



RULE-MAKING ORDER PERMANENT RULE ONLY

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

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: November 22, 2021

TIME: 9:31 AM

WSR 21-24-029

Agency: Office of the Insurance Commissioner

Effective date of rule:

Permanent Rules

31 days after filing.

Other (specify) _____ (If less than 31 days after filing, a specific finding under RCW 34.05.380(3) is required and should be stated below)

Any other findings required by other provisions of law as precondition to adoption or effectiveness of rule?

Yes No If Yes, explain:

Purpose: ESHB 1196 (Chapter 157, Laws of 2021) was signed into law on May 3, 2021. The legislation addresses coverage of telemedicine services, including audio-only telemedicine services. Prior to passage of this legislation, audio-only telemedicine services were explicitly excluded from the definition of “telemedicine”. Carriers were not required by statute to cover audio-only telemedicine services. During the COVID-19 public health emergency, OIC issued emergency orders requiring coverage of audio-only telemedicine services in order to ensure access to medical services. ESHB 1196 requires coverage of audio-only telemedicine services under specified conditions and amends the statutory language related to telemedicine payment parity.

The proposed rule amends WAC 284-170-130 to add definitions relevant to telemedicine and creates a new WAC section – WAC 284-43-433. The new section addresses coverage of telemedicine services generally, including payment parity and the conditions in ESHB 1196 associated with payment for audio-only telemedicine services.

Citation of rules affected by this order:

New: WAC 284-170-433

Repealed:

Amended: WAC 284-170-130

Suspended:

Statutory authority for adoption: RCW 48.43.735(9)

Other authority:

PERMANENT RULE (Including Expedited Rule Making)

Adopted under notice filed as WSR 21-19-137 on September 21, 2021 (date).

Describe any changes other than editing from proposed to adopted version: The final rule differs from the proposed rule in the following respects:

- A technical reference was changed to refer to the correct WAC section in the definition of “patient consent” in WAC 284-170-130
- In WAC 284-170-433(6)(a), the term “related to” is revised to read “applicable to” in order to clarify the intent of the language
- In WAC 284-170-433(b), subsections were reordered to clarify language. Subsection (b)(iii) was moved up to appear as subsection (b)(ii) and subsection (b)(ii) was renumbered to subsection (b)(iii)
- Language was added to WAC 284-170-433(10) to clarify that the grace period associated with carriers filing conforming changes to their provider contracts does not limit the Commissioner’s underlying authority provided in RCW 48.02.060 to enforce ESHB 1196 or WAC 284-170-433 as of the effective date of those laws.

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

Name: Tabba Alam

Address: PO Box 40260, Olympia, WA 98504-0260

Phone: (360)725-7170

Fax: (360) 586-3109

TTY: (360) 586-0241

Email: rulescoordinator@oic.wa.gov

Web site: www.insurance.wa.gov

Other:

**Note: If any category is left blank, it will be calculated as zero.
No descriptive text.**

**Count by whole WAC sections only, from the WAC number through the history note.
A section may be counted in more than one category.**

The number of sections adopted in order to comply with:

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

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

New	___	Amended	___	Repealed	___
-----	-----	---------	-----	----------	-----

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

New	<u>1</u>	Amended	<u>1</u>	Repealed	___
-----	----------	---------	----------	----------	-----

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

New	___	Amended	___	Repealed	___
-----	-----	---------	-----	----------	-----

The number of sections adopted using:

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

Date Adopted: November 22, 2021

Name: Mike Kreidler

Title: Insurance Commissioner

Signature:



WAC 284-170-130 Definitions. Except as defined in other sub-chapters and unless the context requires otherwise, the following definitions shall apply throughout this chapter.

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

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

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

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

(d) A rescission of coverage determination; or

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

(2) "Allowed amount" has the meaning set forth in RCW 48.43.005.

(3) (a) "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.

(b) "Audio-only telemedicine" does not include:

(i) The use of facsimile, email, or text messages, unless the use of text-like messaging is necessary to ensure effective communication with individuals who have a hearing, speech, or other disability; or

(ii) 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.

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

~~((3))~~ (5) "Clinical review criteria" means the written screens, or screening procedures, decision rules, medical protocols, or clinical practice guidelines used by the carrier as an element in the evaluation of medical necessity and appropriateness of requested admissions, procedures, and services, including prescription drug benefits, under the auspices of the applicable health plan. Clinical approval criteria has the same meaning as clinical review criteria.

