless transfer to an appropriate facility or lower level of care under.		
		RCW 48.43.761 (2)(c)(iii)	After the required time period has passed and receipt of required material, the plan may initiate a medical necessity review process, based on the standard set of criteria.		
			If the health plan determines within one business day from the start of the medical necessity review period and receipt of the required material that the admission to the facility was not medically necessary and advises the agency of the decision in writing, the health plan is not required to pay the facility for services delivered after the start of the medical necessity review period, subject to the conclusion of a filed appeal of the adverse benefit determination.		
			If the health plan's medical necessity review is completed more than one business day after start of the medical necessity review period and receipt of the required material, the health plan must pay for the services delivered from the time of admission until the time at which the medical necessity review is completed and the agency is advised of the decision in writing.		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Mental Health and Substance Use Disorder Services (EHB) (Cont'd)	Withdrawal Coverage Requirements (Cont'd)	RCW 48.43.761 (5)(a)	If the behavioral health agency is not in the enrollee's network: • The health plan is not responsible for reimbursing the behavioral health agency at a greater rate than would be paid had the agency been in the enrollee's network; and • The behavioral health agency may not balance bill, as definedin RCW 48.43.005(5).		
		RCW 48.43.761 (5)(b)			
		RCW 48.43.761 (6)	When the treatment plan approved by the health plan involves transfer of the enrollee to a different facility or to a lower level of care, the care coordination unit of the health plan shall work with the current agency to make arrangements for a seamless transfer as soon as possible to an appropriate and available facility or level of care. • The health plan shall pay the agency for the cost of care at the current facility until the seamless transfer to the different facility or lower level of care is complete. • A seamless transfer to a lower level of care may include same day or next day appointments for outpatient care, and does not include payment for nontreatment services, such as housing services. • If placement with an agency in the health plan's network is not available, the health plan shall pay the current agency until a seamless transfer arrangement is made.		
		RCW 48.43.761 (7)	• The requirements of this section do not apply to treatment provided in out-of-state facilities.		
		RCW 48.43.761(8)	For the purposes of this section "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 on medications for addiction recovery.		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Neuro-developmental Therapy	Requirement to Cover Neuro-Developmental Therapy	WAC 284-43-5642(10)	Contract must provide benefits for neurodevelopmental therapies. (Washington 2017 Base benchmark Plan subject to RCW 48.44.450(1))		
		O.S.T. v. Regence BlueShield, RCW 48.44.450(2); WAC 284-43-5642(10)(a)(i)	○ Must provide benefits for mental health diagnoses (Diagnoses listed in the DSM) without any "blanket limitations" (e.g., age six and under) O.S.T. v. Regence BlueShield, No. 88940-6 (WN October 9, 2014). WAC 284-43-5642(10)(b). ○ Services covered must include physical, speech, and occupational therapies.		
		RCW 48.44.450(3)	○ Benefits shall be payable only where the services have been delivered pursuant to the referral and periodic review of a holder of a license issued pursuant to chapter 18.71 or 18.57 RCW or where covered services have been rendered by such licensee. ○ Benefits shall be provided to restore and improve function, and for the maintenance of a covered individual in cases where significant deterioration in the patient's condition would result without the service.		
		RCW 48.44.450(3)	○ Must cover medically necessary services. WAC 284-43-5642(10)(b)		
		WAC 284-43-5622(10)	○ Benefits may not be subject to annual or lifetime dollar limits, but may be subject to visit limits, deductible, cost sharing, and requirements for written treatment plans. WAC 284-43-5642(5); Benchmark Plan.		
		WAC 284-43-5642 (5 and) (10)(b);	○ The contract may not exclude or limit coverage for assessment or testing to determine the amount and type of neurodevelopmental therapy needed. Benchmark Plan		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Non-Discrimination	Non-Discrimination Notice	RCW 48.43.0128; WAC 284-43-5980(1)	The issuer must file a Non Discrimination Notice to include:		
		WAC 284-43-5980(1)(a)	• That 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;		
		45 CFR § 92.102(b); WAC 284-43-5980(1)(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;		
		45 CFR § 92.101(2); WAC 284-43-5980(1)(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; and		
		WAC 284-43-5980(1)(d)	• How to obtain these aids and services; and		
		WAC 284-43-5980(1)(e)	• Identify and provide contact information for the employee responsible for compliance with RCW 48.43.0128 and WAC 284-43-5935 through 284-43-5980; and		
		WAC 284-43-5980(1)(f)	• How to file a grievance with the issuer related to the issuers compliance with RCW 48.43.0128 and WAC 284-43-5935 through 284-43-5980; and		
		WAC 284-43-5980(1)(g)	• 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		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Non-Discrimination	Non-Discrimination Notice (Cont'd)		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).		
		WAC 284-43-5980(4)	• Taglines in at least the top 15 languages spoken by individuals with limited English proficiency of the relevant State or States.		
		WAC 284-43-5980(7)	• Contract must include, in a conspicuously visible font size, notice of the following,		
		WAC 284-43-5980(7)(a)(i)	This notice must be included 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;		
		WAC 284-43-5980(7)(a)(ii)	• In conspicuous physical locations where the issuer interacts with the public; and		
		WAC 284-43-5980(7)(a)(iii)	In a conspicuous location on the issuer's website accessible from the home page of the issuer's website.		
		WAC 284-43-5980(8)	In significant publications and significant communications that are small-sized, such as postcards and tri-fold brochures:		
		WAC 284-43-5980(9)	An issuer may combine the content of the notice required in WAC 284-43-5980(1) with the content of the other notices required in WAC 284-43-5980 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).		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Pediatric Oral Services (EHB)	Requirement to Cover Pediatric Oral Services	42 USC §18021 (a)(1)(B); 42 USC 18022(b)(1)(J)	A health plan must include pediatric dental benefits as an embedded set of benefits, or through a combination of a health benefit plan and a stand-alone dental plan that includes pediatric dental benefits certified as a qualified dental plan. WAC 284-43-5760.		
		WAC 284-43-5760(1)(a)	Plan must satisfy the requirement in one of two ways: • The plan includes pediatric dental benefits as an embedded benefit **(issuer must submit the "Embedded Pediatric Dental EHB Checklist" in addition to this checklist);** or		
		WAC 284-43-5760(1)(b)	• The plan does not have pediatric dental benefits, and the issuer receives reasonable assurance that the applicant has obtained or will obtain pediatric dental benefits through a stand-alone QDP. This reasonable assurance must be received by the issuer within 60 days.		
Pediatric Vision Services (EHB)	Requirement for Coverage	WAC 284-43-5782(1 - 2)	• Plan must cover pediatric vision services as an embedded set of services.		
		42 USC §18021 (a)(1)(B); 42 USC 18022(b)(1)(J)	○ Plan must cover pediatric vision services for enrollees until at least the end of the month in which enrollees turn age nineteen.		
	Required Services	WAC 284-43-5782(1)	• Plan must cover the following services in a manner substantially equal to the base benchmark plan and classify them as pediatric vision services:		
		WAC 284-43-5782(2)(a)	○ Routine vision screening without cost sharing [WAC 284-43-5642(9)(b)(iv)(A)]		
		WAC 284-43-5782 (2)(b)	○ a comprehensive eye exam for children, including dilation as professionally indicated and with refraction every calendar year;		
		WAC 284-43-5782(2)(c)	○ One pair of prescription lenses or contacts every calendar year, including polycarbonate lenses and scratch resistant coating.		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Pediatric Vision Services (EHB) (Cont'd)	Required Services (cont'd)		Lenses may include single vision, conventional lined bifocal or conventional lined trifocal, or lenticular lenses;		
		WAC 284-43-5782(2)(d)	○ One pair of frames every calendar year. Plan may have networks or tiers of frames within the plan design as long as there is a base set of frames to choose from available without cost-sharing;		
		WAC 284-43-5782(2)(e)	○ Contact lenses covered once every calendar year in lieu of the lenses and frame benefits. ▪ This limitation must be based on the manner in which the lenses must be dispensed; if disposable lenses are prescribed, a sufficient number and amount for one calendar year's equivalent must be covered.		
			▪ This benefit must include the evaluation, fitting and follow-up care relating to contact lenses. ▪ If determined to be medically necessary, contact lenses must be covered in lieu of eyeglasses at a minimum for the treatment of the following conditions: Keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, and irregular astigmatism;		
		WAC 284-43-5782(2)(f) (2)(f)(i) (2)(f)(ii) (2)(f)(iii)	▪ Low vision optical devices including low vision services, training and instruction to maximize remaining usable vision as follows: • One comprehensive low vision evaluation every five years; • High power spectacles, magnifiers and telescopes as medically necessary, with reasonable limitations permitted; and • Follow-up care of four visits in any five-year period, with prior approval.		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Pediatric Vision Services (EHB) (Cont'd)	Allowed Exclusions	WAC 284-43-5782(3)(a)	The plan may include the following exclusions: • Visual therapy that is otherwise covered under the medical/surgical benefits of the plan; and		
		(3)(b)	• Ordering two pairs of glasses in lieu of bifocals.		
PKU Formula Phenylketonuria (PKU) Formula (Cont'd)		RCW 48.44.440	• Plan must provide coverage for the formulas necessary for the treatment of phenylketonuria. WAC 284-44-450(2).		
		WAC 284-44-450(3)	○ Coverage may be limited to the usual and customary charge for such formulas. ○ Coverage may be subject to deductibles, copayments, coinsurance or other reductions applicable to other benefits. ○ Relating the PKU formula to a special expense benefit, such as a prescription drug benefit, is not acceptable unless it results in the PKU formula benefit being paid at an amount no less than other benefits.		
		WAC 284-44-450(4)	○ Premium charged must be no greater as a result of a family or individual receiving PKU benefits.		
Prescription Drug Services (EHB)	Required Prescription Drug Services	42 USC §18021(a)(1)(B); 42 USC 18022(b)(1)(F)	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. WAC 284-43-5642(6).		
		WAC 284-43-5642(6)(a)(i)	Plan must include the following services, which are specifically covered by the base-benchmark plan, and classify them as prescription drug services:		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Prescription Drug Services (EHB) (Cont'd)	Required Services (Cont'd)		• Drugs and medications both generic and brand name, including self-administrable prescription medications,		
		WAC 284-43-5642(6)(a)(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;		
		WAC 284-43-5642 (6)(a)(iii); RCW 48.43.072 (1)(a)	• All contraceptive drugs, devices, and other products, approved by the federal food and drug administration, including over-the-counter contraceptive drugs, devices, and products, approved by the federal food and drug administration..		
		RCW 48.43.072 (1)(b)	• This includes condoms, regardless of the gender or sexual orientation of the covered person, and regardless of whether they are to be used for contraception or exclusively for the prevention of sexually transmitted infections		
		RCW 48.43.072 (1)(c)	• The consultations, examinations, procedures, and medical services that are necessary to prescribe, dispense, insert, deliver, distribute, administer, or remove the drugs, devices, and other products or services in (a) and (b) of this subsection;		
		RCW 48.43.072 (1)(e)	• Medically necessary services and prescription medications for the treatment of physical, mental, sexual, and reproductive health care needs that arise from a sexual assault.		
		WAC 284-43-5150(2)(e)	"Prescription contraceptives" include United States Food and Drug Administration (FDA) approved contraceptive drugs, devices, and prescription barrier methods including: • contraceptive products declared safe and effective for use as emergency contraception by the FDA.);		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Prescription Drug Services (EHB) (Cont'd)	Required Services (Cont'd)	RCW 48.43.072(1)	• over-the counter contraceptive drugs, devices and products approved by the FDA; • Voluntary sterilization procedures; • consultations, examinations, procedures, and medical services that are necessary to prescribe, dispense, insert, deliver, distribute, administer, or remove the drugs, devices, and other products or services as required by law.		
		RCW 48.43.072(2)(a)	Plan may not require copayments deductibles, or other forms of cost sharing, unless the health plan is offered as a qualifying health plan for a health savings account.		
		RCW 48.43.072(2)(a); RCW 48.43.072(1)	• For a qualifying health plan, the carrier must establish the plan's cost sharing for the coverage required by law at the minimum level necessary to preserve the enrollee's ability to claim tax exempt contributions and withdrawals from his or her health savings account under internal revenue service laws and regulations; and		
		RCW 48.43.072(2)(b)	• May not require a prescription to trigger coverage of over-the-counter contraceptive drugs, devices, and products, approved by the federal food and drug administration.		
		RCW 48.43.072(3)	A health carrier may not deny the coverage required in subsection (1) of this section because an enrollee changed his or her contraceptive method within a twelve-month period.		
		RCW 48.43.072 (4)	• Except as otherwise authorized under this section, a health benefit plan may not impose any restrictions or delays on the coverage required under this section, such as medical management techniques that limit enrollee choice in accessing the full range of contraceptive drugs, devices, or other products, approved by the federal food and drug administration.		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Prescription Drug Services (EHB) (Cont'd)	Required Services (Cont'd)	RCW 48.43.072 (5)	Benefits provided under this section must be extended to all enrollees, enrolled spouses, and enrolled dependents.		
		RCW 48.43.072 (6)	Plan may not allow for denial of care on the basis of race, color, national origin, sex, sexual orientation, gender expression or identity, marital status, age, citizenship, immigration status, or disability.		
		RCW 48.43.072 (7)	A health plan or student health plan, including student health plans deemed by the insurance commissioner to have a short-term limited purpose or duration or to be guaranteed renewable while the covered person is enrolled as a regular full-time undergraduate or graduate student at an accredited higher education institution, **issued or renewed on or after January 1, 2021**, may not issue automatic initial denials of coverage for reproductive health care services that are ordinarily or exclusively available to individuals of one gender, based on the fact that the individual's gender assigned at birth, gender identity, or gender otherwise recorded in one or more government-issued documents, is different from the one to which such health services are ordinarily or exclusively available; and		
		WAC 284-43-5150(2)(a)	Plan must not cover prescription contraceptives on a less favorable basis than other covered prescription drugs and prescription devices. Coverage of prescription contraceptives includes coverage for medical services associated with the prescribing, dispensing, delivery, distribution, administration and removal of a prescription contraceptive to the same extent, and on the same terms, as other outpatient services.		
		WAC 284-43-5150(2)(b)	Plan may not impose benefit waiting periods, limitations, or restrictions on prescription contraceptives that are not required or imposed on other covered prescription drugs and prescription devices.		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Prescription Drug Services (EHB) (Cont'd)	Required Services (cont'd)	WAC 284-43-5150(2)(d)	Issuer may use, and Plan may limit coverage to, a closed formulary for prescription contraceptives if they otherwise use a closed formulary, but the formulary shall cover each of the types of prescription contraception defined above.		
		RCW 48.43.195	A health benefit plan issued or renewed on or after January 1, 2018, that includes coverage for contraceptive drugs must provide reimbursement for a twelve-month refill of contraceptive drugs obtained at one time by the enrollee, unless the enrollee requests a smaller supply or the prescribing provider instructs that the enrollee must receive a smaller supply. • The health plan must allow enrollees to receive the contraceptive drugs on-site at the provider's office, if available. Any dispensing practices required by the plan must follow clinical guidelines for appropriate prescribing and dispensing to ensure the health of the patient while maximizing access to effective contraceptive drugs.		
		RCW 48.44.440; WAC 284-43-5642(6)(a)(iv) and (v)	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 Medical foods to treat inborn errors of metabolism.		
		RCW 48.43.176 (1)(a)	Plan must provide coverage for medically necessary elemental formula, regardless of delivery method, when a licensed physician or other health care provider with prescriptive authority diagnoses a patient with an eosinophilic gastrointestinal associated disorder.		
	Cost sharing reuirements	RCW 48.43.430	The applicable cost sharing for the prescription medication must be; • The amount the person would pay for the prescription medication if the person purchased the prescription medication without using a health plan.		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Prescription Drug Services (EHB) (Cont'd)	Cost sharing requirements (Cont'd)		• A health carrier or pharmacy benefit manager may not require a pharmacist to dispense a brand name prescription medication when a less expensive therapeutically equivalent generic prescription medication is available		
			• "pharmacy benefit manager" has the same meaning as in RCW 48.200.020(12)		
		SB 5610 RCW 48.43. (1)(a)	• Effective January 1, 2023 - A health carrier offering a nongrandfathered health plan with a pharmacy benefit, or a health care benefit manager administering benefits for the health carrier, shall include any cost-sharing amounts paid by the enrollee directly or on behalf of the enrollee by another person when calculating an enrollee's contribution to any applicable cost-sharing or out-of-pocket maximum for a covered prescription drug that is either:		
		(1)(a)(i)	• Without a generic equivalent; or		
		(1)(a)(ii)	• With a generic equivalent where the enrollee has obtained access to the drug through:		
		(1)(a)(ii)(A)	▪ Prior authorization;		
		(1)(a)(ii)(B)	▪ Step therapy; or		
		(1)(a)(ii)(C)	▪ The prescription drug exception request process under RCW 48.43.420.		
		SB 5610 RCW 48.43. (2)	• Any cost-sharing amounts paid directly by or on behalf of the enrollee by another person for a covered prescription drug under subsection (1) of this section shall be applied towards the enrollee's applicable cost-sharing or out-of-pocket maximum in full at the time it is rendered.		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Prescription Drug Services (EHB) (Cont'd)	Sole Available Drug Therapy	WAC 284-43-5060(1)	Plan must cover all FDA-approved prescribed drugs, medications or drug therapies that are the sole prescription drug available for a covered medical condition.		
	No Unreasonable Restrictions	WAC 284-43-5060	• Prescription drug benefit must not be such that it results or can reasonably be expected to result in an unreasonable restriction on the treatment of patients.		
		WAC 284-43-5060(2)	• A prescription drug benefit that only covers generic drugs constitutes an unreasonable restriction on the treatment of patients.		
		WAC 284-43-5060(3)	• 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.		
	Coverage of Drugs for Off-Label Use	WAC 284-30-450(4)(a)	• Plan must not exclude coverage of any FDA-approved prescription drug for a particular indication on the grounds that the drug has not been approved by the FDA for that indication, if it is recognized as effective for treatment of that indication:		
		450(4)(a)(i)	○ In one of the standard reference compendia;		
		450(4)(a)(ii)	○ In the majority of relevant peer-reviewed medical literature if not recognized in one of the standard reference compendia; or		
		450(4)(a)(iii)	○ By the Federal Secretary of Health and Human Services.		
		450(4)(b)	• Coverage of a drug for such "off-label" use must also include medically necessary services associated with the administration of the drug.		
		450(4)(c)	• Coverage for off-label use is not required when the FDA has determined its use to be contra-indicated.		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Prescription Drug Services (EHB) (Cont'd)		450(4)(d)	• Coverage is not required for experimental drugs not otherwise approved for any indication by the FDA.		
	Optional Prescription Drug Services	WAC 284-43-5642(6)(b)	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:		
		WAC 284-43-5642(6)(b)(i)	• Insulin pumps and their supplies, which are classified to and covered under the rehabilitation and habilitation services category; and		
		(6)(b)(ii)	• Weight loss drugs.		
	Allowable Limitations on Prescription Drug Services	WAC 284-43-5642(6)(c)(i)	• Prescriptions for self-administrable injectable medication may be 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;		
		WAC 284-43-5642(6)(c)(ii)	• Teaching doses of self-administrable injectable medications may be limited to three doses per medication per lifetime.		
		WAC 284-43-5060	• Plan may restrict prescription drug coverage based on contract or plan terms and conditions that otherwise limit coverage, such as medical necessity.		
		WAC 284-43-5060(4)	• Prescribers may use "Dispense as Written" prescriptions (prescriptions which do not allow substitution of a generic or therapeutic equivalent drug for the drug prescribed), subject to the terms and conditions of the health plan.		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Prescription Drug Services (EHB) (Cont'd)	State benefit requirements classified to the Prescription Drug Services Category	RCW 48.44.440; RCW 48.43.176(1)	State benefit requirements classified to the prescription drug services category include: WAC 284-43-5642(6)(d)(i) • Medical foods to treat inborn errors of metabolism; • Medically necessary elemental formula; and		
		RCW 48.44.315(2)(a); WAC 284-43-5642(6)(d)(ii)	• Diabetes supplies ordered by the physician (Inclusion of this benefit requirement does not bar issuer variation in diabetic supply manufacturers under its drug formulary;		
		RCW 48.44.341 (2)(a)(ii)	• 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. WAC 284-43-5642(6)(d)(iii).		
	Formulary	WAC 284-43-5642(6)(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.		
		WAC 284-43-5642(6)(e)(ii)	• An issuer's formulary does not have to be substantially equal to the base-benchmark plan formulary in terms of formulary placement.		
	Emergency Fill	WAC 284-43-5170(1)(c)	Contract must include a clear statement explaining consumers may be eligible to receive an emergency fill for prescription drugs under WAC 284-170-470, and include the process for obtaining an emergency fill and include any cost sharing requirements, for an emergency fill.		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Prescription Drug Services (EHB) (Cont'd)	Disclosure – Pharmacy Statement	WAC 284-43-5170(4)	Does the contract or certificate of coverage contain the "Your right to Safe and Effective Pharmacy Services" statement?		
	Drug Exception/ Substitution Process	45 CFR 156.122(c)	The Plan must have the following processes in place that allow an enrollee, the enrollee's designee, or the enrollee's prescriber to request and gain access to clinically appropriate drugs not otherwise covered by the plan.		
		45 CFR 156.122(c)	If an exception request is granted, the plan must treat the excepted drug(s) as an essential health benefit, including by counting any cost-sharing towards the plan's annual limitation on cost-sharing under §156.130. WAC 284-43-5110(6)		
		45 CFR 156.122(c)(1)(i)	• Standard exception request. • Plan must have a process for an enrollee, designee, or prescriber to request a standard review of a decision that a drug is not covered by the plan.		
		45 CFR 156.122 (c)(1)(ii)	• Plan must make its determination on a standard exception and notify the enrollee (or designee) and the prescriber of its coverage determination no later than 72 hours following receipt of the request. WAC 284-43-5080(3)(b)		
		45 CFR 156.122 (c)(1)(iii)	• A health plan that grants a standard exception request must provide coverage of the non-formulary drug for the duration of the prescription, including refills. WAC 284-43-5080(3)(b)		

