PROPOSED RULE MAKING

CR-102 (June 2012)
(Implements RCW 34.05.320)
Do **NOT** use for expedited rule making

Agency: Office of the Insurance Commissioner

x **Preproposal Statement of Inquiry was filed as WSR** 12-12-064 **; or**
☐ **Expedited Rule Making--Proposed notice was filed as WSR** ___________**; or**
☐ **Proposal is exempt under RCW 34.05.310(4) or 34.05.330(1).**

☐ **Original Notice**
x **Supplemental Notice to WSR** 12-19-101
Continuance of WSR

Title of rule and other identifying information: Essential health benefits supplementation, scope and limitation requirements, and filing requirements

Insurance Commissioner Matter No. R 2012-17

Hearing location(s):
Training Room, T- 120
5000 Capitol Way S
Tumwater Washington

Date: December 14, 2012 Time: 10:00 a.m.

Submit written comments to:
Name: Meg L. Jones
Address: P.O. Box 40258
Olympia WA 98504
e-mail: rulescoordinator@oic.wa.gov
Fax: 360-586-3109

by (date) December 13, 2012

Date of intended adoption: December 19, 2012
(Note: This is **NOT** the **effective** date)

Assistance for persons with disabilities: Contact Lorie Villaflores by December 10, 2012
TTY (360) 586-0241 or (360) 725-7087

Purpose of the proposal and its anticipated effects, including any changes in existing rules: The proposed rules will establish new sections in Subchapter C of chapter 284-43 RCW (health benefits), explaining the requirements associated with carrier inclusion of the essential health benefits package in non-grandfathered individual and small group plans for plans with coverage beginning January 1, 2014.

Reasons supporting proposal: RCW 48.43.715 directs the Commissioner to designate by rule the small group plan with the largest enrollment as the benchmark plan for purposes of defining the essential health benefits package for non grandfathered individual and small group health benefit plans issued on or after January 1, 2014. The same legislation requires supplementation, and adjustment or establishment of scope and limitation requirements by the commissioner in order to ensure meaningful benefits and prevent bias based on health selection. Carriers require specific guidance in order to prepare plan filings for the Commissioner's review prior to health benefit exchange deadlines, and to ensure time to satisfy plan replacement requirements.

Statutory authority for adoption: RCW 48.02.060; 48.21.241;48.21.320;48.43.715; 48.44.460; 48.44.341; 48.46.291; 48.46.530

Statute being implemented: RCW 48.43.715

Is rule necessary because of a:

Federal Law?	x Yes	☐ No
Federal Court Decision?	☐ Yes	X No
State Court Decision?	☐ Yes	X No

If yes, CITATION: P.L. 111-148, §1302

DATE
October 24, 2012

NAME (type or print)
Mike Kreidler

SIGNATURE
Mike Kreidler

TITLE
Insurance Commissioner

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: October 24, 2012
TIME: 10:35 AM

WSR 12-21-136

(COMPLETE REVERSE SIDE)

Agency comments or recommendations, if any, as to statutory language, implementation, enforcement, and fiscal matters:
None

Name of proponent: (person or organization) Office of the Insurance Commissioner

☐ Private
☐ Public
x Governmental

Name of agency personnel responsible for:

	Name	Office Location	Phone
Drafting..............	Meg Jones	P.O. Box 40258, Olympia WA 98504	360-725-7170
Implementation....	Beth Berendt	P.O. Box 40258, Olympia WA 98504	360-725-7117
Enforcement..........	Carol Sureau	P.O. Box 40258, Olympia WA 98504	360-725-7050

Has a small business economic impact statement been prepared under chapter 19.85 RCW or has a school district fiscal impact statement been prepared under section 1, chapter 210, Laws of 2012?

☐ Yes. Attach copy of small business economic impact statement or school district fiscal impact statement.

A copy of the statement may be obtained by contacting:
Name:
Address:

phone ( ) _____________
fax ( )_____________
e-mail ______________________

x No. Explain why no statement was prepared.

The entities that must comply with the proposed rule are not small businesses, pursuant to chapter 19.85 RCW.