~~((4))~~ (6) "Covered health condition" means any disease, illness, injury or condition of health risk covered according to the terms of any health plan.

((+5+)) (7) "Covered person" or "enrollee" means an individual covered by a health plan including a subscriber, policyholder, or beneficiary of a group plan.

((+6+)) (8) "Disciplining authority" has the meaning set forth in RCW 18.130.020.

(9) "Distant site" has the meaning set forth in RCW 48.43.735.

(10) "Emergency medical condition" means the emergent and acute onset of a symptom or symptoms, including severe pain or emotional distress, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical, mental health, or substance use disorder treatment attention, if failure to provide medical, mental health, or substance use disorder treatment attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

((+7+)) (11) "Emergency services" has the meaning set forth in RCW 48.43.005.

((+8+)) (12) "Enrollee point-of-service cost-sharing" or "cost-sharing" (~~means amounts paid to health carriers directly providing services, health care providers, or health care facilities by enrollees and may include copayments, coinsurance, or deductibles~~) has the meaning set forth in RCW 48.43.005.

((+9+)) (13) "Established relationship" means:

(a) The covered person has had at least one in-person appointment within the past year with the provider providing audio-only telemedicine, with a provider employed at the same clinic as the provider providing audio-only telemedicine, or with a locum tenens or other provider who is the designated back up or substitute provider for the provider providing audio-only telemedicine who is on leave and is not associated with an established clinic; or

(b) The covered person was referred to the provider providing audio-only telemedicine by another provider who has had at least one in-person appointment with the covered person within the past year and has provided relevant medical information to the provider providing audio-only telemedicine. A referral includes circumstances in which the provider who has had at least one in-person appointment with the covered person participates in the audio-only telemedicine encounter with the provider to whom the covered person has been referred.

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

((+10+)) (15) "Formulary" means a listing of drugs used within a health plan.

((+11+)) (16) "Grievance" has the meaning set forth in RCW 48.43.005.

((+12+)) (17) "Health care provider" or "provider" means:

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

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

((+13+)) (18) "Health care service" or "health service" means that service offered or provided by health care facilities and health

care providers relating to the prevention, cure, or treatment of illness, injury, or disease.

~~((14))~~ (19) "Health carrier" or "carrier" means a disability insurance company regulated under chapter 48.20 or 48.21 RCW, a health care service contractor as defined in RCW 48.44.010, and a health maintenance organization as defined in RCW 48.46.020, and includes "issuers" as that term is used in The Patient Protection and Affordable Care Act (P.L. 111-148, as amended (2010)).

~~((15))~~ (20) "Health plan" or "plan" means any individual or group policy, contract, or agreement offered by a health carrier to provide, arrange, reimburse, or pay for health care service except the following:

- (a) Long-term care insurance governed by chapter 48.84 RCW;
- (b) Medicare supplemental health insurance governed by chapter 48.66 RCW;
- (c) Limited health care service offered by limited health care service contractors in accordance with RCW 48.44.035;
- (d) Disability income;
- (e) Coverage incidental to a property/casualty liability insurance policy such as automobile personal injury protection coverage and homeowner guest medical;
- (f) Workers' compensation coverage;
- (g) Accident only coverage;
- (h) Specified disease and hospital confinement indemnity when marketed solely as a supplement to a health plan;
- (i) Employer-sponsored self-funded health plans;
- (j) Dental only and vision only coverage; and
- (k) Plans deemed by the insurance commissioner to have a short-term limited purpose or duration, or to be a student-only plan that is guaranteed renewable while the covered person is enrolled as a regular full-time undergraduate or graduate student at an accredited higher education institution, after a written request for such classification by the carrier and subsequent written approval by the insurance commissioner.

~~((16))~~ (21) "Hospital" has the meaning set forth in RCW 48.43.735.