		45 CFR 156.122(c)(2)(i)
		
		45 CFR 156.122 (c)(2)(ii)
			• Expedited exception request.
			  • Plan must have a process for an enrollee, the enrollee's designee, or the prescriber to request an expedited review based on exigent circumstances. WAC 284-43-5080(3)(c)
			  • Exigent circumstances exist when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function or when an enrollee		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Prescription Drug Services (EHB) (Cont'd)	Drug Exception/ Substitution Process (Cont'd)		is undergoing a current course of treatment using a non-formulary drug. WAC 284-43-5080(3)(c)		
		45 CFR 156.122 (c)(2)(iii)	• Plan must make its determination on an expedited review request and notify the enrollee (or designee) and prescriber of its determination no later than 24 hours following receipt of the request. WAC 284-43-5080(3)(c)(i)		
		45 CFR 156.122 (c)(2)(iv)	• If exception is granted, plan must provide coverage of the non-formulary drug for the duration of the exigency. WAC 284-43-5080(3)(c)(ii)		
		45 CFR 156.122(c)(3)(i)	• External exception request review. • If the Plan denies a request for a standard exception or an expedited exception, the plan must have a process for the enrollee, the enrollee's designee, or the enrollee's prescriber to request that the original exception request and subsequent denial of such request be reviewed by an independent review organization. WAC 284-43-5080(6)		
		45 CFR 156.122 (c)(3)(ii)	• Plan must make its determination on the external exception request and notify the enrollee (or designee) and the prescriber of its determination no later than: WAC 284-43-5080(6)(a)		
		156.122 (c)(3)(ii)	▪ 72 hours following its receipt of the request, if the original request was a standard exception request WAC 284-43-5080(6)(a)		
		156.122 (c)(3)(ii)	▪ no later than 24 hours following its receipt of the request, if the original request was an expedited exception request. WAC 284-43-5080(6)(a)		
		45 CFR 156.122 (c)(3)(iii)	• If the plan grants an external exception review of a standard exception request, the plan must provide coverage of the non-formulary drug for the duration of the prescription. WAC 284-43-5080(6)(b)		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Prescription Drug Services (EHB) (Cont'd)	Drug Exception/ Substitution Process (Cont'd)	45 CFR 156.122 (c)(3)(iii)	• If the plan grants an external exception review of an expedited exception request, the plan must provide coverage of the non-formulary drug for the duration of the exigency. WAC 284-43-5080(6)(b)		
	Drug Utilization Review - Requirement to Maintain Documented Program	WAC 284-43-2020(2) and (5)	• Issuer must maintain a documented drug utilization review program with written procedures to assure that reviews are conducted in a timely manner.		
		WAC 284-43-2020 (1)(a)	Nonurgent review request" means any request for approval of care or treatment where the request is made in advance of the patient obtaining medical care or services, or a renewal of a previously approved request, and is not an urgent care request.		
		WAC 284-43-2020(1)(b)	"Urgent care review request" means any request for approval of care or treatment where the passage of time could seriously jeopardize the life or health of the patient, seriously jeopardize the patient's ability to regain maximum function or, in the opinion of a provider with knowledge of the patient's medical condition, would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.		
		WAC 284-43-2020(5)(a)(i)	• For urgent care review requests:		
		WAC 284-43-2020 (5)(a)(i)(A)	○ Must approve the request within forty-eight hours if the information provided is sufficient to approve the claim and include the authorization number, if a prior authorization number is required, in its approval;		
		WAC 284-43-2020 (5)(a)(i)(B)	○ Must deny the request within forty-eight hours if the requested service is not medically necessary and the information provided is sufficient to deny the claim; or		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Prescription Drug Services (EHB) (Cont'd)	Drug Utilization Review - Requirement to Maintain Documented Program (Cont'd)	WAC 284-43-2020 (5)(a)(i)(C)	○ Within twenty-four hours, if the information provided is not sufficient to approve or deny the claim, the issuer must request that the provider submits additional information to make the prior authorization determination:		
		(5)(a)(i)(C)(i)	▪ The issuer must give the provider forty-eight hours to submit the requested information;		
		(5)(a)(i)(C)(ii)	▪ The issuer must then approve or deny the request within forty-eight hours of the receipt of the requested additional information and include the authorization number in its approval;		
		(5)(a)(ii)	• For nonurgent care review requests:		
		(5)(a)(ii)(A)	○ Must approve the request within five calendar days if the information is sufficient to approve the claim and include the authorization number in its approval;		
		(5)(a)(ii)(B)	○ Must deny the request within five calendar days if the requested service is not medically necessary and the information provided is sufficient to deny the claim; or		
		(5)(a)(ii)(C)	○ Within five calendar days, if the information provided is not sufficient to approve or deny the claim, the issuer must request that the provider submits additional information to make the prior authorization determination:		
		(5)(a)(ii)(C)(I)	▪ The issuer must give the provider five calendar days to submit the requested additional information;		
		(5)(a)(ii)(C)(II)	▪ The issuer must then approve or deny the request within four calendar days of the receipt of the additional information and include the authorization number in its approval.		
	Publishing Formulary	45 CFR 156.122(d)(1)	• Plan must publish an up-to-date, accurate, and complete list of all covered drugs on its formulary drug list, including any tiering structure and any restrictions on the manner in which a drug can be		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Prescription Drug Services (EHB) (Cont'd)	Publishing Formulary (Cont'd)		obtained. List must be in a manner that is easily accessible to plan enrollees, prospective enrollees, the State, the Exchange, HHS, the U.S. Office of Personnel Management, and the general public.		
		45 CFR 156.122 (d)(1)(i)	• A formulary drug list is easily accessible when: ▪ It can be viewed on the plan's public Web site through a clearly identifiable link or tab without requiring an individual to create or access an account or enter a policy number; and		
		156.122 (d)(1)(ii)	▪ If an issuer offers more than one plan, when an individual can easily discern which formulary drug list applies to which plan.		
	Access to Prescription Drugs	45 CFR 156.122(e)(1)	• Plan must have the following access procedures: • Plan must allow enrollees to access prescription drug benefits at in-network retail pharmacies, unless:		
		156.122 (e)(1)(i)	▪ The drug is subject to restricted distribution by the U.S. Food and Drug Administration; or		
		45 CFR 156.122 (e)(1)(ii)	▪ The drug requires special handling, provider coordination, or patient education that cannot be provided by a retail pharmacy.		
		45 CFR 156.122(e)(2)	• Plan may charge enrollees a different cost-sharing amount for obtaining a covered drug at a retail pharmacy, but all cost sharing will count towards the plan's annual limitation on cost sharing.		
	Oral Chemotherapy	RCW 48.44.323; WAC 284-43-5200	• Plan must provide coverage for prescribed, self- administered anticancer medication on a basis at least comparable to cancer chemotherapy medications administered by a health care provider or facility.		
		WAC 284-43-5200(1)	• Plan may not impose dollar limits, copayments, deductibles or coinsurance requirements on coverage for orally administered anticancer drugs or chemotherapy that are less favorable to an enrollee than those that apply to coverage for anticancer medication or chemotherapy that is administered intravenously or by injection.		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Prescription Drug Services(EHB) (Cont'd)	Oral Chemotherapy (Cont'd)	WAC 284-43-5200(2)	• Issuer may not reclassify an anticancer medication or increase an enrollee's out-of-pocket costs as a method of compliance with these requirements.		
	Prescription Synchro-nization	RCW 48.43.096(1)	• Issuer must have a prescription synchronization/coordination policy for the dispensing of prescription drugs to the plan's enrollees.		
		48.43.096 (1)(a)	• If an enrollee requests medication synchronization for a new prescription, the health plan must permit filling the drug:		
		48.43.096 (1)(a)(i)	○ for less than a one-month supply of the drug if synchronization will require more than a fifteen-day supply of the drug; or		
		48.43.096 (1)(a)(ii)	○ for more than a one-month supply of the drug if synchronization will require a fifteen-day supply of the drug or less.		
		48.43.096 (1)(b)	• The health benefit plan shall adjust the enrollee cost-sharing for a prescription drug subject to coinsurance that is dispensed for less than the standard refill amount for the purpose of synchronizing the medications.		
		RCW 48.43.096 (1)(c)	• The health benefit plan shall adjust the enrollee cost-sharing for a prescription drug with a copayment that is dispensed for less than the standard refill amount for the purpose of synchronizing the medications by:		
		(1)(c)(i)	○ Discounting the copayment rate by fifty percent;		
		48.43.096 (1)(c)(ii)	○ Discounting the copayment rate based on fifteen-day increments; or		
		48.43.096 (1)(c)(iii)	○ Any other method that meets the intent of this section and is approved by the OIC. ▪ To have an alternative method approved by OIC, the issuer should submit a request to the Manager of the Health & Disability Forms Unit. The request may be sent by any means,		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Prescription Drug Services (EHB) (Cont'd)	Prescription Synchronization (Cont'd)		including being submitted on the Supporting Documentation tab as part of the filing seeking to utilize the method. The request must include complete information regarding the proposed alternative method.		
			▪ If the plan utilizes an alternative method that has already been approved by the OIC, the issuer should include this information in its filing cover letter or in a separate document attached to the Supporting Documentation tab. The analyst may request verification of approval from the Manager of the Health and Disability Forms Unit.		
		RCW 48.43.096(2)	• Upon request of an enrollee, the prescribing provider or pharmacist must:		
		RCW 48.43.096 (2)(a)	○ Determine that filling or refilling the prescription is in the best interest of the enrollee, taking into account the appropriateness of synchronization for the drug being dispensed;		
		RCW 48.43.096 (2)(b)	○ Inform the enrollee that the prescription will be filled to less than the standard refill amount for the purpose of synchronizing his or her medications; and		
		48.43.096 (2)(c) 48.43.096 (3)(a)	○ Deny synchronization on the grounds of threat to patient safety or suspected fraud or abuse. • "Medication synchronization" means the coordination of medication refills for a patient taking two or more medications for a chronic condition such that the patient's medications are refilled on the same schedule for a given time period.		
	Pharmacists – Eye Drop Refills	RCW 18.64.530	Forms may not include any provision conflicting with the following: A pharmacist is authorized, without consulting a physician or obtaining a new prescription or refill authorization from a physician, to provide for one early refill of a prescription for topical ophthalmic products if:		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Prescription Drug Services (EHB) (Cont'd)	Pharmacists – Eye Drop Refills (Cont'd)	RCW 18.64.530(1) (1)(a)	• The refill is requested by a patient at or after seventy percent of the predicted days of use of		
			○ The date the original prescription was dispensed to the patient; or		
		(1)(b)	○ The date that the last refill of the prescription was dispensed to the patient;		
		RCW 18.64.530(2)	○ The prescriber indicates on the original prescription that a specific number of refills will be needed; and		
		RCW 18.64.530(3)	○ The refill does not exceed the number of refills that the prescriber indicated.		
Preventive and Wellness Services, Including Chronic Disease Management (EHB)	Definition of Preventive and Wellness Services	42 USC §18021 (a)(1)(B); 42 USC 18022(b)(1)(I) WAC 284-43-5642(9)	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.		
	Requirements	WAC 284-43-5800(4)	• Preventive and Wellness Services provided by in-network providers must be covered without cost sharing.		
		WAC 284-43-5642(9)(a)	• If the 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.		
		WAC 284-43-5642(9)(a)	• Plan must not limit sex-specific recommended preventive services based on an individual's sex assigned at birth, gender identity or		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Preventive and Wellness Services (EHB) (Cont'd)	Requirements (cont'd)		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.		
		WAC 284-43-5642(9)(b)(i)	Plan must include the following services as preventive and wellness services, including chronic disease management: • Immunizations recommended by the Centers for Disease Control's Advisory Committee on Immunization Practices;		
		WAC 284-43-5642 (9)(b)(ii)(A)	• Screening and tests for which the U.S. Preventive Services Task Force for Prevention and Chronic Care (USPSTF) have issued A and B recommendations on or before the applicable plan year;		
		WAC 284-43-5642 (9)(b)(ii)(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;		
		WAC 284-43-5642(9)(b)(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		
		45 CFR §147.130 (a)(1)(iv); WAC 284-43-5642(9)(b)(iv)	• Services, tests, screening and supplies recommended in the HRSA women's preventive and wellness services guidelines, as well as maternal depression screening according to the USPSTF Recomendations.		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Preventive and Wellness Services (EHB) (Cont'd)	Requirements (cont'd)	45 CFR §147.130 USPSTF Recom-mendation	• Plan must cover obesity or weight reduction or control services for children ages six and over who qualify as obese, and adult patients who have a body mass index of 30 kg/meter squared or higher.		
		45 CFR §147.130; WAC 284-43-5642 (1)(b)(viii)(A)	• Must cover intensive, multicomponent weight management behavioral interventions without cost-sharing. Services include, but are not limited to: • Group and individual sessions of high intensity; and		
		(B)	• Behavioral management activities, such as weight-loss goals.		
		WAC 284-43-5642(9)(b)(iv)	• Counseling women aged 40 to 60 years with normal or overweight body mass index (BMI) (18.5-29.9 kg/m2) to maintain weight or limit weight gain to prevent obesity. • Counseling may include individualized discussion of healthy eating and physical activity.		
		RCW 48.43.072 (1)(d)(i)	Screening for physical, mental, sexual, and reproductive health care needs that arise from a sexual assault		
		45 C.F.R. 147.130 (a)(1)(i) and (iv)	• Must cover comprehensive lactation support and counseling, by a trained provider during pregnancy and/ or in the postpartum period, and costs for renting breastfeeding equipment, including double electric breast pumps (including pump parts and maintenance) and breast milk storage supplies. Coverage should not be predicated on prior failure of a manual pump. Breastfeeding equipment may also include equipment and supplies as clinically indicated to support dyads with breastfeeding difficulties and those who need additional services. (Resources: CCIIO FAQs About Affordable Care Act Implementation Parts XII and XXIX)		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Preventive and Wellness Services (EHB) (Cont'd)	Requirements (cont'd)	45 CFR §147.130(b)(1)	Plan must cover services and supplies related to **PrEP** (preexposure prophylaxis)		
		WAC 284-43-5642 (9)(b)(iv)(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 or 48.44.210, 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		
		45 CFR §147.130(a)(4); WAC 284-43-5642 (9)(b)(iv)(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.		
		WAC 284-43-5642(9)(b)(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		
		(9)(b)(vi)	• Wellness services.		
		42 USC 300gg-13 (a); WAC 284-43-5642(9)(d)	• Plan may not include cost sharing requirements with respect to the preventive services listed under WAC 284-43-5642(9) (b)(i) through (iv) that are provided in-network.		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Preventive and Wellness Services (EHB) (Cont'd	Prohibited Limitations on Preventive and Wellness Services	WAC 284-170-200(12)	The provider network must include preventive and wellness services, including chronic disease management and smoking cessation services as defined in RCW 48.43.005(46) and WAC 284-43-5642(9). If these services are provided through a quit-line or help-line, the issuer must ensure that when follow-up services are medically necessary, the enrollee will have access to sufficient information to access those services within the service area. Contracts with quit-line or help-line services are subject to the same conditions and terms as other provider contracts under this section.		
		WAC 284-43-5642(10)(b); O.S.T. v. Regence BlueShield	• Plan must cover medically necessary neurodevelopmental therapy for any DSM diagnosis without blanket exclusions. (e.g., Plan may not limit outpatient neurodevelopmental therapy services to person's age six and under.) O.S.T. v. Regence BlueShield, No. 88940-6 (WN October 9, 2014). WAC 284-43-5642(10)(b).		
	State Benefit Requirements Classified to Preventive	RCW 48.43.043; WAC 284-43-5642(9)(b)(ii); WAC 284-43-5642(9)(e)(i)	State benefit requirements classified in this category are: • Colorectal cancer screening. • For a covered individual who is at least 45 years old; • Less than 50 and at high risk or very high risk for colorectal cancer		
			• Cost sharing may not be imposed for items and services that are an integral part of performing the colonoscopy. These items and services include:		
			• Required specialist consultation prior to the screening procedure;		
			• Bowel preparation medications prescribed for the screening procedure;		
			• Anesthesia services performed in connection with a preventive colonoscopy;		
			• Polyp removal performed during the screening procedure; and		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Preventive and Wellness Services (EHB) (Cont'd			• Any pathology exam on a polyp biopsy performed as part of the screening procedure; or		
			• A colonoscopy after a positive non-invasive stool-based screening test or direct visualization screening test is therefore required to be covered without cost sharing		
	Services Category	RCW 48.44.325; RCW 48.43.078 WAC 284-44-046(3)	• Mammogram services, both diagnostic and screening to include Tomosynthesis. WAC 284-43-5642(9)(e)(ii) • Plan can apply standard contract provisions for **diagnostic** mammograms applicable to other benefits such as deductible cost sharing. E.g., may apply deductible and copay requirements; and		
		RCW 48.44.327(1)	• Prostate cancer screening if delivered upon the recommendation of the patient's physician, ARNP, or Physician Assistant. WAC 284-43-5642(9)(e)(iii)		
		WAC 284-43-5642(10); WAC 284-43-5642(10)(a)(i)	Some state benefit requirements are limited to those receiving pediatric services, but are classified to other categories for purposes of determining actuarial value. These benefits include: • 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. This state benefit requirement may be classified to ambulatory patient services or mental health and substance abuse disorder including behavioral health categories; and		
		RCW 48.44.212; WAC 284-43-5642(10)(a)(ii)	• Treatment of congenital anomalies in newborn and dependent children. This state benefit requirement may be classified to hospitalization, ambulatory patient services or maternity and newborn categories.		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Prior Authorization		WAC 284-43-2050(2)	• A carrier or its designated or contracted representative must maintain a documented prior authorization program description and use evidence-based clinical review criteria as outlined in WAC 284-43-2050, which includes a method for reviewing and updating clinical review criteria. • A carrier is obligated to ensure compliance with prior authorization requirements, even if they use a third-party contractor. A carrier is not exempt from these requirements because it relied upon a third-party vendor or subcontracting arrangement for its prior authorization program.		
		WAC 284-43-2050(3)	• A prior authorization program must meet standards set forth by a national accreditation organization including, but not limited to, National Committee for Quality Assurance (NCQA), URAC, Joint Commission, and Accreditation Association for Ambulatory Health Care in addition to the requirements of WAC 284-43-2050 and WAC 284-43-2060. • A prior authorization program must have staff who are properly qualified, trained, supervised, and supported by explicit written, current clinical review criteria and review procedures.		
	Transparency of Standards and Criteria	RCW 48.43.016(1)	• If the plan or its contracted entity imposes different prior authorization standards and criteria for a covered service among tiers of contracting providers of the same licensed profession, the contract must inform enrollees which tier an individual provider or group of providers is in by posting the information on its web site in a manner accessible to both enrollees and providers.		
	Prohibited Practices	RCW 48.43.016 (2)(a)	A health carrier or its contracted entity may not require utilization management or review of any kind including, but not limited to, prior, concurrent or postservice authorization for an initial evaluation and management visit and up to six treatment visits with a contracted provider in a new episode of care of chiropractic, physical therapy,		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Prior Authorization (Cont'd)	Prohibited Practices (Cont'd)		occupational therapy, Eastern medicine, massage therapy, or speech and hearing therapies. Visits for which utilization management or review is prohibited under this section are subject to quantitative treatment limits of the health plan. • Plan may require a referral or prescription for these therapies, other than chiropractic. RCW 48.43.515(5).		
		RCW 48.43.016 (2)(b)	• For visits for which utilization management or review is prohibited under this section, a health carrier or its contracted entity may not:		
		(2)(b)(i)	• Deny or limit coverage on the basis of medical necessity or appropriateness; or		
		(2)(b)(ii)	• Retroactively deny care or refuse payment for the visits.		
		RCW 48.43.016(3)	• Plan must post on its web site and provide upon the request of a covered person or contracting provider any prior authorization standards, criteria, or information the carrier uses for medical necessity decisions.		
		RCW 48.43.016 (7)(a)	○ "New episode of care" means treatment for a new or recurrent condition for which the enrollee has not been treated by the provider within the previous ninety days and is not currently undergoing any active treatment.		
		RCW 48.43.016 (6)(b)	○ "Contracting provider" does not include providers employed within an integrated delivery system operated by an HCSC.		
	Issuer must Consult with Licensed Provider in Field Being Reviewed	RCW 48.43.016(4)	• Any provider with whom the issuer consults regarding a decision to deny, limit, or terminate covered services must hold a license, certification, or registration, in good standing and must be in the same or related health field as the provider being reviewed or of a specialty which entails the same or similar covered health care service.		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Prior Authorization (Cont'd)	No Required Discounts	RCW 48.43.016(5)	• Issuer may not require a provider to provide a discount from usual and customary rates for health care services not covered under a health plan, policy, or other agreement, to which the provider is a party.		
Provider Requirements	Access to Primary Care Providers	RCW 48.43.515(2);	• Plan must allow enrollee to choose a primary care provider who is accepting new enrollees from a list of participating providers. WAC 284-170-360(1)		
		RCW 48.43.515(2);	• Plan must allow enrollees to change primary care providers at any time with the change becoming effective no later than the beginning of the month following the enrollee's request for the change. WAC 284-170-360(1)(a)		
		WAC 284-170-360(2)	• Plan must allow an enrolled child direct access to a pediatrician from a list of in-network pediatricians who are accepting new patients.		
		WAC 284-170-360(2)(a)	• Plan must allow enrollees to change pediatricians at any time, with the change becoming effective not later than the beginning of the month following the enrollee's request for the change.		
		RCW 48.43.515(7)	• Issuer must cover services of a primary care provider whose contract with the plan is being terminated without cause for at least sixty days following notice of termination to the enrollees.		
	Access to Specialists	RCW 48.43.515(3);	• Issuer must have a process whereby an enrollee with a complex or serious medical or psychiatric condition may receive a standing referral to a participating specialist for an extended period of time. WAC 284-170-360(3)		
		RCW 48.43.515(4); WAC 284-170-200(5)	• Issuer must provide for appropriate and timely referral of enrollees to a choice of in-network specialists if warranted. If the type of specialist needed for a specific condition is not in-network, enrollees must have access to out of network specialist at in-network cost sharing.		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Provider Requirements (Cont'd	Direct Access to Chiropractors	RCW 48.43.515(5)	• Plan must provide enrollees with direct access to the participating chiropractor of the enrollee's choice for covered chiropractic care without prior referral. WAC 284-170-360(4)		
		RCW 48.43.515(5)	○ Plan can restrict coverage to in-network chiropractors and utilize managed care and cost containment techniques and processes.		
	Second Opinion	RCW 48.43.515(6); WAC 284-170-360(5)	• Contract must explain how to obtain a second opinion consultation. ○ Enrollee may seek a second opinion regarding any medical diagnosis or treatment plan from a qualified participating provider of the enrollee's choice.		
		WAC 284-170-360(5)	○ Plan cannot impose any charge or cost for the second opinion other than the cost imposed for the same service in otherwise similar circumstances.		
	Definition of "Participating Provider"	RCW 48.44.010(14); WAC 284-43-0160(26)	Plan must define "Participating Provider" consistent with WAC 284-43-0160(26): "'Participating provider' means a provider, 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.		
	Participating Provider – Hold Harmless	WAC 284-170-421	The plan cannot contain language that conflicts with Provider Agreement requirements, including, provider may not bill enrollee for covered services except for deductible, copayment, or coinsurance.		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Rehabilitative and Habilitative Services (EHB)	Required Rehabilitative and Habilitative Services	42 USC §18021 (a)(1)(B); 42 USC 18022 (b)(1)(G); WAC 284-43-5642(7)(a)	• Plan must cover "rehabilitative and habilitative 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 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.		
		WAC 284-43-5642(7)(b)(i)	Plan must include the following services and classify them as rehabilitative services: • Cochlear implants;		
		WAC 284-43-5642(7)(b)(ii)	• Inpatient rehabilitation facilities and professional services delivered in those facilities;		
		WAC 284-43-5642(7)(b)(iii)	• Outpatient physical therapy, occupational therapy and speech therapy for rehabilitative purposes;		
		WAC 284-43-5642(7)(b)(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		
		WAC 284-43-5642(7)(b)(v)	• Durable medical equipment and mobility enhancing equipment used to serve a medical purpose, including sales tax.		
	Optional Rehabilitative and Habilitative	WAC 284-43-5642(7)(c) (7)(c)(i)	Plan may, but is not required to, include the following services as part of the EHB-benchmark package. If plan includes these benefits, they cannot be included in establishing AV for this category: • Off-the-shelf shoe inserts and orthopedic shoes;		
		(7)(c)(ii)	• Exercise equipment for medically necessary conditions;		
		(7)(c)(iii)	• Durable medical equipment that serves solely as a comfort or convenience item; and		
		(7)(c)(iv)	• Hearing aids other than cochlear implants.		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Rehabilitative and Habilitative Services (EHB) (Cont'd)	Habilitative Services Definition	WAC 284-43-5642(7)(d)	For purposes of determining a plan's AV, issuer must classify as habilitative services the range of medically necessary health care services and 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.		
	Requirement for parity between Habilitative and Rehabilitative	WAC 284-43-5642(7)(d)(i)	As a minimum level of coverage, limitations on habilitative services must be on parity with those for rehabilitative services. 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.		
		29 U.S.C. 1185a (MHPAEA); 45 CFR §§ 146.136 and147.160	• **However**, 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 that would otherwise be permitted. WAC 284-43-5642(7)(d)(i)		
	Requirements For Services	WAC 284-43-5642(7)(d)(ii)	• A health benefit plan must not limit an enrollee's access to covered habilitative 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.		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Rehabilitative and Habilitative Services (EHB) (Cont'd)	Requirements For Services (Cont'd)	WAC 284-43-5642(7)(d)(iii) WAC 284-43-5642(7)(d)(iv)	• 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. • Habilitative health care devices may be limited to those that require FDA approval and a prescription to dispense the device.		
		WAC 284-43-5642(7)(d)(v)	• 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.		
		WAC 284-43-5642(7)(d)(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).		
	Allowable Limitations on Rehabilitative and Habilitative Services	WAC 284-43-5642(7)(e)(i)	• Inpatient rehabilitation facilities and professional services delivered in those facilities may be limited to no less than thirty service days per calendar year; and		
		WAC 284-43-5642(7)(e)(ii)	• Outpatient physical therapy, occupational therapy and speech therapy may be limited to no less than twenty-five outpatient visits per calendar year, on a combined basis, for rehabilitative purposes.		
	State Benefit Requirements	WAC 284-43-5642(7)(f)(i)	State benefit requirements classified to this category include: • State sales tax for durable medical equipment; and		
		RCW 48.44.315	• Coverage of diabetic supplies and equipment. WAC 284-43-5642(7)(f)(ii)		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Rehabilitative and Habilitative Services (EHB) (Cont'd)	Prohibition on limitations of medically necessary coverage for chronic conditions or diseases	WAC 284-43-5642(7)(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 requirement, 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. (e.g., 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.		
Rescissions Prohibited	Both Grandfathered and Non-Grandfathered Plans	42 USC § 300gg-12	Issuer may not rescind coverage with respect to an individual (including a group to which the individual belongs or family coverage under which the individual is included) once the individual is covered, UNLESS:		
		45 CFR §147.128(a)(1)	• Individual (or someone seeking coverage on his behalf) performs an act, practice, or omission that constitutes fraud, or		
			• Makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage.		
		45 CFR §147.128(a)(1)	At least 30 days' written notice must be provided to each affected participant.		
		45 CFR §147.128(a)(2)	Rescission means cancellation or discontinuance of coverage that has retroactive effect; *e.g.*, a cancellation that treats a policy as void from the time of the individual's or group's enrollment, or a cancellation that voids benefits paid up to a year before the cancellation. A cancellation or discontinuance of coverage is not a rescission if:		
		45 CFR §147.128(a)(2)(i)	• The cancellation or discontinuance of coverage has only a prospective effect; or		