Is a cost-benefit analysis required under RCW 34.05.328?

xYes A preliminary cost-benefit analysis may be obtained by contacting:

Name: Meg Jones
Address: P.O. Box 40258
Olympia WA 98504
phone (360) 725-7170
fax (360)586-3109
e-mail:
rulescoordinator@oic.wa.gov

☐ No: Please explain:

NEW SECTION

WAC 284-43-849 Purpose and scope. For plan years beginning on or after January 1, 2014, each nongrandfathered health benefit plan offered, issued, amended or renewed to small employers or individuals, both inside and outside the Washington health benefit exchange, must provide coverage for a package of essential health benefits. WAC 284-43-849 through 284-43-885 implements the requirements of RCW 48.43.715, establishing a benchmark base plan and the essential health benefit package required in Washington State for nongrandfathered individual and small group health benefit plans.

(1) The commissioner will implement this subchapter to the extent that federal law or policy does not require the state to defray the costs of benefits included within the definition of essential health benefits.

(2) This subchapter does not apply to a health benefit plan that provides excepted benefits as described in Section 2722 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-21), or a health benefit plan that qualifies as a grandfathered health plan as defined in RCW 48.43.005, unless a plan is providing an essential health benefit for pediatric oral services within the exchange, or as a subcontractor to a health benefit plan.

(3) This subchapter does not require provider reimbursement at the same levels negotiated by the benchmark base plan's carrier for their plan.

(4) This subchapter does not require a plan to exclude the services or treatments from coverage that are excluded in the benchmark base plan. The benchmark base plan's exclusions are used to inform the calculation of the actuarial value of the benchmark essential health benefits package.

(5) This subchapter does not establish requirements regarding the choice of specific types of venues for delivery of outpatient treatment, services or supplies, nor the choice of specific approaches to therapy or treatment.

NEW SECTION

WAC 284-43-852 Definitions. The following definitions apply to this subchapter unless the context indicates otherwise.

"Benchmark base plan" means the small group plan with the largest enrollment, as designated in WAC 284-43-865(1).

“Health benefits” unless otherwise defined pursuant to federal rules, regulations or guidance issued pursuant to Section 1302(b) of PPACA, means health care items or services for injury, disease, or a health condition, including a behavioral health condition. Cost sharing requirements are not included in the definition of health benefits for purposes of

this subchapter.

"Individual plan" means any nongrandfathered health benefit plan offered, issued, amended or renewed by an admitted carrier in the state of Washington for the individual health benefit plan market, unless the certificate of coverage is issued to an individual pursuant to or issued through an organization meeting the definition established in 45 C.F.R. 144.103, and sections 3(5) and 3(40) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.).

"Mandated benefit" means a health plan benefit for a specific type of service, device or medical equipment, or treatment for a specified condition or conditions that is required by either state or federal law.

"Meaningful health benefit" means the range of services or benefits within each of the ten essential health benefit categories identified in Section 1302 of PPACA, that are medically necessary to ensure enrollees covered access to clinically effective services, including services critical to the needs of those with chronic disease or those with special needs based on age or gender.

"Medical necessity determination process" means the process used by a health carrier to make a coverage determination about whether a medical item or service, which is a covered benefit, is medically necessary for an individual patient's circumstances.

"PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

"Scope and limitation requirements" means a requirement applicable to a benefit that limits the duration of a benefit, the number of times coverage is available for the benefit, or imposes a legally permitted eligibility limitation on a specific benefit.

"Small group plan" means any nongrandfathered health benefit plan offered, issued, amended or renewed by an admitted carrier in the state of Washington for the small group health benefit plan market to a small group, as defined in RCW 48.43.005, unless the certificate of coverage is issued to a small group pursuant to a master contract held by or issued through an organization meeting the definition established in 45 C.F.R. 144.103, and sections 3(5) and 3(40) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.).

"Stand-alone dental plan" means a contract or agreement covering a set of benefits limited to oral care including, but not necessarily limited to, pediatric oral care.

NEW SECTION

WAC 284-43-860 Medical Necessity Determination

(1) A carrier may not apply its medical necessity determination process in a manner that results in a uniformly applied limitation on the scope, visit number or duration of a benefit that applies regardless of the specific treatment requirements of the patient, unless that uniform limitation is specifically explained in the certificate of coverage and the Summary of Coverage and Explanation of Benefits for the health plan.