(22) "Indian health care provider" means:

- (a) The Indian Health Service, an agency operated by the U.S. Department of Health and Human Services established by the Indian Health Care Improvement Act, Section 601, 25 U.S.C. Sec. 1661;
- (b) An Indian tribe, as defined in the Indian Health Care Improvement Act, Section 4(14), 25 U.S.C. Sec. 1603(14), that operates a health program under a contract or compact to carry out programs of the Indian Health Service pursuant to the Indian Self-Determination and Education Assistance Act (ISDEAA), 25 U.S.C. Sec. 450 et seq.;
- (c) A tribal organization, as defined in the Indian Health Care Improvement Act, Section 4(26), 25 U.S.C. Sec. 1603(26), that operates a health program under a contract or compact to carry out programs of the Indian Health Service pursuant to the ISDEAA, 25 U.S.C. Sec. 450 et seq.;
- (d) An Indian tribe, as defined in the Indian Health Care Improvement Act, Section 4(14), 25 U.S.C. Sec. 1603(14), or tribal organization, as defined in the Indian Health Care Improvement Act, Section 4(26), 25 U.S.C. Sec. 1603(26), that operates a health program with funding provided in whole or part pursuant to 25 U.S.C. Sec. 47 (commonly known as the Buy Indian Act); or

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

~~((17))~~ (23) "Managed care plan" means a health plan that coordinates the provision of covered health care services to a covered person through the use of a primary care provider and a network.

~~((18))~~ (24) "Medically necessary" or "medical necessity" in regard to mental health services and pharmacy services is a carrier determination as to whether a health service is a covered benefit because the service is consistent with generally recognized standards within a relevant health profession.

~~((19))~~ (25) "Mental health provider" means a health care provider or a health care facility authorized by state law to provide mental health services.

~~((20))~~ (26) "Mental health services" means in-patient or out-patient treatment including, but not limited to, partial hospitalization, residential treatment, out-patient facility-based treatment, intensive outpatient treatment, emergency services, or prescription drugs to manage, stabilize, or ameliorate the effects of a mental disorder listed in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association, including diagnoses and treatment for substance use disorder.

~~((21))~~ (27) "Network" means the group of participating providers and facilities providing health care services to a particular health plan or line of business (individual, small, or large group). A health plan network for issuers offering more than one health plan may be smaller in number than the total number of participating providers and facilities for all plans offered by the carrier.

~~((22))~~ (28) "Originating site" means the physical location of a patient receiving health care services through telemedicine, and includes those sites described in WAC 284-170-433.

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

~~((23))~~ (30) "Participating provider" and "participating facility" mean a facility or provider who, under a contract with the health carrier or with the carrier's contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, from the health carrier rather than from the covered person.

~~((24))~~ (31) "Patient consent" means a voluntary and informed decision by a patient, following an explanation by the provider or auxiliary personnel under the general supervision of the provider presented in a manner understandable to the patient that is free of undue influence, fraud or duress, to consent to a provider billing the patient or the patient's health plan for an audio-only telemedicine service under RCW 48.43.735 or WAC 284-170-433.

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

~~((25))~~ (33) "Pharmacy services" means the practice of pharmacy as defined in chapter 18.64 RCW and includes any drugs or devices as defined in chapter 18.64 RCW.

~~((26))~~ (34) "Primary care provider" means a participating provider who supervises, coordinates, or provides initial care or continuing care to a covered person, and who may be required by the health carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person.

~~((27))~~ (35) "Preexisting condition" means any medical condition, illness, or injury that existed any time prior to the effective date of coverage.

~~((28))~~ (36) "Premium" means all sums charged, received, or deposited by a health carrier as consideration for a health plan or the continuance of a health plan. Any assessment or any "membership," "policy," "contract," "service," or similar fee or charge made by a health carrier in consideration for a health plan is deemed part of the premium. "Premium" shall not include amounts paid as enrollee point-of-service cost-sharing.

~~((29))~~ (37) "Real time communication" means synchronous and live communication between a provider and a patient. It does not include delayed or recorded messages, such as email, facsimile or voice mail.

(38) "Same amount of compensation" means providers are reimbursed by a carrier using the same allowed amount for telemedicine services as they would if the service had been provided in-person unless negotiation has been undertaken under RCW 48.43.735 or WAC 284-170-433(2). Where consumer cost-sharing applies to telemedicine services, the consumer's payment combined with the carrier's payment must be the same amount of compensation, or allowed amount, as the carrier would pay the provider if the telemedicine service had been provided in person. Where an alternative payment methodology other than fee-for-service payment would apply to an in-person service, "same amount of compensation" means providers are reimbursed by a carrier using the same alternative payment methodology that would be used for the same service if provided in-person, unless negotiation has been undertaken under RCW 48.43.735 or WAC 284-170-433(2).