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		45 CFR §147.128(a)(2)(ii)	• The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage. *See, also:* ACA FAQs Part II		
Standard of Care		RCW 48.43.545	Issuer may not attempt to waive, shift, or modify its responsibility to adhere to the accepted standard of care for health care providers when arranging for medically necessary health care for enrollees. Issuer is liable for any harm proximately caused by its failure to follow the standard of care when the failure results in denial, delay, or modification of the health care service recommended for, or furnished to, the enrollee. This includes all the issuer's employees, agents, or ostensible agents.		
Subrogation		Thiringer v. American Motors Ins., 91 WN 2d 215, 588 P.2d 191 (1978) Mahler v. Szucs	If the contract includes a subrogation provision, it must: • Make clear that the issuer is entitled only to excess after the enrollee is fully compensated; and • The Contract must not have any provision which would inappropriately require full reimbursement for all medical expenses.		
		WAC 284-44-040(7)	• The contract cannot unreasonably restrict or delay the payment of benefits. Delays are not justified because the expenses incurred, or the services received, resulted from an act or omission of a third party.		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Telemedicine	Requirements for Coverage	RCW 48.43.735(1)(a); WAC 284-43-5622(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 coverage for a service provided via telemedicine or store and forward technology if:		
		RCW 48.43.735 (1)(a)(i)	○ the service would be covered when provided in person; and		
		RCW 48.43.735 (1)(a)(ii)	○ the service is medically necessary; and		
		RCW 48.43.735 (1)(a)(iii)	○ the service is an EHB;		
		RCW 48.43.735 (1)(a)(iv)	○ the health care service is determined to be safely and effectively provided through telemedicine or store and forward technology according to generally accepted health care practices and standards, and the technology used to provide the health care service meets the standards required by state and federal laws governing the privacy and security of protected health information; and		
		RCW 48.43.735(1)(a)(v	○ for audio-only telemedicine, the covered person has an established relationship with the provider.		
		RCW 48.43.735(2)	○ Reimbursement of store and forward technology is available only for those covered services specified in the negotiated agreement between the health carrier and the health care provider.		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Telemedicine (Cont'd)	Rules for "Originating Sites"	RCW 48.43.735 (3)(a)	• An originating site for a telemedicine health care service includes a: o Hospital;		
		(3)(b)	o Rural health clinic;		
		(3)(c)	o Federally qualified health center;		
		(3)(d)	o Physician's or other health care provider's office;		
		(3)(e)	o Community mental health center;		
		(3)(f)	o Skilled nursing facility; or		
		(3)(g)	o Home		
		(3)(h)	o Renal dialysis center, except an independent renal dialysis center.		
		RCW 48.43.735(4)	• Any originating site (except for a home) may charge a facility fee for infrastructure and preparation of the patient. Reimbursement must be subject to a negotiated agreement between the originating site and the health plan. A distant site or any other site not identified above may not charge a facility fee.		
		RCW 48.43.735(5)	• Plan may not distinguish between originating sites that are rural and urban in providing this coverage.		
		RCW 48.43.735(6)	• Coverage of telemedicine may be subject to all terms and conditions of the plan, including, but not limited to, utilization review, prior authorization, deductible, copayment, or coinsurance applicable to the service when provided in person.		
		RCW 48.43.735(7)	• Plan does not have to pay for originating site professional fees; service that is not covered; or an out-of-network originating site or provider.		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Telemedicine (Cont'd)	Definitions	RCW 48.43.735 (9)(a)(i)	• "Audio-only telemedicine" means the delivery of health care services through the use of audio-only technology, permitting real-time communication between the patient at the originating site and the provider, for the purpose of diagnosis, consultation, or treatment.		
		RCW 48.43.735(9) (a)(ii)	• "Audio Only" telemedicine does not include:		
		RCW 48.43.735(9) (a)(ii)(A)	○ The use of facsimile or email; or		
		RCW 48.43.735(9) (a)(ii)(B)	○ The delivery of health care services that are customarily delivered by audio-only technology and customarily not billed as separate services by the provider, such as the sharing of laboratory results;		
		RCW 48.43.735 (9)(c)	• "Distant site" means the site at which a physician or other licensed provider, delivering a professional service, is physically located at the time the service is provided through telemedicine.		
		RCW 48.43.735 (9)(d)	• "Established relationship" means the provider providing audio-only telemedicine has access to sufficient health records to ensure safe, effective, and appropriate care services and		
		RCW 48.43.735 (9)(d)(i)	• For health care services included in the essential health benefits category of mental health and substance use disorder services, including behavioral health treatment:		
		RCW 48.43.735 (9)(d)(i)(A)	○ The covered person has had, within the past three years, at least one in-person appointment, or at least one real-time interactive appointment using both audio and video technology, with the provider providing audio-only telemedicine or with a provider		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Telemedicine (Cont'd)	Definitions (Cont'd)		employed at the same medical group, at the same clinic, or by the same integrated delivery system operated by a carrier licensed under chapter 48.44 or 48.46 RCW as the provider providing audio-only telemedicine; or		
		RCW 48.43.735 (9)(d)(i)(B)	○ The covered person was referred to the provider providing audio-only telemedicine by another provider who has had, within the past three years, at least one in-person appointment, or at least one real-time interactive appointment using both audio and video technology, with the covered person and has provided relevant medical information to the provider providing audio-only telemedicine;		
		RCW 48.43.735 (9)(d)(ii)	• For any other health care service:		
		RCW 48.43.735 (9)(d)(ii)(A)	○ The covered person has had, within the past two years, at least one in-person appointment, or, until January 1, 2024, at least one real-time interactive appointment using both audio and video technology, with the provider providing audio-only telemedicine or with a provider employed at the same medical group, at the same clinic, or by the same integrated delivery system operated by a carrier licensed under chapter 48.44 or 48.46 RCW as the provider providing audio-only telemedicine; or		
		RCW 48.43.735 (9)(d)(ii)(B)	○ The covered person was referred to the provider providing audio-only telemedicine by another provider who has had, within the past two years, at least one in-person appointment, or, until January 1, 2024, at least		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Telemedicine (Cont'd)	Definitions (Cont'd)		one real-time interactive appointment using both audio and video technology, with the covered person and has provided relevant medical information to the provider providing audio-only telemedicine;		
		RCW 48.43.735 (9)(g)	• "Originating site" means the physical location of a patient receiving health care services through telemedicine;		
		RCW 48.43.735 (9)(i)	• "Store and forward technology" means use of an asynchronous transmission of a covered person's medical information from an originating site to the health care provider at a distant site which results in medical diagnosis and management of the covered person, and does not include the use of audio-only telephone, facsimile, or email.		
		RCW 48.43.735 (9)(j)	• "Telemedicine" means the delivery of health care services through the use of interactive audio and video technology, permitting real-time communication between the patient at the originating site and the provider, for the purpose of diagnosis, consultation, or treatment. Telemedicine does not include audio-only telephone, fax, or email.		
Transgender Services		42 USC §18116; RCW 48.30.300; RCW 49.60.040 (25) and (26)	Broad exclusions of coverage, and denial of a medically necessary service, on the basis of gender identity are prohibited. This prohibition applies in the issuance, cancellation, or renewal of any contract of insurance, as well as amount of benefits payable, or any term, rate, condition, or type of coverage offered. A plan may not limit or exclude otherwise covered services on the basis that the insured/enrollee identifies as a transgender or requires the service for treatment of gender identity disorder or gender dysphoria.		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Unfair and Discriminatory Practices	False Representation Prohibited	RCW 48.44.110; RCW 48.44.120 ; RCW 48.44.140	• No person shall make, publish, or disseminate any false, deceptive, or misleading representation or advertising on behalf of an HCSC. Nor shall the terms of a contract be misrepresented or misleading comparisons be made to induce a member to terminate or retain a contract or membership.		
	Cost Sharing Levels	WAC 284-43-5800(5)	• If plan has cost-sharing structures or tiers for EHBs, they must not be discriminatory.		
		WAC 284-43-5800(5)(a)	○ Plan must not apply cost-sharing or coverage limitations differently to enrollees with chronic disease or complex underlying medical conditions than to other enrollees, unless the difference provides the enrollee with access to care and treatment commensurate with the enrollee's specific medical needs, without imposing a surcharge or other additional cost to the enrollee beyond normal cost-sharing requirements under the plan.		
		WAC 28443-5800(5)(b)	○ Plan must not establish a different cost-sharing structure or tier for a benefit than is applied to the plan in general if the sole type of enrollee who would access that benefit or benefit tier is one with a chronic illness or medical condition.		
	Discrimination Prohibited	RCW 48.30.300; 48.44.220	No Issuer may refuse to issue any contract of insurance or cancel or decline to renew such contract because of the sex, marital status, or sexual orientation as defined in RCW 49.60.040, or the presence of any disability of the insured or prospective insured. The amount of benefits payable, or any term, rate, condition, or type of coverage may not be restricted, modified, excluded, increased, or reduced on the basis of the sex, marital status, or sexual orientation, or be restricted, modified, excluded, or reduced on the basis of the presence of any disability of the insured or prospective insured.		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Unfair and Discriminatory Practices (Cont'd)	Discrimination Prohibited (cont'd)	RCW 48.43.0128 (1)(a)	A health plan may not, in its benefit design or implementation of its benefit design, 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; or		
		RCW 48.43.0128 (1)(b)	• discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation.		
		RCW 48.43.0128 (2)	• Nothing in this section may be construed to prevent an issuer from appropriately utilizing reasonable medical management techniques.		
		WAC 284-43-5622(9)(c)	• A benefit may not have 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 the federal Mental Health Parity and Addiction Equity Act of 2008.		
		WAC 284-43-5940(1)(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, 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 discriminatory against transgender, nonbinary, gender nonconforming, or intersex individuals;		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Unfair and Discriminatory Practices (Cont'd)	Discrimination Prohibited (cont'd)	WAC 284-43-5940(1)(v)	• Have or implement a categorical coverage exclusion or limitation for all medical, surgical, or behavioral health services related to a person's gender identity or sexual orientation; or		
		WAC 284-43-5940(1)(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 identity or sexual orientation if such denial, limitation, or restriction results in discrimination against a transgender, nonbinary, gender nonconforming or intersex individual.		
		WAC 284-43-5940(1)(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, 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 discriminatory against transgender, nonbinary, gender nonconforming, or intersex individuals;		
	Discrimination on the Basis of a Health Factor Prohibited – In General	42 U.S.C. §300gg-4(a)	• Plans may not discriminate on the basis of a health factor. 45 CFR §147.110(a)		
		45 CFR §146.121(a)(1)	○ "Health Factor" means, in relation to an individual: ▪ Health status;		
		45 CFR §146.121 (a)(1)	▪ Medical condition (including both physical and mental illnesses);		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Unfair and Discriminatory Practices (Cont'd)	Discrimination on the Basis of a Health Factor Prohibited – In General		▪ Claims experience; ▪ Receipt of health care; ▪ Medial history; ▪ Genetic Information; ▪ Evidence of Insurability; or ▪ Disability.		
		45 CFR §144.103	• *"Medical condition* or *condition* means any condition, whether physical or mental, including, but not limited to, any condition resulting from illness, injury (whether or not the injury is accidental), pregnancy, or congenital malformation. However, genetic information is not a condition.		
		45 CFR §146.121(a)(2)	• "Evidence of Insurability" includes conditions arising out of acts of domestic violence and participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities.		
		45 CFR §146.121(a)(3) 45 CFR §146.117	• The decision whether health coverage is elected for an individual (including whether the individual enrolls during special enrollment or late enrollment) is not, itself, within the scope of any health factor. However, a plan or issuer must treat special enrollees the same as similarly situated individuals who are enrolled when first eligible.		
	Discrimination on the Basis of a Health Factor Prohibited - In Rules for Eligibility	42 U.S.C. §300gg-4 (a) 45 CFR §146.121 (b)(1)(i)	• Prohibited discrimination in rules for eligibility: ○ May not have any rule for eligibility (including continued eligibility) of any individual to enroll that discriminates based on any health factor that relates to that individual or a dependent of that individual, subject to the provisions below regarding how this rule applies to benefits, allows establishment of groups of similarly situated individuals, provides for wellness programs, and permits favorable treatment of individuals with adverse health factors.		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Unfair and Discriminatory Practices (Cont'd)	Discrimination on the Basis of a Health Factor Prohibited - In Rules for Eligibility (Cont'd)	45 C.F.R. §146.121 (b)(1)(ii)(A)	• Rules for eligibility include, but are not limited to, rules relating to— o Enrollment;		
		(b)(1)(ii)(B)	o The effective date of coverage;		
		(b)(1)(ii)(C)	o Waiting (or affiliation) periods;		
		(b)(1)(ii)(D)	o Late and special enrollment;		
		(b)(1)(ii)(E)	o Eligibility for benefit packages (including rules for individuals to change their selection among benefit packages);		
		(b)(1)(ii)(F)	o Benefits (including rules relating to covered benefits, benefit restrictions, and cost-sharing)		
		(b)(1)(ii)(G)	o Continued eligibility; and		
		(b)(1)(ii)(H)	o Terminating coverage (including disenrollment) of any individual.		
		45 CFR 148.180(b)(1)	Plan may not establish rules for the eligibility (including continued eligibility) of any individual to enroll based on genetic information.		
	Discrimination on the Basis of a Health Factor Prohibited – In Benefits	45 CFR §146.121 (b)(2)(i)(A)	• Prohibited discrimination in benefits: o General rule: Issuer is not required to provide coverage for any particular benefit to any group of similarly situated individuals.		
		(b)(2)(i)(B)	o However, benefits that are provided must be uniformly available to all similarly situated individuals.		
		45 CFR §146.121 (b)(2)(i)(B)	o Any restriction on a benefit must apply uniformly to all similarly situated individuals. Must not be directed at individual participants based on any health factor. ▪ Issuer may limit or exclude benefits in relation to a specific disease or condition, limit or exclude benefits for certain types of treatments or drugs, or limit or exclude benefits based on a determination of whether the benefits are experimental or not medically necessary, but only if the benefit limitation or exclusion applies uniformly to all similarly situated individuals		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Unfair and Discriminatory Practices (Cont'd)			and is not directed at individual participants based on any health factor of the participants.		
		45 CFR §146.121 (b)(2)(i)(B)	○ Issuer may require the satisfaction of a deductible, or other cost-sharing requirement if the limit or cost-sharing requirement applies uniformly to all similarly situated individuals and is not directed at individual participants based on a health factor.		
	Discrimination on the Basis of a Health Factor Prohibited - In premiums or contributions	42 U.S.C. §300gg-4 (b) 45 CFR §146.121(c)(1)	• Issuer may not require a person, as a condition of enrollment or continued enrollment in the plan, to pay a premium or contribution greater than that for a similarly situated enrollee in the plan based on any health factor of the individual or a dependent of the individual. This includes discounts, rebates, payments in kind, and any other premium differential mechanisms.		
		45 CFR 148.180(c)(1)	Plan may not adjust premium amount based on genetic information of the enrollee or a family member.		
		45 CFR 148.180 (c)(2)(ii)	○ Manifestation of a disease or disorder in one individual also cannot be used as genetic information about other, covered, individuals.		
	"Source of Injury" Exclusions Prohibited	45 CFR §146.121 (b)(2)(iii)(A)	• If a plan generally provides benefits for a type of injury, the issuer may not deny benefits otherwise provided for treatment of the injury if the injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions). This rule applies in the case of an injury resulting from a medical condition even if the condition is not diagnosed before the injury.		
Utilization Review	Requirement to Maintain Documented Program	RCW 48.43.520; WAC 284-43-2000(2)	Issuer must maintain a documented utilization review program description and written clinical review criteria based on reasonable medical evidence and to assure that reviews and second opinions are conducted in a timely manner.		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Utilization Review (Cont'd)	Time Frames for Review and Notification	WAC 284-43-200(6)	Each issuer must have written procedures to assure that reviews and second opinions are conducted in a timely manner		
		WAC 284-43-2000(5)	Issuer must reimburse reasonable costs of medical record duplications for reviews		
		WAC 284-43-2000(6)(b)	If the review request from the provider is not accompanied by all necessary information, the carrier must tell the provider what additional information is needed and the deadline for its submission		
Wellness Programs		42 U.S.C. §300gg 4 (j)(1);	"Wellness program" means a program of health promotion or disease prevention.		
		45 CFR §146.121 (f)	• Issuer may give a reward for similarly situated individuals in connection with a wellness program that satisfies the requirements below. Reward can be a discount or rebate of a premium or contribution, waiver of all or part of a cost-sharing mechanism, the absence of a surcharge, or the value of a benefit the plan would otherwise not provide. This is not considered impermissible discrimination on the basis of a health factor if the wellness program meets the following criteria as either a "participatory wellness program" or a "Health-contingent wellness program."		
		45 CFR §146.121(f)(1)(i)	• A reward based on a "Participatory wellness program" is allowable IF:		
		42 U.S.C. §300gg-4 (j)(2)(A-E)	○ the program is made available to all similarly situated individuals, AND		
		42 USC §300gg-4(j)(1)(B)	▪ none of the conditions for obtaining a reward under the program are based on an individual satisfying a standard that is related to a health factor (45 CFR §146.121(f)(1)(ii)); OR		
		42 U.S.C. §300gg-4	▪ the program does not provide a reward. 45 CFR §146.121(f)(1)(ii)		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Wellness Programs (Cont'd)		(j)(1)(B)			
		42 USC §300gg-4(j)(2); 45 CFR §146.121(f)(2)	○ Examples: the following programs are permissible "participatory wellness programs" if participation in the program is made available to all similarly situated individuals:		
		42 USC §300gg-4(j)(2)(A)	• A program that reimburses all or part of the cost for memberships in a fitness center; 45 CFR §146.121 (f)(1)(ii)(A)		
		42 USC §300gg-4(j)(2)(B)	• A diagnostic testing program that provides a reward for participation and does not base any part of the reward on outcomes. 45 CFR §146.121 (f)(1)(ii)(B)		
		42 USC §300gg-4(j)(2)(C)	• A program that encourages preventive care through the waiver of the copayment or deductible requirement under a group health plan for the costs of, for example, prenatal care or well-baby visits. 45 CFR §146.121 (f)(1)(ii)(C)		
		42 USC §300gg-4(j)(2)(D)	• A program that reimburses employees for the costs of smoking cessation programs without regard to whether the employee quits smoking. 45 CFR §146.121 (f)(1)(ii)(D)		
		42 USC §300gg-4(j)(2)(E)	• A program that provides a reward to employees for attending a monthly health education seminar. 45 CFR §146.121 (f)(1)(ii)(E)		
		45 CFR §146.121 (f)(1)(ii)(F)	• A program that provides a reward to employees who complete a health risk assessment regarding current health status, without any further action (educational or otherwise) required by the employee with regard to the health issues identified as part of the assessment. (*See also* §146.122 for rules prohibiting collection of genetic information.)		
		42 U.S.C. §300gg-4 (j)(3); 45 CFR	"Health-contingent wellness program": • A wellness program is "health-contingent" if any condition for obtaining a reward under a wellness program is based on an		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Wellness Programs (Cont'd)		§146.121(f)(1)(iii)	individual satisfying a standard that is related to a health factor. There are 2 types of health contingent wellness programs: activity-only and outcome-based.		
		45 CFR §146.121(f)(1)(iv)	• "Activity only" wellness programs require enrollees to perform or complete an activity related to a health factor to get a reward, but not to attain or maintain a specific health outcome. ○ Examples: walking, diet, or exercise programs, which some people may be unable to participate in or complete due to a health factor. A reward based on an activity only wellness program is allowable IF:		
		42 USC §300gg-4(j)(3)(C)	○ Program must give individuals eligible for the program the opportunity to qualify for the reward under the program at least once per year. 45 C.F.R. §146.121(f)(3)(i)		
		42 USC §300gg-4(j)(3)(C); 45 C.F.R. §146.121(f)(3)(ii)	• The reward for the wellness program, coupled with the reward for other wellness programs with respect to the plan that require satisfaction of a standard related to a health factor, must not exceed 30 percent of the cost of employee-only coverage under the plan. BUT, if, in addition to employees, any class of dependents (e.g., spouses or spouses and dependent children) may participate in the wellness program, the reward must not exceed 30 percent of the cost of the coverage in which an employee and any dependents are enrolled.		
		42 USC §300gg-4(j)(3)(A); 45 CFR §146.121(f)(5).	○ However, the reward may be up to 50 percent of the cost of coverage to the extent that the additional percentage is in connection with a program designed to prevent or reduce tobacco use.		
		42 USC §300gg-4(j)(3)(B); 45 C.F.R. §146.121(f)(3)(iii)	Program must be reasonably designed to promote health or prevent disease. • Must have a reasonable chance of improving the health of or preventing disease in participating individuals		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Wellness Programs (Cont'd)			• Must not be overly burdensome • Must not be a subterfuge for discriminating based on a health factor • Must not be highly suspect in the method chosen to promote health or prevent disease.		
		42 USC §300gg-4(j)(3)(D); 42 USC §300gg-4(j)(3)(D)(i)	The reward must be available to all similarly situated individuals. 45 CFR §146.121(f)(3)(iv) • Must allow a reasonable alternative standard (or waiver of the otherwise-applicable standard) for obtaining the reward for an individual for whom, for that period (45 CFR §146.121 (f)(3)(iv)(A)):		
		42 USC §300gg-4(j)(3)(D)(i)(I)	○ it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard (45 CFR §146.121(f)(3)(iv)(A)(1)); OR		
		42 USC §300gg-4(j)(3)(D)(i)(II)	○ it is medically inadvisable to attempt to satisfy the otherwise applicable standard. 45 CFR §146.121(f)(3)(iv)(A)(2)		
		45 CFR §146.121 (f)(3)(iv)(B)	• Reasonable alternative standard must be furnished by the plan or issuer upon the individual's request or the condition for obtaining the reward must be waived.		
		45 CFR §146.121 (f)(3)(iv)(C)	• Whether a plan or issuer has furnished a reasonable alternative standard depends on "all facts and circumstances", including but not limited to:		
		45 CFR §146.121 (f)(3)(iv)(C)(1)	○ If it is completion of an educational program, the issuer must make the program available or assist the enrollee to find a program (may not require enrollee to find it unassisted). May not require enrollee to pay the cost of the program.		
		45 CFR §146.121 (f)(3)(iv)(C)(2)	○ Time commitment required must be reasonable (e.g., requiring nightly one-hour class is unreasonable).		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Wellness Programs (Cont'd)		45 CFR §146.121 (f)(3)(iv)(C)(3)	○ If it is a diet program, issuer is not required to pay for the cost of food but must pay any membership or participation fee.		
		45 CFR §146.121 (f)(3)(iv)(C)(4)	○ If enrollee's physician states that a standard is not medically appropriate for enrollee, issuer must provide a reasonable alternative standard that accommodates the medical appropriateness recommendations of the enrollee's physician. Issuer may impose standard cost sharing under the plan for medical items and services furnished pursuant to the physician's recommendations.		
		45 CFR §146.121 (f)(3)(iv)(D)	• To the extent that a reasonable alternative standard under an activity-only wellness program is, itself, an activity-only wellness program, it must comply in the same manner as if it were an initial program standard. (e.g., if the reasonable alternative standard to a running program is a walking program, individuals who cannot complete the walking program must be provided a reasonable alternative standard to the walking program.) To the extent that a reasonable alternative standard under an activity-only wellness program is, itself, an outcome-based wellness program, it must comply with the requirements for an outcome-based wellness program.		
		42 USC §300gg-4(j)(3)(D)(ii); 45 CFR §146.121 (f)(3)(iv)(E)	• If reasonable under the circumstances, an issuer may seek verification, such as a statement from an individual's personal physician, that a health factor makes it unreasonably difficult for the individual to satisfy, or medically inadvisable for the individual to attempt to satisfy, the otherwise applicable standard of an activity-only wellness program.		
		42 USC §300gg-4(j)(3)(E); 45 CFR	• Issuer must disclose in all plan materials describing the terms of an activity-only wellness program the availability of a reasonable		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Wellness Programs (Cont'd)		§146.121 (f)(3)(v)	alternative standard to qualify for the reward (and, if applicable, the possibility of waiver of the otherwise applicable standard), including contact information for obtaining a reasonable alternative standard and a statement that recommendations of an individual's personal physician will be accommodated. If plan materials merely mention that such a program is available, without describing its terms, this disclosure is not required.		
		45 CFR §146.121(f)(6)	• May use the following sample language, or substantially similar: "Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at [insert contact information] and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status."		
		42 U.S.C. §300gg-4 (j)(3); 45 CFR §146.121(f)(1)(v)	• An "Outcome-based wellness program" requires enrollees to attain or maintain a specific health outcome (e.g., not smoking) to obtain a reward. These wellness programs typically have two tracks to obtaining the reward: achieving the health outcome or, for enrollees who do not attain or maintain the health outcome, compliance with an alternative. *Example*: a wellness program tests enrollees for high blood pressure and provides a reward to those identified as within a normal or healthy range, while requiring those outside the normal or healthy range (or at risk) to take additional steps (e.g., adhering to a health improvement action plan) to obtain the same reward. A reward based on an "outcome-based wellness program" is allowable IF:		
		42 USC §300gg-4(j)(3)(C)	• Enrollees have the opportunity to qualify for the reward under the program at least once per year. 45 CFR §146.121(f)(4)(i)		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Wellness Programs (Cont'd)		42 USC 300gg-4(j)(3)(A); 45 CFR §146.121(f)(4)(ii); 45 C.F.R. §146.121(f)(5)	• The reward for the outcome-based wellness program, together with the reward for other health-contingent wellness programs with respect to the plan, must not exceed 30 percent (50% in connection with a program designed to prevent or reduce tobacco use) of the total cost of employee-only coverage under the plan. If dependents may participate in the wellness program, the reward must not exceed 30% (50% if in connection with a program to reduce or prevent tobacco use) of the total cost of the coverage for employee and dependents. The "cost of coverage" means the total amount of employer and employee contributions towards the coverage.		
		42 USC 300gg-4(j)(3)(B); 45 CFR §146.121(f)(4)(iii)	The program: • must be reasonably designed to promote health or prevent disease • Must have a reasonable chance of improving the health of, or preventing disease in, participating enrollees, • Must not be overly burdensome, • Must not be a subterfuge for discriminating based on a health factor, and • Must not be highly suspect in the method chosen to promote health or prevent disease. Determination is based on all the relevant facts and circumstances. Reasonable alternative standard to qualify for the reward must be provided to any individual who does not meet the initial standard based on a measurement, test, or screening that is related to a health factor.		
		42 USC 300gg-4(j)(3)(D)	The full reward under the outcome-based wellness program must be available to all similarly situated individuals. 45 CFR §146.121(f)(4)(iv)		
		42 USC 300gg-4(j)(3)(D)(i)	• Reward is not available to all similarly situated individuals unless the program allows a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Wellness Programs (Cont'd)			any individual who does not meet the initial standard based on the health factor measurement. 45 CFR §146.121 (f)(4)(iv)(A)		
		45 CFR §146.121 (f)(4)(iv)(B)	• Reasonable alternative standard must be furnished upon request or the condition for obtaining the reward must be waived.		
		45 CFR §146.121 (f)(4)(iv)(C)	• Whether issuer has furnished a reasonable alternative standard based on "all facts and circumstances", including but not limited to:		
		45 CFR §146.121 (f)(4)(iv)(C)(1)	○ If it is completion of an educational program, issuer must make the program available or help the enrollee find one (instead of making them find it unassisted), and may not require enrollee to pay for the program.		
		§146.121 (f)(4)(iv)(C)(2);	○ Time commitment required must be reasonable (e.g., a nightly one-hour class would be unreasonable).		
		§146.121 (f)(4)(iv)(C)(3);	• If it is a diet program, the issuer is not required to pay for the cost of food but must pay any membership or participation fee.		
		45 CFR §146.121 (f)(4)(iv)(C)(4)	• If an enrollee's physician states that a plan standard is not medically appropriate for that enrollee, the plan or issuer must provide a reasonable alternative standard that accommodates the enrollee's physician's medical appropriateness recommendations. Issuers may impose standard cost sharing under the plan for medical items and services furnished pursuant to the physician's recommendations.		
		45 CFR §146.121 (f)(4)(iv)(D)	• To the extent that a reasonable alternative standard under an outcome-based wellness program is, itself, an activity-only wellness program, it must comply with the requirements as if it were an initial program standard. To the extent that the alternative standard is, itself, another outcome-based wellness program, it		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Wellness Programs (Cont'd)			must comply with the requirements for an outcome-based wellness program, subject to the following special rules:		
		45 CFR §146.121 (f)(4)(iv)(D)(1)	○ The alternative standard cannot be a different level of the same standard without additional time to comply that takes into account the individual's circumstances. (e.g., if the initial standard is to achieve a BMI less than 30, the reasonable alternative standard cannot be to achieve a BMI less than 31 on that same date. But it could be to reduce BMI by a small amount or small percentage, over a realistic period of time.		
		45 CFR §146.121 (f)(4)(iv)(D)(2)	○ Enrollee must be given the opportunity to comply with the recommendations of the enrollee's physician as a second reasonable alternative standard to meeting the reasonable alternative standard defined by the plan or issuer, but only if the physician joins in the request. The individual can make a request to involve a personal physician's recommendations at any time and the personal physician can adjust the physician's recommendations at any time, consistent with medical appropriateness.		
		45 CFR §146.121 (f)(4)(iv)(E)	○ It is not reasonable to seek verification (e.g., a statement from an enrollee's physician) under an outcome-based wellness program that a health factor makes it unreasonably difficult for the individual to satisfy, or medically inadvisable for the individual to attempt to satisfy, the otherwise applicable standard as a condition of providing a reasonable alternative to the initial standard. ○ But, if issuer provides an alternative health factor measurement that involves an activity related to a health factor, then the requirements for activity-only wellness programs apply to that component of the wellness program. Under those rules, the issuer may, if reasonable under the circumstances, seek		