(2) A carrier's medical necessity determination process must:

(a) Be clearly explained in the certificate of coverage, plan document, or contract for health benefit coverage;

(b) Conducted fairly, and with transparency, at a minimum when an enrollee or their representative appeals or seeks review of an adverse benefit determination;

(c) Include consideration of services that are a logical next step in reasonable care if they are appropriate for the patient, even if the service has not been the subject of clinical studies;

(d) Ensure that its process for interpretation of the medical purpose of interventions is broad enough to address any of the services encompassed in the ten essential health benefits categories of care;

(e) Comply with inclusion of the ten essential health benefits categories, and prohibitions against discrimination based on age, disability, and expected length of life; and

(f) Consider the 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.

(4) A carrier's 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 criteria for determining medical necessity if it is not limited to lowest price.

(5) Medical necessity criteria for medical/surgical benefits and mental health/substance use disorder benefits or for other essential health benefit categories must be furnished to an enrollee or provider within thirty days of a request to do so.

NEW SECTION

WAC 284-43-875 Application of the definition and scope requirements for essential health benefit categories. (1) When calculating the actuarial value of a plan's essential health benefit package, each health benefit carrier must appropriately classify services covered by the plan consistent with WAC 284-43-877.

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

NEW SECTION

WAC 284-43-877 Essential Health Benefits Package Benchmark Parameters A carrier must classify its services to an essential health benefits category consistent with this section for purposes of determining actuarial value and the scope of coverage.

(1) When the commissioner determines that a health benefit plan's "ambulatory patient services" category covers 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, and which are not included in a more specifically defined essential health benefits category, in a substantially equivalent manner to the benchmark base plan, it provides a meaningful benefit in this category.

(a) The benchmark base plan specifically excludes the following services that would otherwise be included in this category:

(i) Infertility treatment and reversal of voluntary sterilization;

(ii) Routine foot care;

(iii) Dental services provided to prevent, diagnose or treat diseases or conditions of the teeth and adjacent supporting soft tissues, including treatment that restores the function of teeth are excluded;

(iv) Private duty nursing;

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

(vi) Hearing care, routine hearing examinations, programs or treatment for hearing loss including, but not limited to, externally worn or surgically implanted hearing aids, and the surgery and services necessary to implant them, other than for cochlear implants, which are covered, and for hearing screening tests required under the preventive services category;

(vii) Obesity or weight reduction or control other than covered nutritional counseling.

(b) The benchmark base plan's limitation on nutritional counseling to three visits per lifetime is an unreasonable restriction on patient treatment. A carrier may establish a reasonable visit limitation requirement for nutritional counseling for medical conditions when supported by evidence based medical criteria.

(c) The benchmark base plan's visit limitations on services in this category include:

(i) Ten spinal manipulation services without referral;

(ii) Twelve acupuncture services per year without referral;

(iii) One vision examination per calendar year, with one hundred fifty dollars per year for hardware, including frames, contacts, lenses, and tints;

(iv) Fourteen days respite care on either an inpatient or outpatient basis for hospice patients, per lifetime. Where respite services are delivered on an inpatient basis in a hospital or skilled nursing facility, the benefit may be classified to the hospital category;

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

(d) Services specifically classified under this category that the benchmark base plan covers include, but are not limited to:

(i) Home and out-patient dialysis services;

(ii) Hospice and home health care;

(iii) Provider office visits and treatments;

(iv) Urgent care center visits.

(e) State mandates classified to this category are:

(i) Chiropractic care (RCW 48.20.412, 48.21.142 and 48.44.310,);

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

(iii) Home health care and hospice services delivered in the home (RCW 48.21.220 and 48.44.320)'

(iv) Diabetes-related care, exclusive of those supplies or prescribed drugs, medications and therapies covered under other categories (RCW 48.20.391; 48.21.143; 48.44.315; 48.46.272).

(2) When the commissioner determines that a health benefit

plan's "emergency medical services" category covers care and services related to an emergency medical condition in a manner substantially equivalent to the benchmark base plan, the plan provides a meaningful benefit for this category.

(a) Benefits classified under this category include:

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

(ii) Emergency room based services and treatment.

(b) State mandates classified under this category include services necessary to screen and stabilize a covered person (RCW 48.43.093).

(3) When the commissioner determines that a health benefit plan's "hospitalization" category covers medically necessary medical 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, in a manner substantially equivalent to the benchmark base plan, the plan provides a meaningful benefit for this category.