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

~~((30))~~ (40) "Small group plan" means a health plan issued to a small employer as defined under RCW 48.43.005(34) comprising from one to ~~((fifty))~~ 50 eligible employees.

~~((31))~~ (41) "Store and forward technology" has the meaning set forth in RCW 48.43.735.

(42) "Substance use disorder services" means in-patient or out-patient treatment including, but not limited to, partial hospitalization, residential treatment, or out-patient facility-based treatment, intensive outpatient treatment, emergency services, or prescription drugs to manage, stabilize, or ameliorate the effects of a substance use disorder listed in the most current version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) published by the American Psychiatric Association, including diagnoses and treatment for substance use disorder.

~~((32))~~ (43) "Substitute drug" means a prescription medication, drug or therapy that a carrier covers based on an exception request. When the exception request is based on therapeutic equivalence, a substitute drug means a therapeutically equivalent substance as defined in chapter 69.41 RCW.

~~((33))~~ (44) "Supplementary pharmacy services" or "other pharmacy services" means pharmacy services involving the provision of drug therapy management and other services not required under state and federal law but that may be rendered in connection with dispensing, or that may be used in disease prevention or disease management.

(45) "Telemedicine" means the delivery of health care services through the use of interactive audio and video technology or 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. For purposes of this chapter, "telemedicine" does not include facsimile, email, or text messaging, unless the use of text-like messaging is necessary to ensure effective communication with individuals who have a hearing, speech, or other disability.

NEW SECTION

WAC 284-170-433 Provider contracts—Telemedicine. (1)(a) Every participating provider contract must, for health plans issued or renewed on or after January 1, 2017, provide that a health carrier shall reimburse a provider for a health care service provided to a covered person through telemedicine or store and forward technology if:

(i) The plan provides coverage of the health care service when provided in person by the provider;

(ii) The health care service is medically necessary;

(iii) The health care service is a service recognized as an essential health benefit under section 1302(b) of the federal Patient Protection and Affordable Care Act in effect on January 1, 2015, RCW 48.43.005 and 48.43.715;

(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

(b) Beginning January 1, 2023, for audio-only telemedicine, the covered person has an established relationship with the provider.

(2)(a) Every participating provider contract must, for health plans issued or renewed on or after January 1, 2021, provide that, except as provided in (b) of this subsection, a carrier will reimburse a provider for a health care service provided to a covered person through telemedicine as provided in RCW 48.43.735(1) or subsection (1) of this section the same amount of compensation the carrier would pay the provider if the health care service was provided in person by the provider.

(b) Hospitals, hospital systems, telemedicine companies, and provider groups consisting of 11 or more providers may elect to negotiate

an amount of compensation for telemedicine services that differs from the amount of compensation for in-person services.

For purposes of (b) of this subsection, the number of providers in a provider group refers to all providers within the group, regardless of a provider's location.

(c) For purposes of this section, 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.

(3)(a) Every participating provider contract must, for health plans issued or renewed on or after January 1, 2017, provide that an originating site for a telemedicine health care service subject to subsection (1) of this section includes a:

- (i) Hospital;
- (ii) Rural health clinic;
- (iii) Federally qualified health center;
- (iv) Physician's or other provider's office;
- (v) Licensed or certified behavioral health agency;
- (vi) Skilled nursing facility;

(vii) Home or any location determined by the individual receiving the service including, but not limited to, a pharmacy licensed under chapter 18.64 RCW or a school-based health center as defined in RCW 43.70.825. If the site chosen by the individual receiving service is in a state other than the state of Washington, a provider's ability to conduct a telemedicine encounter in that state is determined by the licensure status of the provider and the provider licensure laws of the other state; or

(viii) Renal dialysis center, except an independent renal dialysis center.

(b) Except for (a)(vii) of this subsection and a hospital that is an originating site for an audio-only telemedicine encounter, any originating site under this subsection may charge a facility fee for infrastructure and preparation of the patient. Reimbursement for a facility fee must be subject to a negotiated agreement between the originating site and the health carrier. A distant site, a hospital that is an originating site for an audio-only telemedicine encounter, or any other site not identified in this subsection may not charge a facility fee.