Topic	Sub Topic	Reference	Specific Issue	Form and page or section	Additional Information / Comments
Wellness Programs (Cont'd)			verification that the alternative activity is unreasonably difficult due to a medical condition or medically inadvisable. (e.g., if an outcome-based wellness program requires participants to maintain a certain healthy weight and provides a diet and exercise program for enrollees who do not meet the target weight, the issuer may seek verification, if reasonable under the circumstances, that a second reasonable alternative standard is needed for an enrollee for whom it would be unreasonably difficult due to a medical condition, or medically inadvisable to attempt to comply, with the diet and exercise program, due to a medical condition.)		
		42 U.S.C. §300gg-4 (j)(3)(E); 45 CFR §146.121 (f)(4)(v)	• Issuer must disclose in all plan materials describing the terms of an outcome-based wellness program, and in any disclosure that an individual did not satisfy an initial outcome-based standard, the availability of a reasonable alternative standard to qualify for the reward (and, if applicable, the possibility of waiver of the otherwise applicable standard), including contact information for obtaining a reasonable alternative standard and a statement that recommendations of an individual's personal physician will be accommodated. If plan materials merely mention that such a program is available, without describing its terms, this disclosure is not required.		
		RCW 48.43.670	• Modification of a wellness program upon renewal of a plan does not constitute discontinuation or renewal of that plan. *Resources*: ACA FAQ Part V; ACA FAQ Part XVIII		