(a) The benchmark base plan specifically excludes the following services that would otherwise be included in this category:

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

(ii) Obesity surgery and supplies,

(iii) Orthognathic surgery and supplies unless due to Temporomandibular joint disorder or injury, sleep apnea or congenital anomaly’

(iv) Sexual reassignment treatment and surgery;

(v) Reversal of sterilizations;

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

(b) The benchmark base plan's visit limitations on services in this category are:

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

(ii) Transplant services delivered prior to the end of a six month waiting period that is inclusive of prior creditable coverage. Beginning January 1, 2014, the waiting period may be no longer than ninety days.

(d) Covered services specifically classified under this category that the benchmark base plan covers include:

(i) Transplant services for donors and recipients, including the transplant facility fees;

(ii) Dialysis services delivered in a hospital;

(iii) Artificial organ transplants based on medical guidelines;

(iv) Hospital visits, and provider services and treatments delivered during an inpatient hospital stay, including inpatient pharmacy services;

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

(e) State mandates covered under this category include:

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

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

(iii)Coverage for Temporomandibular joint disorder (RCW 48.21.320; 48.44.460, 48.46.530).

(4) When the commissioner determines that a health benefit plan's "maternity and newborn" category covers medically necessary care and services delivered to women during pregnancy, and in relation to delivery and recovery from delivery, and to newborn children, in a manner substantially equivalent to the benchmark base plan, the plan provides a meaningful benefit for this category.

(a) The benchmark base plan's visit limitations on services in this category include home birth by a midwife or nurse midwife is covered only for low risk pregnancy.

(b) Services specifically classified under this category that the benchmark base plan covers include:

(i) In utero treatment for the fetus;

(ii) Delivery in a hospital or birthing center, including facility fees;

(iii) Professional and nursery services for newborns;

(iv) Infertility diagnosis;

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

(vi) Termination of pregnancy.

(c) State mandates classified under this category include:

(i) Women's health care services including maternity services performed by a midwife, M.D., D.O., or ARNP (RCW 48.42.100; 48.43.115);

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

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

(iv) Prenatal diagnosis of congenital disorders by

screening/diagnostic procedures if medically necessary (RCW 48.20.430, 48.21.244, 48.44.344, and 48.46.375,).

(d) The commissioner finds that the exclusion of maternity coverage for dependent daughters is an unreasonable restriction on patient treatment, and violates the women's wellness coverage requirements in PPACA. The limitation is not included as part of the benchmark base plan.

(f) The commissioner finds that the limitation on coverage for newborns delivered of dependent daughters, covering the newborn for seventy-two hours, is an unreasonable restriction on patient treatment, and is discriminatory. The limitation is not included as part of the benchmark base plan.

(5) When the commissioner determines that a health benefit plan's "mental health and substance use disorder services, including behavioral health treatment" category covers 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, including behavioral health treatment for those conditions, in a manner substantially equivalent to the benchmark base plan, the plan provides a meaningful benefit for this category.

(a) The benchmark base plan specifically excludes the following services that would otherwise be included in this category:

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

(ii) Mental health treatment for diagnostic codes 302 through 302.9 in the DSM-IV, or for "V code" diagnoses in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders, 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, and bereavement for children five years of age or younger.

(b) The benchmark base plan's specific limitations on services in this category include:

(i) A limit of four employee assistance program counseling sessions;

(ii) Court ordered treatment only when medically necessary.

(c) Services specifically classified under this category that the benchmark base plan covers include:

(i) Inpatient, residential, and outpatient mental health treatment;

(ii) Chemical dependency detoxification;