(4) A health carrier may not distinguish between originating sites that are rural and urban in providing the coverage required in subsection (1) of this section.

(5) A health carrier may subject coverage of a telemedicine or store and forward technology health service under subsection (1) of this section to all terms and conditions of the plan in which the covered person is enrolled including, but not limited to, utilization review, prior authorization, deductible, copayment, or coinsurance requirements that are applicable to coverage of a comparable health care service provided in person.

(6)(a) Every participating provider contract must, effective July 25, 2021, provide that if a provider intends to bill a covered person or the covered person's health plan for an audio-only telemedicine service, the provider must obtain patient consent from the covered person for the billing in advance of the service being delivered, consistent with the requirements of this subsection and state and federal laws applicable to obtaining patient consent.

(b)(i) A covered person's consent must be obtained prior to initiation of the first audio-only encounter with a provider and may con-

stitute consent to such encounters for a period of up to 12 months. If audio-only encounters continue beyond an initial 12-month period, consent must be obtained from the covered person for each prospective 12-month period.

(ii) Consent to be billed for audio-only telemedicine services must be obtained by the provider or auxiliary personnel under the general supervision of the provider.

(iii) A covered person may consent to a provider billing them or their health plan in writing or verbally. Consent to billing for an audio-only telemedicine encounter may be obtained and documented by the provider or auxiliary personnel under the general supervision of the provider as part of the process of making an appointment for an audio-only telemedicine encounter, recorded verbally as part of the audio-only telemedicine encounter record or otherwise documented in the patient record. Consent must be documented and retained by the provider for a minimum of five years. As needed, a carrier also may request documentation of the covered person's consent as a condition of claim payment.

(iv) A patient may revoke consent granted under this subsection. Revocation of the patient's consent must be communicated by the patient or their authorized representative to the provider or auxiliary personnel under the general supervision of the provider verbally or in writing and must be documented and retained by the provider for a minimum of five years. Once consent is revoked, the revocation must operate prospectively.

(7)(a) A carrier may not deny, reduce, terminate or fail to make payment for the delivery of health care services using audio and visual technology solely because the communication between the patient and provider during the encounter shifted to audio-only due to unanticipated circumstances. In these instances, a carrier may not require a provider to obtain consent from the patient to continue the communication.

(b) A carrier has no obligation to reimburse a provider for both an audio-visual and an audio-only encounter when both means of communication have been used during the encounter due to unforeseen circumstances.

(8)(a) If the commissioner has cause to believe that any provider has engaged in a pattern of unresolved violations of RCW 48.43.735(8) or subsection (6) of this section, the commissioner may submit information to the department of health or the appropriate disciplining authority, as defined in RCW 18.130.020, for action.

(b) In determining whether there is cause to believe that a provider has engaged in a pattern of unresolved violations, the commissioner shall consider, but is not limited to, consideration of the following:

(i) Whether there is cause to believe that the provider has committed two or more violations of RCW 48.43.735(8) or subsection (6) of this section;

(ii) Whether the provider has been nonresponsive to questions or requests for information from the commissioner related to one or more complaints alleging a violation of RCW 48.43.735(8) or subsection (6) of this section; and

(iii) Whether, subsequent to correction of previous violations, additional violations have occurred.

(c) Prior to submitting information to the department of health or the appropriate disciplining authority, the commissioner may give the provider an opportunity to cure the alleged violations or explain

why the actions in question did not violate RCW 48.43.735(8) or subsection (6) of this section.

(9) Every participating provider contract must, for health plans issued or renewed on or after July 25, 2021, ensure that access to telemedicine services is inclusive for those patients who may have disabilities or limited-English proficiency and for whom the use of telemedicine technology may be more challenging, consistent with carriers' obligations under WAC 284-43-5940 through 284-43-5965 with respect to design and implementation of plan benefits.

(10) Each carrier's provider contracts must include language conforming to the requirements of this section by July 1, 2022. The grace period associated with carriers filing conforming changes to their provider contracts under this section in no way limits the authority of the commissioner to enforce the provisions of RCW 48.43.735 or this section on or after the effective date of those laws.

(11) This section does not require a health carrier to reimburse:

(a) An originating site for professional fees;

(b) A provider for a health care service that is not a covered benefit under the plan; or

(c) An originating site or provider when the site or provider is not a participating provider under the plan.