Exhibit B
(Filed under seal)

Exhibit C
(Filed under seal)

Exhibit D

2022

GUIDANCE FOR PARTICIPATION OF HEALTH PLANS IN THE WASHINGTON HEALTH BENEFIT EXCHANGE

Washington Health Benefit Exchange
810 Jefferson Street SE
Olympia, Washington 98501

Section 1: Introduction

This Guidance for Participation specifies requirements for a health insurance issuer to participate in the Washington State Health Benefit Exchange (WAHBE or the Exchange). An issuer may participate in the individual Exchange by offering qualified health plans (QHPs) from November 1, 2021 through January 15, 2022 for coverage in plan year 2022.

The Guidance will provide information on the following:

- Certifying a health plan to become a QHP
- Monitoring and compliance of a QHP
- Decertifying a QHP
- Standards for issuers offering QHPs through the Exchange
- Requirements for the standard plan offering
- Expectations for issuer coordination with the Exchange
- Special guidance for coverage of American Indian/Alaska Natives

This Guidance is in accordance with the Patient Protection and Affordable Care Act of 2010 (ACA) and Chapters 43.71 RCW and 48.43 RCW. This Guidance applies to issuers offering plans that meet public option requirements as described in RCW 41.05.410 for 2022 coverage. Any product intended to be offered under those public option plan requirements will be required to be certified as a QHP under this Guidance before it may be offered as a public option plan.

The Washington State Office of the Insurance Commissioner (OIC) regulates health insurance issuers and health plans. This document does not provide guidance on achieving regulatory approval by the OIC. Throughout this document, however, WAHBE may refer issuers to OIC as the source of regulatory information.

1.1 Glossary

WAHBE applies the standard definitions found within the Affordable Care Act and subsequent guidance whenever possible.

ACTUARIAL VALUE

The percentage paid by a health plan of the total allowed costs of benefits.

AFFORDABLE CARE ACT

The comprehensive health care reform enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name Affordable Care Act (ACA) is used to refer to the final, amended version of the law.

APPEAL

An official request from a health insurance issuer that WAHBE reconsider a decision to certify a health plan as a QHP, deny recertification of a QHP, or decertify a QHP.

CASCADE CARE

The Washington state health care law passed in May 2019 (Engrossed Substitute Senate Bill (ESSB) 5526) directing the Exchange to establish standard plans. The law also grants the Health Care Authority the authority to procure qualified health plans (the standard plans and meet certain affordability and quality standards as defined in the legislation "public option" plans). The term "Cascade Care" as used in this document may refer to both standard plans and public option plans.

ENROLL

The point at which coverage is effective under a QHP.

ENROLLEE

Qualified individual enrolled in a QHP.

EXPIRE

The end of a plan year in which a QHP issuer elects not to seek recertification of a QHP offered through the Exchange for the following year. This act by the QHP issuer will constitute voluntary expiration of certification and result in non-certification for a subsequent consecutive certification cycle (45 CFR §156.290).

HEALTH BENEFIT EXCHANGE BOARD

The governing board of WAHBE as established in Chapter 43.71 RCW.

HEALTH INSURANCE ISSUER OR ISSUER

An issuer, which includes a disability insurer, health care service contractor, or health maintenance organization, as defined in RCW 48.43.005 and defined in the Employee Retirement Income Security Act and used in the ACA.

(In this document, "issuer" refers to a health insurance company, "product" refers to a suite of plans that share, for example, a common set of health benefits, and "health plan" refers to the actual insurance coverage purchased by a consumer. The document does not refer to insurance companies as the "plans" or "the health plans.")

HEALTH PLAN

Health plan means any policy, contract, or agreement as defined in RCW 48.43.005 and offered by an issuer and used in accordance with section 1301(b)(1) of the ACA. A health plan is the specific health benefit plan purchased by a subscriber, employer, or employee. Each health plan is the pairing of a product's benefits with a particular cost-sharing structure, provider network, and service area. Multiple health plans can be associated with a single product.

NAVIGATOR

An organization that has been awarded a contract by the Exchange to carry out activities and meet the standards described in 45 CFR §155.210. Navigator representatives are qualified, trained, and certified to engage in education, outreach, and facilitation of selection of QHP or Washington Apple Health (Medicaid) by a consumer in *Washington Healthplanfinder*.

OPEN ENROLLMENT PERIOD

The period each year during which consumers may enroll or change coverage in QHP and QDP through *Washington Healthplanfinder*.

The open enrollment period for 2022 coverage is from November 1, 2021 through January 15, 2022, unless otherwise published by the Exchange in an amendment to the 2022 Guidance for Participation

PLAN YEAR

The consecutive-12-month period during which a health plan provides coverage for health benefits. For individuals, it is the calendar year.

PRODUCER

A person licensed by OIC as an agent to sell or service insurance policies.

PUBLIC OPTION PLAN

A Cascade Care qualified health plan procured by the Health Care Authority and offered on the Health Benefit Exchange as described in RCW 41.05.840 that meets the standard plan design and additional affordability and quality metrics included in the Health Care Authority procurement

QUALIFIED DENTAL PLAN OR QDP

A stand-alone dental plan that is certified by the exchange and is a commitment to insure at a minimum the essential health benefit of pediatric oral services (established as essential health benefit under

ACA § 1302(b) and defined under WAC 284-43-5700) under specific cost sharing (deductibles, copayments, and out-of-pocket maximum amounts) and other regulatory and contractual requirements.

QUALIFIED HEALTH PLAN OR QHP

A health plan that is certified by an exchange. To be certified in Washington, a health plan must be approved by OIC, satisfy the certification criteria specified in RCW 43.71.065, satisfy the minimum federal requirements of a QHP as outlined in 45 CFR 155 and §156, and be certified by the Exchange Board

SPECIAL ENROLLMENT PERIOD

A period during which a qualified individual or enrollee experiences certain qualifying events may enroll in, or change enrollment in, a QHP through *Washington Healthplanfinder* outside of the annual open enrollment period.

STANDARD OR STANDARDIZED PLAN

A Cascade Care qualified health plan that meets specific benefit design and cost sharing requirements published annually by the Washington Health Benefit Exchange, pursuant to RCW 43.71.095

WASHINGTON HEALTHPLANFINDER OR HEALTHPLANFINDER

The marketplace in Washington State created by the Washington Health Benefit Exchange where qualified individuals can shop for and purchase qualified health plans (QHPs) and qualified dental plans (QDPs).

1.2 Overview of Guidance

1.2.1 Objective

The purpose of this Guidance is to provide health insurance issuers the foundational information needed to offer individual QHPs through the Exchange. The certification criteria set forth within this document do not supersede a QHP issuer's responsibility to provide coverage based upon state and federal laws and rules. While the Guidance specifies some federal and state laws or regulations that apply to offering health insurance coverage through the Exchange, a QHP issuer is required to comply with all relevant state and federal laws in order to offer coverage through the Exchange.

The Guidance also specifies the certification criteria that apply to a participating health plan. To be certified a QHP must:

- Be approved by OIC;
- Satisfy the certification criteria specified in RCW 43.71.065;
- Satisfy the minimum federal requirements of a QHP as outlined in 45 CFR parts §155 and §156; and
- Be certified by the Exchange Board.

To participate in the Exchange, a QHP issuer must meet the legal requirements of offering health insurance in Washington State, including the offering of standard plans as required under RCW 43.71.095. A QHP issuer must also sign a Participation Agreement with WAHBE to participate in the Exchange.

1.2.2 Term of Engagement

An individual health insurance plan certified or recertified as a QHP will be offered through the Exchange. New and renewed individual plans will be available for preview prior to the start of open enrollment for a period as determined by the Exchange. New and renewed individual plans will be available for selection beginning November 1, 2021 with an initial effective date of coverage beginning no earlier than January 1, 2022.

Health insurance issuers responding to this Guidance may offer certified or recertified individual QHPs for a term of one year beginning January 1, 2022 and ending December 31, 2022. Only OIC-approved health plans certified by the Board may be offered as QHPs through the Exchange during this period.

The Guidance shall be amended as required to incorporate changes to federal and state law.

1.2.3 Contact

Your contact at WAHBE for this document is Christine Gibert, Policy Director. Please direct all questions regarding plan certification and this document to Christine Gibert at (360) 688-7773 or christine.gibert@wahbexchange.org.

For questions about OIC regulatory requirements referenced throughout this document, please contact the OIC Rates, Forms, and Provider Networks HelpDesk at (360) 725-7111.

1.2.4 Plan Certification Timeline and Letter of Intent

An issuer is recommended to inform WAHBE of its intent to participate in the Exchange by submitting a letter of intent. Submitting a letter of intent is not mandatory and is nonbinding, but will help WAHBE communicate with potential participating issuers and prepare for the certification process. The letter of intent should be in letter format on official letterhead and be signed by the issuer's Chief Executive Officer or their designee, or any C-suite executive. The due date for the letter of intent is specified in the plan certification timeline. Issuers are not required to indicate the specific health plans they intend to offer through the Exchange, but should include a list of counties in which they intend to offer coverage. The letter of intent is for internal Exchange use only and will not be shared publicly. An issuer may submit a letter of intent at QHP@wahbexchange.org.

PLAN CERTIFICATION TIMELINE

The Exchange expects issuers to adhere to the plan certification timeline. Please click on the following link to find the 2022 plan certification timeline:

https://www.wahbexchange.org/about-the-exchange/committees-and-workgroups/plan-certification-workgroup/

1.3 Participating in the Exchange

A QHP issuer participating in WAHBE's individual market is not required to participate in the individual market outside of the Exchange.

1.3.1 Initial Certification of Qualified Health Plans

WAHBE certifies QHPs annually and only those health plans certified or recertified by WAHBE may be offered as QHPs through the Exchange.

An issuer must comply with OIC category requirements, and OIC will provide regulatory review of health insurance issuers and health plans. WAHBE will determine if the issuer satisfies the Exchange based certification criteria. Once the Board issues QHP certifications, WAHBE will inform an issuer of the decision.

An issuer must enter into a Participation Agreement with WAHBE before offering QHPs through the Exchange. The Participation Agreement requires issuers to adhere to all health plan certification criteria described in this Guidance. WAHBE, in addition to the Legislature and OIC, reserves discretion to modify and amend the terms and conditions of current QHP certification criteria and how they may be applied in the certification or decertification process, consistent with current laws and rules, at any time including after the execution of issuer Participation Agreements.

Prior to publishing plan offerings, an issuer must also enter into an Electronic Data Interchange (EDI) Trading Partner Agreement and one or more EDI interfaces will need to be tested between the issuer and WAHBE. These steps ensure that the issuer and WAHBE will be able to communicate enrollment data.

Issuers who rely primarily on third-party vendors for communication of enrollment data are required to coordinate with WAHBE when there is a change in vendors. Issuers are responsible for ensuring their vendors conform to the EDI Trading Partner Agreement.

1.3.2 Recertification of Qualified Health Plans

WAHBE will consider renewing QHPs for recertification annually. The recertification process will involve a review of the certification criteria reflected in this document.

1.3.3 Submitting Health Plans to Become Certified as a QHP

The WAHBE certification process begins when an issuer submits SERFF Binder and network filings to OIC for regulatory review. Please contact OIC for information on when, how, and where to submit the filing documents. For a health plan, issuers shall submit to the Exchange the QHP submission form provided by WAHBE at the time of filing.

WAHBE intends to complete the certification or recertification process for 2022 plans by September 9, 2021. Issuers should have received OIC approval of any plans for which they are seeking Exchange certification by September 2, 2021, to guarantee consideration for certification for 2022. If an issuer wishes to withdraw a plan from consideration for QHP certification after plan approval by OIC, the issuer must submit a plan withdrawal form to the Exchange.

Plans certified by September 16 will be included in the Exchange's plan preview period for the 2022 plan year. Any plans certified after September 16 may be considered for inclusion in the plan preview period on a case-by-case basis.

Plans certified by September 16, 2021 will be included in the Exchange's auto-renewals for the 2022 plan year. Any plans certified after September 16, 2021 will be considered for inclusion in the auto renewal process on a case-by-case basis.

Plans certified by October 1, 2021 will be available through the Exchange in open enrollment for 2022 coverage. Any plans certified after October 1, 2021, will be considered for inclusion in open enrollment on the Exchange for 2022 on a case-by-case basis

Section 2: Specifications for Participation

2.1 Summary Table 1: Initial Certification and Recertification Criteria

To participate in WAHBE's QHP certification process, an issuer must submit plans and supporting documentation as specified for each criterion. The following chart summarizes the nineteen criteria applied in the certification process for QHPs. Each criterion is reviewed and approved by OIC, WAHBE, or both

NUMBER	CRITERIA LEVEL	CRITERIA	OIC OR WAHBE REVIEW	INITIAL CERTIFICATION CRITERIA	RECERTIFICATION CRITERIA
1	Issuer	Issuer must be in good standing	OIC	Yes	Yes
2	Issuer	Issuer must pay user fe if QHPs assessed	WAHBE	Yes	Yes
3	Issuer	Issuer must comply wit the risk adjustment program	OIC	Yes	Yes
4	Issuer	Issuer must comply wit market rules on offering plans	OIC	Yes	Yes
5	Issuer	Issuer must comply wit non-discrimination rules	OIC	Yes	Yes
6	Issuer	Issuer must be accredit by an entity that HHS recognizes for accreditation of health plans	WAHBE	Yes	Yes
7	Product	QHP must meet marketing requirements	WAHBE	Yes	Yes
8	Product	QHP must meet networ access requirements, including ECPs	OIC	Yes	Yes
9	Product	Issuer must submit provider directory data	WAHBE	Yes	Yes
10	Product	Issuer must implement quality improvement strategy	WAHBE	Yes	Yes
11	Product	Issuer must submit healt plan data to be used in standard format for presenting health benef plan options	WAHBE	Yes	Yes

12	Product	Issuer must report quali and health performance data	WAHBE	No	Yes
13	Product	Issuer must use the Exchange enrollment application	WAHBE	Yes	Yes
14	Product	Issuer may only contrac with a hospital with mor than 50 beds if the hospital utilizes a patier safety evaluation syster	OIC	Yes	Yes
15	Product	Services provided unde QHP through a direct primary caremedical home must be integrate with the QHP issuer	OIC	Yes	Yes
16	Plan	A QHP must comply wit benefit design standard (e.g. cost sharing limits "metal level," EHB, standard plan design	OIC/WAHBE	Yes	Yes
17	Plan	Issuer must submit a QHP's service area and rates for a plan year	OIC	Yes	Yes
18	Plan	Issuer must post justifications for QHP premium increases	OIC	No	Yes
19	Plan	Issuer must submit QHI benefit and rate data for public disclosure	WAHBE/OIC	Yes	Yes

2.2 QHP Specifications

An issuer's health plan must satisfy the following criteria to become certified as a QHP offered through the Exchange

2.2.1 Licensed and Good Standing

An issuer must have restricted authority to write its authorized lines of business in Washington in order to be considered "in good standing" and to offer a QHP in the Exchange

OIC determines if an issuer is in good standing. Please direct requests for a good standing to companysupervisionfilings@oic.wa.gov

OIC determinations of good standing will be based on authority granted to OIC by Title 48 RCW and Title 284 WAC. Such authority may include restricting an issuer's ability to issue new or renew existing coverage for an enrollee.