(iii) Behavioral treatment;
(iv) Prescription medication prescribed during an inpatient and residential course of treatment; and
(v) Acupuncture services for treatment of chemical dependency, without visit limitation.
(d) State mandates classified under this category include:
(i) Mental health parity (RCW 48.20.580, 48.21.241; 48.44.341, and 48.46.285);
(ii) Chemical dependency detoxification services (RCW 48.21.180, 48.44.240, 48.44.245, 48.46.350, and 48.46.355,);
(iii) Services delivered pursuant to involuntary commitment proceedings (RCW 48.21.242; 48.44.342; 48.46.292).
(e) For purposes of this section, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343) (MHPAEA) applies to a health benefit plan subject to this section. Coverage of mental health and substance use disorder services, along with any scope and duration limits imposed on the benefits, must comply with the MHPAEA, and all rules, regulations and guidance issued pursuant to Section 2726 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26).
(6) When the commissioner determines that a health benefit plan's "prescription drug services" category covers medically necessary prescribed drugs, medication and drug therapies, in a manner substantially equivalent to the benchmark base plan, the plan provides a meaningful benefit for this category.
(a) The benchmark base plan's specifically excludes weight loss drugs under this benefit.
(b) The benchmark base plan's exclusion of coverage for medication prescribed as part of a clinical trial, that is not the subject of the trial, is an impermissible exclusion of coverage under state and federal law.
(c) The benchmark base plan applies the following limitations to coverage:
(i) Prescriptions for self-administrable injectible medication are limited to thirty-day supplies at a time;
(ii) Teaching doses of self-administrable injectible medications are limited to three doses per medication per lifetime.
(e) Services specifically classified under this category that the benchmark base plan covers include:
(i) Those classes of drugs, and the specific drugs in the drug formulary;
(ii) Prescribed medical supplies, including diabetic supplies that are not otherwise covered as durable medical equipment under the rehabilitative and habilitative services category;
(iii) All FDA approved contraceptive methods, sterilization

procedures for all women with reproductive capacity.

(f) A carrier’s formulary is part of the prescription drug benefit category, and must be substantially equal to the benchmark base plan formulary, both as to therapeutic class and included drugs in the class. The benchmark formulary includes the following therapeutic classes: Anti-infectives, Cardiovascular, Cholesterol Lowering, Diabetes, Ear/Nose/Throat, Gastrointestinal, Hormones, Mental Health, Neurological, Ophthalmic, Pain and Inflammatory Disease, Respiratory, Skin, Women’s Health. A carrier must file its formulary with a representative product identifier code in each therapeutic class, when filing its rates and forms with the commissioner. Acceptable product identifier codes include Generic Sequence Number (GSN), Generic Code Number (GCN), Generic Product Identifier (GPI), or National Drug Code (NDC).

(g) State mandates classified under this category include:

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

(ii) Diabetes supplies ordered by the physician (RCW 48.44.315, 48.46.272, 48.20.391, and 48.21.143);

(iii) Orally administered anticancer medication parity requirements (RCW 48.20.389; 48.21.223; 48.44.323; 48.46.274);

(iv) Mental health prescription drugs (RCW 48.44.341, 48.46.291, 48.20.580, and 48.21.241).

(7) When the commissioner determines that a health benefit plan's "rehabilitative and habilitative services" category covers the following, the plan provides a meaningful benefit in this category:

(a) Medically necessary rehabilitative 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, in a manner substantially equivalent to the benchmark base plan; and

(b) Habilitative services that include the range of medically necessary health care services and health care devices designed to assist an individual in partially or fully developing, learning and retaining developed or learned age appropriate skills and functioning, within the individual's environment or to compensate for a person's progressive physical, cognitive and emotional illness and that:

(i) Are provided in a manner consistent with RCW 48.43.045;

(ii) Take into account the unique needs of the individual;

(iii) Target measurable, specific treatment goals appropriate for the person's age, and physical and mental condition; and

(iv) Are consistent with the carrier's utilization review guidelines and practice guidelines recognized by the medical

community as efficacious, and do not necessarily require a return to a prior level of function, if the scope of the services complies with (g) of this subsection.

A carrier may limit the definition of health care devices under the habilitative services category to those that require Food and Drug Administration (FDA) approval, and a prescription to dispense the device.

(c) The benchmark base plan's specific limitations on services in this category include:

(i) Hearing aid devices are limited to cochlear implants;

(ii) Inpatient rehabilitation facility and professional services delivered in those facilities are limited to thirty days per year;

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

(d) The benchmark base plan specifically classifies orthotics used to support, align or correct deformities or to improve the function of moving parts under this category.