An issuer should inform WAHBE immediately, but in any case no later than 5 business days, if OIC has restricted in any way the issuer's authority to write any of its authorized lines of business. If OIC has restricted the issuer's ability to underwrite current or new health plans, WAHBE will determine, consistent with OIC restrictions, if the issuer can submit a health plan certification or recertification as a QHP.

Restrictions on an issuer's ability to underwrite current or new health plans may result in QHP decertification by WAHBE.

2.2.2 User Fee Adherence

RCW 43.71.065 designates a portion of premium tax receipts and a fee assessed on QHPs as funding for WAHBE's operating expenses.

If a QHP issuer's payment of the QHP assessment is delinquent, WAHBE will assess a penalty equal to 1%, rounded up to the nearest whole dollar, of the issuer's delinquent amount for each 15-day period that an issuer's payment is overdue. To avoid penalties for late payment, a QHP issuer is encouraged to pay any and all assessed amounts while contesting a fee.

If WAHBE determines that a QHP issuer is not making timely and full payment of the QHP assessment, and WAHBE determines that the QHP issuer will not resume making timely and full payments, WAHBE will decertify all the issuer's QHPs.

2.2.3 Risk Adjustment Program

A QHP issuer must comply with the requirements of the risk adjustment program as specified in the ACA standards set in federal rules 45 CFR part 153, Washington State statue, rules adopted by OIC, the annual Notice of Benefit and Payment Parameters published by the Department of Health and Human Services (HHS), and other applicable law.

OIC will monitor a QHP issuer's compliance with the risk adjustment program. If OIC determines that a QHP issuer is no longer complying with the requirements of the risk adjustment program, and determines that the QHP issuer will not resume full compliance with the requirements of the risk adjustment program, WAHBE will decertify all the issuer's QHPs.

2.2.4 Market Rules for Offering QHPs

An issuer must comply with the market rules for offering individual QHPs set forth by the ACA and Washington State law, including the four metal levels of coverage (bronze, silver, gold, and platinum) designated in §1302 of the ACA and the standardized plans as required in RCW 43.71.095.

Please refer to OIC regulatory specifications for information on the calculation of the actuarial value for each metal level.

Only a QHP issuer that satisfies the following market rules may offer QHPs through the Exchange:

- A QHP issuer must offer at least one QHP at the silver level and at least one QHP at the gold level in all counties in which it offers coverage through the Exchange.
- An issuer must offer a standard plan at least at the gold and silver level in any county in which it participates, and if offering bronze, a bronze standard plan.
- An issuer must offer a child-only plan at the same metal level as any QHP offered through the exchange (not including catastrophic plans) (45 CFR §156.200(c)(2)) to individuals who, at the start of the plan year, have not reached the age of 21.
- If OIC determines that a QHP issuer is not complying with the market rules, and OIC further determines that the QHP issuer will not resume compliance with the market rules, WAHBE will decertify all the issuer's QHPs in that market.

2.2.5 Non-Discrimination

A QHP issuer must comply with federal and Washington State nondiscrimination requirements. A QHP issuer may not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation (45 CFR §156.125, §156.200(e), RCW 48.43.0128, and WAC 284-43-5940-5950), or on the basis of an individual's degree of medical dependency, health status or condition, quality of life, or expected length of life (ACA Sec. 1302(b)(4)(D), RCW 48.43.0128, and WAC 284-43-5940).

OIC will enforce nondiscrimination requirements and monitor for noncompliance. If OIC determines that a QHP issuer is not complying with the nondiscrimination requirements, and OIC determines that the QHP issuer will not resume compliance with the nondiscrimination requirements, WAHBE will decertify all the issuer's QHPs affected by that noncompliance.

2.2.6 Accreditation

The QHP issuer must meet a minimum level of accreditation by an accrediting entity recognized by HHS. WAHBE will verify an issuer's accreditation status for certification or recertification.

A QHP issuer must achieve AAAHC, NCQA, or URAC exchange accreditation at least 90 days before the first day of the annual open enrollment period that follows the QHP issuer's fourth certification process. QHP issuers must maintain current accreditation every subsequent year of participation and provide proof of ongoing accreditation at least 90 days prior to the annual open enrollment period. The issuer must present a copy of each accreditation certificate (one per accredited product type (e.g., HMO, EPO, PPO)) to the Exchange.

A QHP issuer shall notify the Exchange of any accreditation review scheduled for the upcoming plan year. The issuer shall notify WAHBE within five business days if there is a change in accreditation status or if there is a failure to maintain up-to-date accreditation.

WAHBE reserves the right to decertify a QHP if accreditation is terminated or not achieved by the relevant deadline.

WAHBE will certify a health plan as accredited if one of the following statuses is held by the QHP issuer:

- NCQA: accredited with a star rating, if applicable, provisional with a star rating, if applicable, or interim with a star rating, if applicable (interim status requires a second review within 18 months)
    - WAHBE will not recognize NCQA status: denied with a star rating, if applicable
- URAC: full, provisional, or conditional (conditional status requires a second review within three to six months)
    - WAHBE will not recognize URAC status: denial
- AAAHC: Certificate of Accreditation
    - WAHBE will not recognize AAAHC status: denial

WAHBE may certify a QHP prior to that health plan becoming exchange-accredited as described below. During a new issuer's initial and next two certification processes, WAHBE may certify a health plan as a QHP that is unaccredited if the issuer satisfies the following:

- When submitting a health plan for certification, an issuer must attest that it will schedule the "exchange accreditation" (in accordance with 45 CFR §§156.275 and 156.1045) in the product types (HMO, EPO, MCO, POS, or PPO) used in offering its QHPs.
- A QHP issuer must achieve Exchange accreditation and provide proof of that accreditation at least 90 days before the first day of the annual enrollment period that follows the QHP issuer's fourth certification process. For example, if an unaccredited issuer began offering QHP coverage in the 2021 plan year, it would need to achieve and document Exchange accreditation by August 2023 for offering QHP coverage in the 2024 plan year.

2.2.7 Marketing

A QHP issuer is encouraged to actively market products available through *Washington Healthplanfinder* and to participate in joint marketing efforts with WAHBE, as applicable. WAHBE has created its own logos that designate the certification of a QHP. Issuers that offer products certified as QHPs give the Exchange the right to use their logos in the Exchange application and acknowledge that Exchange-designated logos are included in QHP displays sold through the Exchange. The QHP issuer will be provided any WAHBE marketing materials, for review, that use the QHP issuer's logo.

An issuer can use the *Washington Healthplanfinder* or Cascade Care logos, if applicable, to co-brand on-Exchange QHP marketing materials or web pages in accordance with guidelines developed by WAHBE Communications. The logos cannot be modified, and no other logos can be used to represent *Washington Healthplanfinder*, Cascade Care, or QHP certification. WAHBE must review and approve the use of the logos on an issuer's marketing materials. Only plans offered on the Exchange and meeting the requirements to be classified as Cascade Care may use any logos or verbiage that indicates the plan meets such requirements, and issuers that use the Cascade Care logos must do so consistently across

their line of Cascade Care products consistent with WAHBE Communications guidance. Plans not meeting this requirement may not use "Cascade," "Cascade Select," or "Cascade Care" or any logos for **such brand in marketing materials, marketing name, or network.**

Issuers must use a standard naming convention for Cascade Care standard plans and public option plans in their plan filings and when marketing the plans.

For standard plans that are not public option plans, issuers are required to use the following convention:

> **[IssuerName] + Cascade + [Metal Level]**
>
> *Example:* **IssuerXYZ Cascade Silver**

For public option plans, issuers are required to use the following naming convention:

> **[IssuerName] + Cascade Select + [Metal Level]**
>
> *Example:* **IssuerXYZ Cascade Select Silver**

The above naming conventions should be used for cost sharing reduction versions of the standard plans, including cost sharing reduction silver plan variants for consumers up to 250% of the federal poverty level and zero cost share and limited cost share plan variants for AI/AN consumers.

Issuers generally may not add additional elements to the name of a Cascade Care plan. When following the above naming convention for Cascade Care plans results in the same plan name being applied to multiple plan offerings, an issuer must contact the Exchange to discuss this and receive approval from the Exchange for the addition of any additional identifying element in the name of a Cascade Care plan.

If an issuer uses a plan marketing name instead of an issuer name for its Exchange products generally, it may request to use the same plan marketing name for its Cascade Care products in place of the "Issuer Name" in the **naming convention above. Issuers that wish to use a plan marketing name that is different than their issuer name for this purpose must contact the Exchange to receive approval.**

Issuers should provide WAHBE with a marketing brochure for each QHP in English and in Spanish for display on *Washington Healthplanfinder*. Issuers are encouraged to have unique marketing materials for each product offered. The Exchange intends to display the marketing brochure through a direct link to a PDF hosted on the issuer's website. **The Exchange will obtain these links from the Exchange's URL Template, and issuers will be expected to update content to reflect accurate information for open enrollment. If an issuer cannot provide an updated marketing brochure via direct link, it may submit the marketing brochure to the Exchange via email. The due date for providing marketing materials is specified in the plan certification timeline.**

The QHP issuer cannot inform consumers that certification of a QHP implies any form of further endorsement or support of the QHP. The QHP issuer and its officials, employees, agents and representatives must not employ marketing practices or benefit designs that discourage the enrollment of individuals with preexisting conditions or significant health needs in QHPs (45 CFR §156.225(b)).

Issuers will be expected to confirm the accuracy of the display of marketing and enrollment materials during issuer ratification (the validation of plan data in *Washington Healthplanfinder*).

Marketing materials will not be displayed on *Washington Healthplanfinder* if they do not conform to the standards set through this criterion.

2.2.8 Network Access

An issuer must ensure that a QHP's network satisfies at least the following standards:

- Is sufficient in number and type of providers, including providers that specialize in mental health and substance use disorder services, to assure that all services will be accessible without unreasonable delay;
- Includes essential community providers in accordance with 45 CFR §156.235 or meets the alternate standard; and
- Is consistent with the network access provisions of section 2702(c) of the PHS Act (45 CFR §156.230(a)) and WAC 284-170-200, et. seq., and any subsequent federal or state rules.

OIC will enforce network access requirements and monitor for noncompliance. If OIC determines that a QHP issuer is not complying with the network access requirements, and OIC determines that the QHP issuer will not resume compliance with the network access requirements, WAHBE will decertify all the issuer's QHPs affected by that noncompliance. Please refer to OIC for additional regulatory guidance on network access.

An issuer shall notify the Exchange in writing, in addition to OIC, when notification of network changes is required under WAC 284-170-230. Issuers should notify WAHBE of network changes described in WAC 284-170-230 that will be occurring from one plan year to the next by September 15 (or, if later, as soon as possible after the issuer becomes aware of the anticipated change).

2.2.9 Provider Directory

Issuers must provide data on the health care providers that participate in networks associated with their QHPs sold on the Exchange. Issuers are required to update their provider directory data with the Exchange, and any vendor utilized by the Exchange to support the provider directory, on or by the 15th of each month, unless otherwise instructed. If the 15th falls on a weekend or holiday, provider directory data is due by midnight the business day prior.

For the provider directory data to be used for the start of open enrollment, issuers must include providers for the current and upcoming plan years. Provider rosters for the 2022 plan year should be submitted to WAHBE for the first time in a stand-alone submission due by September 15, 2021. For the duration of the 2021 plan year, provider rosters for both the 2021 and 2022 plan years should be included in the issuer data submissions due the 15th of each month. Issuers should identify the appropriate plan year associated with each provider roster file. If there is no network variance across plan years, issuers may submit a single roster file. At the conclusion of the 2021 plan year, the 2021 roster submission is no longer necessary and should be discontinued.

On-time submissions are processed and published to *Washington Healthplanfinder* the following month. Issuers may submit more than one submission in a month if their provider contracts change after their regular submission, and WAHBE will work with the provider directory vendor to publish the updated provider information the following month, or as soon as operationally possible. A QHP issuer must ensure that the network name for each provider exactly matches the network name as approved by OIC.

Issuers are responsible for conducting quality assurance of provider directory data prior to submission and are required to participate in ongoing provider directory testing activities.

Quest Analytics, WAHBE's provider directory vendor, conducts ongoing provider outreach to validate provider data with the goal of improving provider directory data for the Exchange. Weekly error reports are generated by Quest Analytics based on provider attestation. In addition, WAHBE identifies potential provider errors during testing, from OIC, from consumers, and through the Provider Directory Comment Form, available on the WAHBE website. Issuers shall review weekly error reports provided by Quest Analytics and errors escalated by WAHBE and correct erroneous data in their systems in a timely manner. Issuers shall submit a corrected provider roster the following month to resolve discrepancies.

If a discrepancy is not pertinent to the issuer, or the issuer does not agree with the findings, the issuer should address the discrepancy with Quest Analytics or WAHBE, depending on who identifies the discrepancy, and discrepancies should be resolved between the parties. If Quest Analytics and the issuer cannot come to a resolution, the discrepancy shall be elevated to WAHBE. During 2021, the Exchange will continue efforts to improve provider directory data. Issuers will be invited to establish next steps regarding reducing data discrepancies.

In addition to requirements outlined in this Guidance related to provider directory, issuers are required to adhere to requirements provided in the Exchange's Provider Directory Guide.

2.2.10 Quality Improvement Strategy

Participation Criteria

Any eligible QHP issuer participating in the Exchange must implement and report on a quality improvement strategy (QIS) in accordance with ACA § 1311(g) and Exchange guidance. Issuers applying for QHP certification on the Exchange for the 2022 Plan Year are expected to submit a QIS form in calendar year 2021 to either implement a new QIS beginning no later than January 2022 or provide a progress update on an existing QIS. This state requirement differs from the federal participation criterion that issuers offer coverage for two or more consecutive years prior to participating in a quality improvement strategy (QIS), 45 CFR 156.1130.

An eligible issuer for the 2022 plan year is any QHP issuer that provides medical coverage and intends to offer coverage on Exchange for plan year 2022. There will be no minimum enrollment threshold for participation in the QIS program. The QIS requirements apply to all eligible issuers offering QHPs, including QHPs compatible with health savings accounts (HSAs). For plan year 2022, QIS requirements will not apply to child only plans or stand-alone dental plans.

QIS Requirements

General QIS Requirements

A QIS is required to incentivize quality by tying payments to performance measures when providers meet specific quality indicators or enrollees make choices or exhibit behaviors associated with improved health.

All eligible issuers must comply with the following QIS requirements for the 2022 plan year:

- Implement a QIS, which is a payment structure that provides increased reimbursement or other market-based incentives for improving health outcomes of plan enrollees.
- Implement a QIS that has a topic area of at least one of the following:
  - Activities for improving health outcomes;
  - Activities to prevent hospital readmissions;
  - Activities to improve patient safety and reduce medical errors;
  - Activities for wellness and health promotion; and/or
  - Activities to reduce health and health care disparities;
- Implement a QIS that monitors QIS progress by using the following National Quality Forum (NQF)-endorsed clinical measures:
  - Cervical Cancer Screening (NQF ID: 0032);
  - Plan All-Cause Readmissions (NQF ID: 1768).
- Address health and health disparities by choosing "activities to reduce health and health care disparities" as a topic area or addressing the reduction of health and health care disparities as part of the activities implemented within any other chosen topic area(s).
- Adhere to federal QIS requirements.
- Adhere to Exchange guidelines, including the QIS User Guide for 2021.
- Report on progress implementing the QIS to the Exchange in accordance with guidelines established by the Exchange.

Issuers may implement one QIS that applies to all eligible QHPs in the Exchange, or may implement more than one QIS, tailored to the needs of different QHPs. A QIS does not have to address the needs of all enrollees in a given QHP but may address needs of specified sub-populations. All QIS are required to monitor the two NQF-endorsed measures that are outlined above: Cervical Cancer Screening and Plan All-Cause Readmissions. Issuers are encouraged to adopt Breast Cancer Screening (NQF ID: 2372) into their QIS but this measure will not be required for the 2022 plan year. Issuers may monitor and track progress on additional quantitative measures to analyze progress towards the goals of the QIS.

Issuers must use the WAHBE Quality Improvement Strategy form, unique to Washington, to report QIS to the Exchange.

Eligible issuers for the 2022 plan year must submit the following documents and receive confirmation of completion from WAHBE in order to meet this certification criterion:

- A 2022 WAHBE Quality Improvement Strategy form for each QIS applicable to any QHP to be offered in the Exchange.

Issuers that operated a QIS during the 2021 plan year are required to complete the progress portion of the 2022 WAHBE Quality Improvement Strategy form as part of their 2022 QIS submission. This progress portion of the form should include a description of activities conducted to implement the QIS and results of the QIS.

Issuers should refer to the WAHBE Quality Improvement Strategy User Guide for additional guidance on howto complete the Quality Improvement Strategy (QIS) form.

Addressing Health and Health Care Disparities

The Exchange seeks to reduce health and health care disparities that exist in the QHP population. Race and ethnicity enrollee data is essential to assess health equity and disparities. Because efforts by issuers and the Exchange to identify health disparities and effectively monitor activities to reduce disparities in the Exchange population have been limited by a lack of consistent and comprehensive population data, the Exchange intends to set a benchmark for demographic data collection.

For 2022, issuers must achieve sixty percent (60%) identification of race and ethnicity data for *Washington Healthplanfinder* (HPF) enrollees. WAHBE will support this reporting by passing race and ethnicity information collected in HPF to issuers through enrollment files (834). Issuers will report race and ethnicity data to WAHBE through the Quality Improvement Strategy form. Issuers are encouraged to support collection of race and ethnicity data by collecting enrollee data after enrollment.

Incentivizing Primary Care

The Exchange believes that investing in primary care and care coordination is an important component of improving health care delivery and providing high value care to Exchange enrollees. QHP issuers should promote and encourage use of primary care in their Exchange line of business. Exchange issuers will be required to participate in one of the following primary care strategies identified by the Collaborative Primary Care workgroup:

1. Enrollees should receive information about the value of primary care, how to access primary care within the available plan options, and are asked or otherwise encouraged to select a primary care provider/team at enrollment.

2. Members select or are paneled to a primary care provider/team through a claims-based attribution process or other assignment mechanism.

3. A payment mechanism supports primary care features that are not reimbursed through traditional fee-for-service payments. These mechanisms include value-based reimbursement such as fee-for-service enhancements or prospective payments made in the form of per member per month (PMPM) payments that could include incentives for transformation, performance-based incentives, or more expansive forms of capitation.

Issuers will select a strategy and identify this strategy through the Quality Improvement Strategy form. WAHBE encourages issuers to work on a new strategy for their QHP line of business. If an issuer selects a strategy that they are already implementing, they will work with the Exchange to identify an appropriate improvement benchmark. Issuers agree to work with the Exchange on these focus areas and report their progress to the Exchange. The Exchange and issuers will agree on timelines for accomplishing the strategy based on the strategy selected. The Exchange may set targets for the issuers in future requirements.

2.2.11 Standard Format for Presenting Health Benefit Plan Options

Summary of Benefits and Coverage

Issuers are required to provide WAHBE with a Summary of Benefits and Coverage (SBC) for each plan variant of a QHP, in English and Spanish, for display on *Washington Healthplanfinder*. **Issuers should use the standard SBC form developed by the Department of Health and Human Services (HHS). The Exchange intends to display the SBC through a direct link to a PDF hosted on** the issuer's website. **The Exchange will obtain SBCs from the** Exchange's URL Template, **and issuers will be expected to update content to reflect accurate information for open enrollment. If an issuer cannot provide an updated SBC via a direct link, it may submit the SBC to the Exchange via email. The due date for providing SBCs is specified in the plan certification timeline.**

The Exchange will review submitted SBCs for completeness and provide feedback to issuers. Issuers should respond to feedback by incorporating feedback or providing a response as to why feedback cannot be incorporated. Issuers may choose to wait for feedback prior to submitting Spanish language SBCs.

HHS resources on SBCs, including the standard SBC form, may be found here:

https://www.cms.gov/cciio/Resources/Forms-Reports-and-Other-Resources/index.html;

https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/SBC Template-Accessible-Format-01-2020.pdf
A QHP must provide notice of covered abortion services in the SBC in the "other covered services" **section (45 CFR 156.280(f)).**

If an issuer does not include one or more state required benefits as a covered service, this must be clearly indicated in the "Excluded Services" section of the SBC, in addition to any other state or federal **requirements.**

Issuers will include direct links to a plan's drug formulary in each SBC that must be accessible to consumers. This link must take a client directly to a webpage that displays the formulary for the benefit package reflected on the SBC. A direct link is a link that does not require logging on to a website, entering a policy number, clicking through web pages, or creating user accounts, memberships, or registrations. A direct link is not a link to a search tool or webpage that requires additional navigation by the client to get to the formulary.

All SBCs are required to include underlined terms that are included in CMS's Uniform Glossary. The **Exchange encourages issuers to hyperlink all underlined terms in the Uniform Glossary so that** consumers are directed to the term's definition when **they click on the term.**

Formulary

WAHBE will upload an issuer's formulary filings to display prescription drug coverage information to consumers through Smart Planfinder, WAHBE's consumer decision support tool. WAHBE will receive an issuer's first quarter formulary information from the **CMS QHP Prescription Drug Template in the binder after OIC completes its review. Subsequent quarterly formulary filings (second, third and fourth quarters) will be transmitted to WAHBE from OIC after they complete their review. WAHBE cannot guarantee issuers who submit their quarterly updates after the deadlines set by OIC will have their**

information uploaded into Smart Planfinder. WAHBE reserves the right to charge issuers costs for late submissions to be reflected in the Exchange. Before changing for incurred costs, the Exchange will take into consideration the circumstances of the late filing.

2.2.12 Quality Measures

CMS Participation Criteria

Qualifying issuers are required to participate in the federal Quality Rating System (QRS) as provided ACA Section 1311(c)(3), including the disclosure and reporting of information on health care quality and outcomes described in ACA Sections 1311(c)(1)(H) and 1311(c)(1)(I), and the implementation of appropriate enrollee satisfaction surveys consistent with ACA Section 1311(c)(4) (and 45 CFR §156.200(b)(5)). Issuers must also comply with additional federal guidance regarding the QRS and enrollee satisfaction surveys, including requirements described in the Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2020 and the 2020 Quality Rating System Measure Technical Specification, published by CMS, and any subsequent updates to that guidance.

All qualifying issuers offering a QHP of any metal level through the Exchange must comply with QRS requirements and report on all quality measures defined by CMS. For data reporting to CMS during 2021 (to be displayed during the open enrollment period for the 2022 plan year), a qualifying issuer is an issuer that offered through the Exchange in the prior year (2020 calendar year) and offered through an Exchange in the ratings year (2021 calendar year) at least one product type in the Exchange that meets the minimum enrollment threshold (more than 500 enrollees in that type as of both July 1, 2020 and January 1, 2021).

Washington Participation Criteria

QHP issuers are required to collect and submit validated QRS clinical measure data directly to the Exchange at the time of submission to CMS via NCQA's Interactive Data Submission System (IDSS). Issuers should export this data from IDSS and transmit via email to WAHBE QHP inbox at QHP@wahbexchange.org. This submission is due on June 15, 2021 for the 2021 QRS. The Exchange will not require submission of QHP Enrollee Survey response data to the Exchange.

If an issuer does not meet the federal requirements for participation due to a lower enrollment count than the federal threshold, the Exchange will still require issuers to report their data to the Exchange. Issuers should forgo submitting to CMS but should use the same IDSS format for reporting to the Exchange via the QHP inbox. The Exchange will utilize its flexibility as a state exchange to explore display options for star ratings when issuers are not required to report to CMS. This is an effort to increase the availability of quality information for consumers shopping on the Exchange.

An issuer that meets the minimum enrollment threshold but is offering a different product type for 2022 coverage will have their QRS rating displayed in *Washington Healthplanfinder* for plans of the different product type if one is available from CMS

Issuers must administer the QHP Enrollee Survey to eligible enrollees if they meet the requirements of participation outlined above. Issuers eligible to field the QHP Enrollee Survey should use the maximum oversampling of 1,690 surveys for the QRS member survey to increase response rates. If a QHP issuer has a sample of eligible enrollees that is less than 1,690, they should use all eligible enrollees. CMS will work with issuers to collect data and calculate the quality performance ratings for QHPs offered through the Exchange. During 2021, qualifying issuers will report data from the 2020 plan year to CMS, and that data will be analyzed by CMS and be the basis for the quality performance ratings that will be displayed in the Exchange during open enrollment for 2022 coverage. The Exchange will not require submission of QHP Enrollee Survey data to the Exchange directly. All submissions should be directed to CMS.

For the 2022 plan year, the Exchange expects to display the overall plan rating and three summary indicator ratings for each eligible QHP. In future years, additional quality ratings may be displayed.

In addition to the requirements described above, a QHP issuer will also be required to participate in any other quality reporting requirements that may be authorized by federal regulation or specified by WAHBE. WAHBE intends to investigate additional quality and value standards, beginning with alignment to HCA quality and value reporting. Issuers reporting to HCA either authorize HCA to share their report with WAHBE or shall share their HCA report with WAHBE. Additional standards to be discussed for future years will be discussed with issuer's quality teams, and could include:

1. Value-based purchasing
2. High value networks
3. Primary care
4. Health disparities
5. Population health

2.2.13 Exchange Enrollment Application

The electronic enrollment application process within *Washington Healthplanfinder* is the single streamlined application for determination of eligibility and enrollment in Washington State as required under 45 CFR §155.405 and satisfies this criterion for issuers.

2.2.14 Hospital Patient Safety Contracts

A QHP issuer may only contract with a hospital with more than 50 beds if the hospital meets certain patient safety standards, including use of a patient safety evaluation system and a comprehensive hospital discharge program. These contractual requirements are monitored by OIC. In addition, a QHP issuer must provide the CMS Certification Number (CCN) to the Exchange upon request for each hospital subject to these requirements with which it is contracted.

2.2.15 Direct Primary Care Medical Homes

The ACA directs that a QHP may provide coverage through a qualified direct primary care medical home plan so long as the services covered by the medical home plan are coordinated with the QHP issuer. State law, Chapter 48.150 RCW, specifies that a direct primary care medical home must be integrated with an issuer's QHP. If a QHP filing contains a direct primary care medical home, WAHBE will recognize OIC's approval of the plan to confirm that the medical home is integrated with the QHP.

2.2.16 Benefit Design Standards

A QHP issuer must ensure that each QHP complies with the benefit design standards specified in the ACA, including the cost-sharing limits, actuarial value requirements for metal levels, and the essential health benefits (45 CFR §156.200(3)).

The ACA, §1302(d), requires non-grandfathered individual health insurance plans, except for catastrophic plans, to be offered through one of four metal level categories (platinum, gold, silver, or bronze) in an Exchange. The actuarial value calculator, provided by HHS, can be used to produce computations of a QHP's metal level based upon benefit design features.

Please refer to OIC for further regulatory guidance on benefit design standards.

Standard Plan Designs

Washington State law RCW.43.71.095 requires issuers participating in the Exchange to offer standardized health plans designed by the Health Benefit Exchange in consultation with the Office of the Insurance Commissioner and the Health Care Authority and approved by the Exchange Board. Issuers must offer, at minimum, the following in each county in which it offers coverage:

- 1 standard gold plan;
- 1 standard silver plan;
- 3 standard cost-sharing reduction (CSR) variants for the standard silver plan to be made available to households with attested income up to 250% of the Federal Poverty Level; and
- 2 cost-sharing alternatives for each standard plan that conform to requirements as defined in 45 CFR § 156.420 and 45 CFR § 155.350 to be made available to members of federally recognized American Indian tribes or Alaskan Natives.

If an issuer offers a bronze plan in a county, it must at minimum offer the bronze standard plan in that county.

Nothing shall prohibit an issuer from offering only a standard plan at any metal level and discontinuing its non-standard plans, as long as it complies with applicable state and federal renewability requirements.

The Exchange is authorized to make necessary changes to the approved plans to remain in compliance with federal and state regulation. The Exchange will notify issuers if changes are made to the plans after approval by the Exchange Board.

The 2022 standard plans can be found at: https://www.wahbexchange.org/wp-content/uploads/2020/11/Wakely-DRAFT-WAHBE-2022-Standard-Plan-Desgin-Chart-Appendix.pdf

Non-standard Plan Designs

In addition to the required standard plans, participating Exchange issuers may continue to offer plans that do not use the standard benefit design. There is no limit on the number of non-standard plans an issuer may offer. In accordance with RCW 43.171.095, a non-standard silver plan may not have an actuarial value less than that of the standard silver plan finalized by the Exchange for 2021. An issuer that offers a non-standard bronze plan in a county must also offer a standard bronze plan in that county.

2.2.17 Services Areas and Rating Requirements

The QHP service area must be established without regard to racial, ethnic, language, or health status related factors specified under section 2705(a) of the Public Health Service Act, or other factors that exclude specific high utilization, high cost, or medically-underserved populations (45 CFR §155.1055(b)). A QHP service area will be generally defined by county or counties; however, an issuer demonstrating good cause, as specified in WAC 284-43-0160(29), may request that OIC approve a QHP service area defined by zip codes. Good cause includes geographic barriers within a service area, or other conditions that make offering coverage throughout an entire county unreasonable. Consumers will be able to identify a service area by providing a zip code and county in *Washington Healthplanfinder*.

Please refer to OIC for further regulatory guidance on service area requirements.

WAHBE will display plan rates on the *Washington Healthplanfinder* web pages. A QHP issuer's health plan rates are for an entire plan year. Approval of a plan by OIC will confirm that a QHP has met the service area and rating requirements.

Tobacco surcharges, if utilized by an issuer, will apply only when the definition of tobacco use is met. Section 2701(a)(4) of the ACA defines tobacco use as:

- Using any tobacco product other than for religious or ceremonial use on average four or more times per week within the last six months.

Tobacco use does not include the use of e-cigarettes or other vaping products and therefore the tobacco surcharge will not apply in those instances.

2.2.18 Posting Justifications for Premium Increases

Issuers must provide premium increase justifications as part of the regulatory rate filing procedure. OIC posts this justification, along with its own summary of the premium increase justification, for the public. The submission of the justification to OIC will satisfy this criterion for an issuer submitting a plan to become a certified QHP.

2.2.19 Reporting Data

As part of the OIC regulatory filing process, a QHP issuer must use the federally supplied data templates during the SERFF filing process. OIC will forward the data for approved plans to WAHBE after plan regulatory approval has been completed.

WAHBE will use these templates to populate *Washington Healthplanfinder* with rates, benefits, service area, and provider network names. WAHBE will not alter the data within these templates without written direction from OIC. Issuers are required to review this data during the annual ratification process (the validation of plan data in *Washington Healthplanfinder*) to ensure the accuracy of the information. The Exchange reserves the right to charge an issuer for incurred costs if the issuer requests changes to plan data after the issuer has reviewed and ratified that plan data. Before charging for incurred costs, the Exchange will take into consideration the circumstances of the request to make changes to plan data.

Issuers offering QHPs through the Exchange must provide enrollment, payment, and disenrollment data in a manner and frequency specified by the Exchange as necessary to support Exchange operations, including but not limited to:

- Eligibility, enrollment, or disenrollment processes.
- Reports or provision of information required by the U.S. Department of Health and Human Services, Internal Revenue Service, or the Washington State Legislature.
- Estimation or collection of assessments or fees specified in RCW 43.71.080.

WAHBE will make enrollment data available to issuers to support issuers in complying with this certification criterion.

2.3 Pediatric Dental Essential Health Benefit

RCW 43.71.065 specifies that *Washington Healthplanfinder* will offer stand-alone dental plans, required under Section 1311(d)(2) of the ACA to include the pediatric dental essential health benefit (described in ACA Section 1302). Washington law further specifies that dental benefits must be offered and priced separately to assure transparency for consumers through *Washington Healthplanfinder*. Please refer to OIC for further guidance on setting the rate for stand-alone dental plans.

A separate Guidance for Participation for Qualified Dental Plans offered through *Washington Healthplanfinder* can be found on the WAHBE website.

Stand-alone dental plans in the individual market that offer the pediatric dental essential health benefit must be Qualified Dental Plans and must be certified by the Exchange Board, and are offered only outside the Exchange. Any issuer filing a plan for OIC review that is seeking the designation of Qualified Dental Plan in 2020 outside the Exchange must notify WAHBE of the plan filing when it is submitted to OIC, so that the Exchange Board may prepare to consider the plan for certification.

2.4 Monitoring and Compliance of Qualified Health Plans

2.4.1 Summary Table 2: Monitoring and Compliance of Qualified Health Plans

The following chart summarizes the monitoring and compliance activities associated with the 19 certification criteria. Monitoring activities are conducted by OIC, WAHBE, or both. Any penalties associated with criteria #2-7 were described in section 2.2. See sections 2.1 and 2.2 for further detail on the certification criteria.

NUMBER	CRITERIA LEVEL	CRITERIA	MONITORING ENTITY	WAHBE PENALTY	DECERTIFICATION CRITERIA
1	Issuer	Issuer must be in good standing	OIC	N/A	Yes
2	Issuer	Issuer must pay user fee if QHPs assessed	WAHBE	Yes (see Section 2.2)	Yes
3	Issuer	Issuer must comply with the risk adjustment program	OIC	N/A	Yes
4	Issuer	Issuer must comply with market rules on offering plans	OIC	N/A	Yes
5	Issuer	Issuer must comply with non-discrimination rules	OIC	N/A	Yes
6	Issuer	Issuer must be accredited by an entity that HHS recognizes for accreditation of health plans within specified timeframe	WAHBE	No	Yes
7	Product	QHP must meet marketi requirements	WAHBE	Yes (see Section 2.2.7	No
8	Product	QHP must meet network access requirements, including ECPs	OIC	N/A	Yes
9	Product	Issuer must submit provider directory data	WAHBE	No	No
10	Product	Issuer must implement a quality improvement strategy	WAHBE	No	No
11	Product	Issuer must submit heal plan data to be used in standard format for presenting health benefi plan options	WAHBE	No	No

12	Product	Issuer must report quali and health performance measures	WAHBE	No	No
13	Product	Issuer must use the Exchange enrollment application	WAHBE	No	No
14	Product	Issuer may only contract with a hospital with mor than 50 beds if the hospital utilizes a patien safety evaluation systen	OIC	N/A	Yes
15	Product	Services provided under QHP through a direct primary care medical home must be integrate with the QHP issuer	OIC	N/A	Yes
16	Plan	A QHP must comply with benefit design standards (e.g. cost sharing limits, "metal level," EHB, standard plan design)	OIC/WAHBE	No WAHBE penalty	Yes
17	Plan	Issuer must submit a QHP's service area and rates for a plan year	OIC	N/A	No
18	Plan	Issuer must post justifications for QHP premium increases	OIC	N/A	No
19	Plan	Issuer must submit QHP benefit and rate data for public disclosure	WAHBE/OIC	No	No

2.5 QHP Status Changes

2.5.1 Changes to Plans as Part of the Annual Certification Process

WAHBE certification of a QHP lasts for one plan year and must be renewed for each future plan year in which the issuer seeks to offer the QHP in the Exchange, as set forth in 45 CFR §156.290 and 45 CFR §155.1080. During the annual plan filing and certification process, a QHP issuer may elect not to seek Exchange recertification of a QHP and may discontinue the plan at the end of the year. A QHP issuer must notify WAHBE of any QHPs for which it intends to seek certification upon filing the plan with OIC. An issuer must fulfill the obligations set forth in 45 CFR §156.290 with respect to any QHP that will be discontinued at the end of a plan year, including providing coverage until the end of the plan year and providing the required 90-day discontinuation notice to enrollees. During the Exchange's automated renewal process in open enrollment, the Exchange will map enrollees in discontinued plans to another plan of the same issuer, if available, in accordance with 45 CFR §155.335 and other applicable regulations. If an enrollee's plan is discontinued and no other plan of the same issuer is available, the Exchange may enroll the enrollee in an available plan of a different issuer in accordance with 45 CFR 155.335 and other applicable regulation.

If a QHP issuer exits the individual market entirely, it must provide written notice to WAHBE that all of the issuer's QHPs in the individual market will be discontinued at least 180 days before the date the coverage will expire. The QHP issuer must also provide formal 180-day notice to enrollees as required in RCW 48.43.038 for individual market QHPs. The QHP issuer must terminate coverage for the enrollees, as set forth in 45 CFR §156.270, only after the enrollees have had an opportunity to participate in open enrollment as set forth in 45 CFR §156.290.

2.5.2 Denial of Recertification

A renewed plan that is approved by OIC may be denied certification as a QHP by WAHBE if the plan does not meet the certification criteria described in this Guidance for QHPs. If a QHP is denied recertification by WAHBE, the QHP will not be offered through the Exchange for the next plan year and the issuer must fulfill the obligations set forth in 45 CFR §156.290, which include providing coverage until the end of the plan year.

2.5.3 Changes to Plans After Certification

WAHBE reserves the right to recoup from an issuer costs incurred by the Exchange from the withdrawal of a plan from being offered in the Exchange after the QHP certification process is completed and plan data has been loaded into Exchange systems and ratified by issuers.

This section shall not apply to a plan approved by the OIC and intended to be offered through the procurement process by the Health Care Authority as described in 1.05 RCW which is later determined not to be offered as a public option plan for the plan year.