(e) Services that would otherwise be classified under this category but the benchmark base plan specifically excludes are:

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

(ii) Exercise equipment for medically necessary conditions;

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

(f) State mandates classified under this category include:

(i) State sales tax for durable medical equipment;

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

(g) The scope of habilitative services must include, but is not limited to, the following requirements:

(i) The services and devices must be covered on not less than a parity basis to rehabilitative benefits. Habilitative services must not be limited to speech, physical and occupational therapy if medical necessity requires other types of habilitative services and devices that are consistent with the definition in (b) of this subsection;

(ii) Habilitative services and devices delivered pursuant to federal Individuals with Disabilities Education Act of 2004 (IDEA) requirements or other habilitative services delivered in an educational setting may be excluded from coverage;

(iii) Habilitative services must be covered both as to type of service and amount of the service. The phrase "the amount" refers to the number of services, subject to a carrier's medical necessity and utilization review determinations. A carrier may not exclude coverage for services delivered outside an educational setting on the basis that the enrollee is receiving some of the prescribed number of services in an educational

setting;

(iv) Habilitative services do not necessarily require a return to a prior level of function.

(h) The scope of rehabilitative services may not be applied in a manner that results in a limitation of coverage that is inconsistent with evidence based medical guidelines for therapies specific to disease recovery, other than on the basis of medical necessity. A health benefit plan must classify therapies specific to disease recovery to the ambulatory patient services category or, when delivered in an inpatient setting, the hospitalization category. Examples of these are, but are not limited to, breast cancer rehabilitation therapy, respiratory therapy, and cardiac rehabilitation therapy.

(8) When the commissioner determines that a health benefit plan's "laboratory services" category covers 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, in a manner substantially equivalent to the benchmark base plan, the plan provides a meaningful benefit for this category.

(9) When the commissioner determines that a health benefit plan's "preventive and wellness services, including chronic disease management" category covers 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, services of particular preventive or early identification of disease or illness of value to specific populations, such as women, children and seniors, in a manner substantially equivalent to the benchmark base plan, the plan provides a meaningful benefit for this category.

(a) The benchmark base plan specifically covers preventive services recommended by the Centers for Disease Control's Advisory Committee on Immunization Practices, the U.S. Preventive Services Task Force A and B guidelines for prevention and chronic care, the U.S. Health Resources and Services Administration Bright Futures guidelines as set forth by the American Academy of Pediatricians.

(b) State mandates classified in this category are:

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

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

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

(10) When the commissioner determines that a health benefit

plan's "pediatric services" category covers persons who would otherwise be eligible for child only coverage under state law, in a manner substantially equivalent to the benchmark base plan in each of the essential health benefits categories, includes the pediatric vision benefits set forth in the Federal Employees Vision Plan with the largest enrollment and published by the U.S. Department of Health and Human Services at www.cciioo.cms.gov on July 2, 2012, and includes the pediatric oral benefits found in the Washington state CHIP plan, in a manner substantially equivalent to these supplemental benchmark plans, the plan provides a meaningful benefit for this category.

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

(i) Routine vision screening for children, including dilation and with refraction every calendar year, including dilation;

(ii) One pair of prescription lenses or contacts every calendar year, including polycarbonate lenses and scratch resistant coating;

(iii) One pair of frames every calendar year;

(iv) Low vision optical devices including low vision services, and an aid allowance with follow-up care when preauthorized.

(b) The pediatric vision benefits specifically exclude:

(i) Visual therapy;

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

(c) The oral benefits included in the "pediatric" category are:

(i) Diagnostic services;

(ii) Preventive care;

(iii) Restorative care;

(iv) Oral surgery and reconstruction to the extent not covered under the hospitalization benefit;

(v) Endodontic treatment;

(vi) Periodontics;

(vii) Crown and fixed bridge;

(viii) Removable prosthetics;

(ix) Medically necessary orthodontia.

(d) The pediatric oral benefits include the following scope and limitation requirements:

(i) Diagnostic exams once every six months, beginning before one year of age;

(ii) Bitewing X ray once a year;

(iii) Panoramic X rays once every three years;

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

(v) Fluoride three times in a twelve month period for ages

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

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

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

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

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

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

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

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

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

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

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

(xvi) One resin based partial denture, replaced once within a three year period;

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

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

(e) The pediatric oral benefit specifically excludes implants.

(f) State mandates classified under this category include:

(i) Neurodevelopmental therapy to age six, consisting of physical, occupational and speech therapy and maintenance to restore or improve function based on developmental delay, which cannot be combined with rehabilitative services for the same condition (RCW 48.44.450, 48.46.520, and 48.21.310);

(ii) Congenital anomalies in newborn and dependent children (RCW 48.20.430, 48.21.155, 48.44.212, 48.46.250, and 48.21.155).