2.5.4 Changes to Plans During a Plan Year

Decertification of a QHP could occur in the middle of a plan year if OIC withdraws regulatory approval or if WAHBE determines that a QHP no longer satisfies certification criteria. WAHBE will decertify QHPs as set forth in 45 CFR §156.290 and 45 CFR §155.1. Issuers must terminate coverage for the enrollees as set forth in 45 CFR §155.430. Termination of coverage may only occur after the Exchange has notified enrollees and the enrollees have had an opportunity to participate in special or open enrollment.

outlined in 45 CFR §155.1080. If the plan is decertified by WAHBE but maintains OIC regulatory approva
the plan shall be made available outside of *Washington Healthplanfinder* for any current enrollees.

If a QHP issuer petitions OIC to suspend new sales for the individual market, the QHP issuer must notify WAHBE of the petition and subsequent action on the petition for suspension within two business days of OIC's decision. The QHP issuer must enroll any new enrollees who have selected a plan up through the date of suspension, including those with effective dates after the date of suspension WAHBE will not offer a suspended QHP for new enrollees for the following year's coverage during open enrollment. A suspended QHP must continue to provide special enrollment to its current enrollees with qualifying events but will not participate in special enrollment when enrollees of other QHPs or new enrollees experience qualifying events to be offered through *Washington Healthplanfinder*, a suspended QHP must continue to achieve annual recertification.

Section 3: Enrollment in a QHP

3.1 Individual Enrollment Processes and Timelines

Issuers will be expected to comply with the enrollment and payment processes outlined in the WAHBE Enrollment and Payment Process Guide and EDI standards contained in the 834 Companion Guide. The Enrollment and Payment Process Guide and 834 Companion Guide can be obtained on the WAHBE website.

A QHP issuer must agree to comply with WAHBE standards and processes established for the individual market for transfer of EDI transactions, enrollment, reconciliation, and reporting. This includes accepting all required forms of payment, managing grace periods, participating in process improvement initiatives with WAHBE (e.g., the implementation and enhancements to the monthly reconciliation process), and adhering to sponsorship program requirements established in RCW 43.71.030 and the WAHBE Sponsorship Policy available on the WAHBE website (e.g., accepting payments on behalf of individuals from Exchange-registered sponsors; issuing refunds (including medical loss ratio rebates) to Exchange-registered sponsors; providing a sponsor with an accounting of the total amount owed to the issuer).

As required by 45 CFR 147.120, issuers making dependent coverage of children available, must make coverage available up to age 26. Issuers offering coverage through the Exchange shall not disenroll such individuals from a parent's plan due to attaining age 26 until the end of the plan year in which the individual attains the age of 26. These individuals will not be eligible for renewal into their parent's QHP and the Exchange will not auto-renew them into the parent's QHP for the plan year following the year they turn 26.

3.1.1 Plan Mapping

WAHBE utilizes plan mapping to facilitate renewals during the annual open enrollment period and help consumers avoid breaks in coverage. Plan mapping may be applied in circumstances in which an issuer discontinues a plan or product for the following year. WAHBE may utilize plan mapping across issuers to enroll individuals who no longer have an Exchange plan available to them from the same issuer. These individuals will be cross-mapped into a similar plan from a different issuer for the following year.

All issuers that offer QHP coverage through the Exchange in 2021 and 2022 must perform mapping for plan year 2022 in accordance with applicable state law and federal requirements. Issuers must map all prior year non-renewing QHPs to another QHP available in the same county for the subsequent year. WAHBE will review each issuer's mapping assignments for compliance with applicable law, including federal requirements set forth in 45 CFR 155.335, state law, and WAHBE guidance. WAHBE may cross-map enrollees from one issuer to another, as permitted by applicable law and in accordance with OIC guidance.

Issuers must use WAHBE's Plan Mapping Submission Form to provide plan mapping information; WAHBE will not accept the CMS Plan Crosswalk Template.

3.1.2 File Transfer and Payment Due Dates

For 2022 enrollments, issuers are expected to comply with the following due dates for initial payments and effectuation, cancellation, and termination files:

Effectuation during Open Enrollment

- Binder payment due date must be no earlier than the coverage effective date, but no later than 30 calendar days from the coverage effective date.
- Payment due date must allow a minimum of 15 business days for a consumer to make a binding payment after the consumer receives an invoice.
- An effectuation or cancellation transaction is due to the Exchange within 10 business days of binder payment due date.

Effectuation during Special Enrollment

Binder payment due date:

- Payment due date must allow a minimum of 15 business days for a consumer to make a binding payment after the consumer receives an invoice.

If issuer does not verify the qualifying event:

- For coverage being effectuated under regular coverage effective dates (i.e., coverage is effective the first of the next month if a plan is selected by the 15th of a month, and effective the second following month if a plan is selected after the 15th of a month), binder payment deadlines must be no earlier than the coverage effective date, but no later than 30 calendar days from the coverage effective date.
- For coverage being effectuated under retroactive or special effective dates, binder payment deadlines must be no later than 30 calendar days from the date the issuer receives the enrollment transaction.

If issuer does verify the qualifying event:

- For coverage being effectuated under regular coverage effective dates (i.e., coverage is effective the first of the next month if a plan is selected by the 15th of a month, and effective the second following month if a plan is selected after the 15th of a month), binder payment deadlines must be no earlier than the coverage effective date, but no later than 30 calendar days from the date of verification.
- For coverage being effectuated under retroactive or special effective dates, binder payment deadlines must be no later than 30 calendar days from the date of verification.

Rescission due to failure to prove special enrollment qualifying event:

- During special enrollment, issuers may rescind an enrollee's coverage if the documentation provided to an issuer does not support the qualifying event. Cancellations of coverage due to failure to provide documentation to support the qualifying event shall be communicated to the Exchange via the manual reconciliation process (i.e., issuers will not transmit an 834 transaction).

Termination for Nonpayment

A termination for nonpayment transaction is due to the Exchange within 15 business days of expiration of the one-month (non-APTC) or three-month (APTC) grace period.

The grace period for non-payment of premiums may span two plan years if enrollees receiving APTC fail to pay premiums for November or December coverage. Consistent with guaranteed renewability of coverage, issuers must accept the renewal of the enrollee since the enrollee is still in a grace period (45 CFR §147.106). If the enrollee does not pay all outstanding premiums by the end of the three-consecutive-month grace period, the issuer should terminate the enrollment retroactively to the last day of the first month of the grace period. If the 2022 coverage resulted from renewal of the 2021 coverage, the 2022 coverage should also be cancelled as never effective. (See 45 CFR §156.270 and §155.430.)

Changing from Termination for Nonpayment to Voluntary Termination

If an issuer accepts a payment for a prior year enrollment after an enrollee is terminated for nonpayment, the issuer should change the reason for termination to voluntary termination. This change must be communicated to the Exchange via the reconciliation process within 15 days of the payment being processed. These changes impact 1095-As sent to members and IRS reporting.

Premium Payment Threshold

Issuers are required to report to the Exchange on their use of a premium payment threshold as described under 45 CFR § 155.400(g) with respect to Exchange enrollees' premium payments.

3.1.3 Cost-sharing Accumulation Policies

WAHBE intends for consumers to have access to a consistent experience as it relates to information and policies regarding their cost-sharing, regardless of their selection of issuer.

- Issuers with policies that limit the amount of cost-sharing that accumulates toward the deductible and out-of-pocket maximum, for example in the instance that a drug coupon is used, will be required to provide notice in the Summary of Benefits and Coverage by indicating which benefits are subject to such policies in the "Limitations, Exceptions, and Other Important Information" column.
- In the event that disenrollment of the primary subscriber, for any reason, and remaining members maintaining enrollment results in the issuance of a new plan, the issuer is expected to apply any amounts previously paid toward the enrollee's deductible and out-of-pocket maximum in the first plan toward the enrollee's deductible and out-of-pocket maximum in the second plan.
- As outlined in the Sponsorship Policy, payments made on behalf of consumers by a charitable organization, tribe, government entity, or other sponsor organization under the Exchange's sponsorship policy must accumulate toward the consumer's deductible if they would have accumulated toward the deductible had a consumer made the payment directly.

3.2 Producer and Navigator Specifications

3.2.1 Producer

Producers who are authorized to sell *Washington Healthplanfinder* products will be able to present QHP offerings to individuals in Washington State. To become a registered producer with WAHBE, a producer must hold a valid Washington State disability producer license, sign the WAHBE User Participation Agreement, and attend a certification or recertification class annually.

Issuers offering plans on the Exchange that are Cascade Care plans will be required to pay commission for the sale of those plans at a level at least equivalent to those of other Exchange plans offered by the Issuer. Issuers will honor enrollments completed by any WAHBE assister including producers, regardless of commission.

Proposed amendments to the Public Health Service Act (42 U.S.C. 300gg, et seq.) require a QHP issuer to disclose to enrollees direct or indirect compensation provided by the issuer to a producer or broker associated with enrolling individuals in such coverage. The QHP issuer disclosure must include the amount of direct or indirect compensation provided to a producer or broker for services provided by the producer or broker associated with plan selection and enrollment. The disclosures must be made prior to the individual finalizing plan selection and included on any documentation confirming the individual's enrollment. If these amendments are finalized, issuers will be required to inform HBE of their timeframe and approach to implement this requirement and provide WAHBE with a sample of their disclosure language when developed

If an issuer has knowledge of producer noncompliance with applicable agent and broker conduct standards of 45 CFR 155 Subpart H, the issuer shall notify the Exchange as soon as possible.

If an issuer terminates a producer from an issuer appointment agreement, the issuer shall notify the Exchange as soon as possible.

Please refer to OIC for more information on producer licensing requirements.

3.2.2 Navigator

WAHBE will award contracts to organizations to deliver in-person application and enrollment assistance that meets the standards described in 45 CFR §155.215. Certified assisters will be trained to engage in education, outreach, and enrollment related to *Washington Healthplanfinder,* including enrollment in both QHPs and Washington Apple Health (Medicaid). The navigator program primarily focuses on outreach and assistance to populations that experience barriers to enrolling in and accessing health care coverage. Navigators must meet security, confidentiality, and conflict of interest standards, and are prohibited from receiving indirect or direct compensation from a health insurance issuer based on enrollment. Health insurance issuers cannot act as Navigators.

3.3 Complaints

An issuer must notify WAHBE of any complaints received from enrollees with respect to the operation of the *Washington Healthplanfinder* marketplace within seven business days. WAHBE will work with the issuer to resolve any such grievances where the issuer is responsible for resolution.

Section 4: Special Guidance for Coverage for American Indian/Alaska Natives (AI/AN)

An issuer must comply with all federally required laws and regulations specific to AI/AN individuals in the ACA and other federal regulations, including but not limited to:

- A once-a-month enrollment period to enroll or change plans in *Washington Healthplanfinder* for any AI/AN individual enrolled in a federally recognized tribe or Canadian Indian lawfully present in the US under the Jay Treaty;
- No cost sharing for AI/AN QHP enrollees with incomes under 300% of federal poverty level who are otherwise eligible for tax credits through the Exchange;
- No cost sharing for AI/AN QHP enrollees for any item or service furnished through Indian Health Care Providers or through referral under contract health services as defined in Section 1402(d)(2) of the ACA;
- Health programs operated by Indian Health Care Providers will be the payer of last resort for services provided by such programs, notwithstanding any federal, state, or local law to the contrary; and,
- Compliance with Indian Health Care Improvement Act §206 and §408.

The Office of the Insurance Commissioner requires issuers to offer contracts to all Indian Health Care Providers in their service area. If an issuer contracts with an Indian Health Care Provider, the issuer will notify WAHBE in a timely fashion of this relationship.

Issuers are strongly recommended to use the Centers for Medicare and Medicaid Services Model QHP Addendum for Indian Health Care Providers when contracting with a specified Indian Health Care Provider.

A QHP issuer must adhere to sponsorship program requirements as referenced in Section 3.1 above, including accepting payments from and issuing refunds (including medical loss ratio rebates) to Exchange-registered tribal sponsors.

Section 5: Issuer Certification Appeal Process

A QHP issuer may appeal a Board decision to deny initial certification of a health plan or recertification of a QHP. A QHP issuer may also appeal a decision by the WAHBE Board to decertify a QHP. An issuer is required to fully cooperate with WAHBE during an appeal process to prepare the health plan to be offered during the open enrollment period.

An issuer will have up to 10 calendar days from the date of the notification of a Board decision to deny initial certification of a health plan, deny recertification of a QHP, or decertify a QHP, to submit a written appeal via electronic mail to the General Counsel of WAHBE.

An issuer's appeal must:

- Identify the specific criterion or criteria appealed;
- Provide information that clarifies the issuer's position on each unsatisfactory criterion; and
- Succinctly state the outcome sought by the issuer.

After submitting the appeal:

- WAHBE will send written notice to the issuer within seven calendar days from the date that the appeal was received.
- The issuer will have the opportunity to address the Board about the appeal prior to a Board decision regarding the appeal.
- The Board will have up to 20 calendar days from receipt of the appeal to send a final written decision that upholds or denies the issuer's appeal.

The Board's written response to such an appeal will be a final decision and all appeals with respect to that health plan will be exhausted. This appeal process represents the sole remedy for an issuer with respect to a Board decision regarding initial certification of a health plan or recertification or decertification of a QHP offered through *Washington Healthplanfinder*.

Exhibit E

washington healthbenefitexchange
powering washington healthplanfinder

Resolution of the Washington Health Benefit Exchange Board
Certifying Qualified Health Plans Offered in the Individual Market

Whereas:

1. RCW 43.71.065(1) gives the Washington Health Benefit Exchange Board (the Board) the authority to certify a health insurance plan as a qualified health plan (QHP) to be offered through the Exchange if (a) the Insurance Commissioner determines the plan meets the applicable requirements of Title 48 RCW and the rules adopted to implement it; (b) the Board determines the plan meets the requirements of the Affordable Care Act, P.L. 111-148 of 2010, for certification of QHPs; and (c) the Board determines that tribal clinics and urban Indian clinics are included in the plan's provider network as essential community providers;

2. BridgeSpan Health Company, Community Health Plan of Washington, Coordinated Care Corporation, Kaiser Foundation Health Plan of the Northwest, Kaiser Foundation Health Plan of Washington, LifeWise Health Plan of Washington, Molina Health Care of Washington, PacificSource Health Plans, Premera Blue Cross, Regence BlueCross BlueShield of Oregon, Regence BlueShield, and UnitedHealthcare of Oregon, Inc. are each requesting certification as QHPs for the health plans listed in Exhibit A to this resolution.

3. Each health plan listed in Exhibit A to this resolution has been found by the Insurance Commissioner to meet the applicable requirements of Title 48 RCW and the rules adopted to implement it, and applicable requirements of federal law; and

4. Each health plan listed in Exhibit A meets the requirements for certification as a QHP under the Affordable Care Act, and applicable federal law.

Be it Resolved that:

Having satisfied the requirements of RCW 43.71.065(1), the health plans listed in Exhibit A are CERTIFIED as qualified health plans to be offered through the Exchange beginning November 1, 2022 for plan year 2023.

Adopted in open public meeting this 15th day of September 2022:

Ron Sims, Board Chair
Washington Health Benefit Exchange

washington healthbenefitexchange
powering washington healthplanfinder

Resolution of the Washington Health Benefit Exchange Board
Certifying Qualified Health Plans
EXHIBIT A

BridgeSpan Health Company
BridgeSpan Cascade Bronze
BridgeSpan Cascade Gold
BridgeSpan Cascade Silver
Bronze Care on Demand 8500
Bronze Essential 8000

Community Health Plan of Washington
Community Health Plan of Washington Cascade Select Bronze
Community Health Plan of Washington Cascade Select Gold
Community Health Plan of Washington Cascade Select Silver

Coordinated Care Corporation
Ambetter Cascade Select Gold
Ambetter Cascade Select Silver
Ambetter Balanced Care 4
Ambetter Cascade Bronze
Ambetter Cascade Gold
Ambetter Cascade Select Bronze
Ambetter Cascade Silver
Ambetter Clear Gold
Ambetter Essential Care 1
Ambetter Essential Care: $0 Medical Deductible
Ambetter Secure Care 5

Kaiser Foundation Health Plan of the Northwest
KP Cascade Bronze
KP Cascade Gold
KP Cascade Silver
KP WA Bronze 6900/0% HSA
KP WA Bronze 8900/75
KP WA Gold 0/20
KP WA Gold 2000/20
KP WA Silver 750/30

Kaiser Foundation Health Plan of Washington
Basics Plus Catastrophic Plan
Bronze HSA
Flex Bronze
Flex Gold
Flex Silver
Kaiser Permanente Cascade Bronze
Kaiser Permanente Cascade Gold
Kaiser Permanente Cascade Silver
Virtual Plus Bronze
Virtual Plus Silver

LifeWise Health Plan of Washington
LifeWise Cascade Bronze
LifeWise Cascade Gold
LifeWise Cascade Select Bronze
LifeWise Cascade Select Gold
LifeWise Cascade Select Silver
LifeWise Cascade Silver
LifeWise Essential Bronze
LifeWise Essential Bronze HSA
LifeWise Essential Gold
LifeWise Essential Silver Low Deductible

Molina Healthcare of Washington
Constant Care Silver 1
Molina Cascade Bronze
Molina Cascade Gold
Molina Cascade Silver

PacificSource Health Plans
Navigator Bronze 7000
Navigator Bronze HSA 7050
Navigator Gold 2000
Navigator Silver 5000
PacificSource Cascade Bronze
PacificSource Cascade Gold
PacificSource Cascade Silver

Premera Blue Cross
Premera Blue Cross Cascade Bronze
Premera Blue Cross Cascade Gold
Premera Blue Cross Cascade Silver
Premera Blue Cross Preferred Bronze EPO 6350
Premera Blue Cross Preferred Bronze HSA EPO 6100
Premera Blue Cross Preferred Gold EPO 1500
Premera Blue Cross Preferred Silver EPO 4300

Regence BlueShield
Bronze Care on Demand 8500 Individual and Family Network
Bronze Essential 8000 Individual and Family Network
Gold 2000 With Vision Exam Individual and Family Network
Regence Cascade Bronze Eastside Health Network
Regence Cascade Bronze Individual and Family Network
Regence Cascade Gold Eastside Health Network
Regence Cascade Gold Individual and Family Network
Regence Cascade Silver Eastside Health Network
Regence Cascade Silver Individual and Family Network

Regence BlueCross BlueShield of Oregon
Bronze Care on Demand 8500 Legacy LHP
Bronze Essential 8000 Legacy LHP
Gold 2000 With Vision Exam Individual and

Family Network
Gold 2000 With Vision Exam Legacy LHP
Regence Cascade Bronze Individual and Family Network
Regence Cascade Bronze Legacy LHP Network
Regence Cascade Gold Individual and Family Network
Regence Cascade Gold Legacy LHP Network
Regence Cascade Silver Individual and Family Network
Regence Cascade Silver Legacy LHP Network

United Healthcare of Oregon, Inc.
UHC Bronze Value
UHC Gold Value
UHC Silver Advantage
UnitedHealthcare of Oregon, Inc. Cascade Bronze
UnitedHealthcare of Oregon, Inc. Cascade Gold
UnitedHealthcare of Oregon, Inc. Cascade Silver

Exhibit F
(Filed under seal)