NEW SECTION

WAC 284-43-880 Plan design parameters. (1) A nongrandfathered individual or small group health benefit plan issued, renewed, amended, or offered on or after January 1, 2014, must cover the ten essential health benefits categories as set forth in the benchmark base plan, as supplemented by the commissioner, at least to the extent that the benefits and services included are medically necessary, and so that the benefits are substantially equal to the designated benchmark plan, as supplemented.

For the purposes of this section "substantially equal" means that:

(a) The scope and level of benefits offered within each essential health benefit category is meaningful;

(b) The aggregate value of the benefits across all essential health benefit categories is not less than the aggregate value of the benchmark base plan as supplemented by the commissioner; and

(c) Within each essential health benefit category, the actuarial value of the category is not less than the actuarial value of the category for the benchmark base plan as supplemented by the commissioner.

(2) A carrier may not alter its health benefit plan design by transferring a service from the category assigned to it by the commissioner in WAC 284-43-877 if that transfer results in the elimination of a parity requirement.

(3) Nothing precludes a health carrier from including coverage for benefits in a health benefit plan that are in addition to the benchmark base plan's essential health benefit package, as supplemented by the commissioner. A carrier must identify in its rate filing those services substituted within a category as part of the essential health benefits package, if the carrier includes the service in calculating actuarial value of the essential health benefits package.

(4) To the extent that the benchmark base plan contains benefit limitations that conflict with requirements of PPACA, the benefit limitations must be amended to comply with PPACA's requirements.

(5) A health benefit plan may not be offered if the commissioner determines that:

(a) It creates a risk of biased selection based on health status;

(b) The benefits within an essential health benefit category are not a meaningful benefit; or

(c) The benefit violates the antidiscrimination requirements of PPACA, section 511 of Public Law 110-343 (the federal Mental Health Parity and Addiction Equity Act of 2008),

as amended, or Washington state law.

(6) Pediatric oral benefits must be included in a health benefit plan either as an embedded set of services, offered through a rider or as a contracted service. If a health plan is subsequently certified by the health benefit exchange as a qualified health plan, this requirement is met for that benefit year for the certified plan if a stand-alone dental plan covering pediatric oral services as set forth in the benchmark base plan, as supplemented, is offered in the health benefit exchange for that benefit year.

(7) A carrier must not impose annual or lifetime dollar limits on an essential health benefit.

NEW SECTION

WAC 284-43-882 Plan cost sharing and benefit substitution of limitations (1) At the time a health benefit plan form is filed with the commissioner for approval, if a carrier elects to adjust specific services within any of the essential health benefit categories, or a quantitative limit for a service, a carrier must submit with its filing an actuarial opinion certifying the equivalence of the value of the plan's essential health benefits in the category, and overall, to the benchmark base plan as supplemented.

(2) A health benefit plan must not apply cost-sharing requirements to Native Americans purchasing a health benefit plan through the Exchange, whose incomes are at or below 300% of federal poverty level.

(3) A small group health benefit plan that includes the essential health benefits package may not impose annual cost-sharing or deductibles that exceed the maximum annual amounts that apply to high deductible plans linked to health savings accounts, as set forth in the most recent version of IRS Publication 969, pursuant to section 106(c)(2) of the Internal Revenue Code of 1986, and section 1302(c)(2) of PPACA.

(4) A carrier may use reasonable medical management techniques to control costs, including promoting the use of appropriate, high value preventive services, providers and settings. A carrier's policies must accommodate enrollees for whom it would be medically inappropriate to have the service provided in one setting versus another, as determined by the attending provider, and permit waiver of an otherwise applicable copayment for the service that is tied to one setting but not the preferred high-value setting.

(5) A carrier may not require cost-sharing for preventive services delivered by network providers, specifically related to those with an A or B rating in the most recent recommendations

of the United States Preventive Services Task Force, women’s preventive healthcare services recommended by the U.S. Health Resources and services Administration (HRSA) and HRSA Bright Futures guideline designated pediatric services.

NEW SECTION

WAC 284-43-885 Representations regarding minimum essential coverage. A health carrier must not indicate or imply that a health benefit plan covers the essential health benefits unless the plan contract covers essential health benefits in compliance with this subchapter. This requirement applies to any health benefit plan offered inside or outside the Washington health benefit exchange.