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 30, 2021
TIME: 11:25 AM

WSR 21-24-072

Agency: Office of the Insurance Commissioner

Effective date of rule:

Permanent Rules

☐ 31 days after filing.

☒ Other (specify) 1/1/2022 **(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: To add new sections and amend existing rules as necessary to implement Chapter 280, Laws of 2021, regarding health insurance discrimination and gender affirming treatment.

Citation of rules affected by this order:

New: WAC 284-43-5151

Repealed:

Amended: WAC 284-43-3070, 284-43-5940, 284-43-7080 and 284-170-260

Suspended:

Statutory authority for adoption: RCW 48.02.060, RCW 48.43.515, and Chapter 280, Laws of 2021

Other authority:

PERMANENT RULE (Including Expedited Rule Making)

Adopted under notice filed as WSR 21-20-110 on 10/4/21 (date).

Describe any changes other than editing from proposed to adopted version: References to “facial feminization surgeries” were removed, but the wording “facial gender affirming treatment (such as tracheal shaves)” was retained. References to “hair electrolysis” were replaced with “hair removal procedures.”

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

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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Federal statute:	New		Amended		Repealed	
Federal rules or standards:	New		Amended		Repealed	
Recently enacted state statutes:	New	1	Amended	4	Repealed	

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

	New		Amended		Repealed	

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

	New		Amended		Repealed	

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

	New		Amended		Repealed	

The number of sections adopted using:

Negotiated rule making:	New		Amended		Repealed	
Pilot rule making:	New		Amended		Repealed	
Other alternative rule making:	New		Amended		Repealed	

Date Adopted: November 30, 2021	**Signature:**
Name: Mike Kreidler	
Title: Insurance Commissioner	

AMENDATORY SECTION (Amending WSR 20-24-120, filed 12/2/20, effective 1/2/21)

WAC 284-43-3070 Notice and explanation of adverse benefit determination—General requirements. (1) A carrier must notify enrollees of an adverse benefit determination either electronically or by U.S. mail. The notification must be provided:

(a) To an appellant or their authorized representative;

(b) To the provider if the adverse benefit determination involves the preservice denial of treatment or procedure prescribed by the provider; and

(c) Whenever an adverse benefit determination relates to a protected individual, as defined in RCW 48.43.005, the health carrier must follow RCW 48.43.505.

(2) A carrier or health plan's notice must include the following information, worded in plain language:

(a) The specific reasons for the adverse benefit determination;

(b) The specific health plan policy or contract sections on which the determination is based, including references to the provisions;

(c) The plan's review procedures, including the appellant's right to a copy of the carrier and health plan's records related to the adverse benefit determination;

(d) The time limits applicable to the review; ((~~and~~))

(e) The right of appellants and their providers to present evidence as part of a review of an adverse benefit determination;

(f) Effective April 1, 2022, the following statement: "Enrollees may request that a health insurer identify the medical, vocational, or other experts whose advice was obtained in connection with the adverse benefit determination, even if the advice was not relied on in making the determination. Health insurers may satisfy this requirement by providing the job title, a statement as to whether the expert is affiliated with the carrier as an employee, and the expert's specialty, board certification status, or other criteria related to the expert's qualification without providing the expert's name or address."; and

(g) When the adverse benefit determination concerns gender affirming treatment or services, a confirmation that a health care provider experienced with prescribing or delivering gender affirming treatment has reviewed the determination and confirmed that an adverse benefit determination denying or limiting the service is appropriate and provide information to confirm that the reviewing provider has clinically appropriate expertise prescribing or delivering gender affirming treatment.

(3) If an adverse benefit determination is based on medical necessity, decisions related to experimental treatment, or a similar exclusion or limit involving the exercise of professional judgment, the notification must contain either an explanation of the scientific or clinical basis for the determination, the manner in which the terms of the health plan were applied to the appellant's medical circumstances, or a statement that such explanation is available free of charge upon request.

(4) A health carrier must not issue an adverse benefit determination concerning gender affirming services or treatment until a health care provider with experience prescribing or delivering gender affirming treatment has reviewed and confirmed the appropriateness of the adverse benefit determination.

(5) If an internal rule, guideline, protocol, or other similar criterion was relied on in making the adverse benefit determination, the notice must contain either the specific rule, guideline, protocol, or other similar criterion; or a statement that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to the appellant on request.

((~~(5)~~)) (6) The notice of an adverse benefit determination must include an explanation of the right to review the records of relevant information, including evidence used by the carrier or the carrier's representative that influenced or supported the decision to make the adverse benefit determination.

(a) For purposes of this subsection, "relevant information" means information relied on in making the determination, or that was submitted, considered, or generated in the course of making the determination, regardless of whether the document, record, or information was relied on in making the determination.

(b) Relevant information includes any statement of policy, procedure, or administrative process concerning the denied treatment or benefit, regardless of whether it was relied on in making the determination.

((~~(6)~~)) (7) If the carrier and health plan determine that additional information is necessary to perfect the denied claim, the carrier and health plan must provide a description of the additional material or information that they require, with an explanation of why it is necessary, as soon as the need is identified.

((~~(7)~~)) (8) An enrollee or covered person may request that a carrier identify the medical, vocational, or other experts whose advice was obtained in connection with the adverse benefit determination, even if the advice was not relied on in making the determination. The carrier may satisfy this requirement by providing the job title, a statement as to whether the expert is affiliated with the carrier as an employee, and the expert's specialty, board certification status, or other criteria related to the expert's qualification without providing the expert's name or address. The carrier must be able to identify for the commissioner upon request the name of each expert whose advice was obtained in connection with the adverse benefit determination.

((~~(8)~~)) (9) The notice must include language substantially similar to the following:

> "If you request a review of this adverse benefit determination, (Company name) will continue to provide coverage for the disputed benefit pending outcome of the review if you are currently receiving services or supplies under the disputed benefit. If (Company name) prevails in the appeal, you may be responsible for the cost of coverage received during the review period. The decision at the external review level is binding unless other remedies are available under state or federal law."

NEW SECTION

WAC 284-43-5151 Unfair practice relating to gender affirming treatment and services. When a treatment or service is gender affirm-

ing treatment, as defined in RCW 48.43.0128, it is an unfair practice for any health carrier to:

(1) Deny or limit coverage, issue automatic denials of coverage, impose additional cost sharing or other limitations or restrictions on coverage, or deny or limit coverage of a claim, if gender affirming treatment is:

(a) 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;

(b) Medically necessary; and

(c) Prescribed in accordance with accepted standards of care;

(2) Apply blanket exclusions or categorical exclusions to gender affirming treatment; or

(3) 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.

AMENDATORY SECTION (Amending WSR 20-24-040, filed 11/23/20, effective 12/24/20)

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

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

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

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

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

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

(iv) Deny or limit coverage, deny or limit coverage of a claim, issue automatic denials of coverage or impose additional cost sharing or other limitations or restrictions on coverage, for:

(A) 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; or

(B) Gender affirming treatment, as defined in RCW 48.43.0128, when 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;

(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, including gender affirming treatment; or

(vi) 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; or

(vii) 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.

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

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

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

(5) The commissioner may determine whether an issuer's actions to comply with this section are consistent with current state law, the legislative intent underlying RCW 48.43.0128 to maintain the enrollee protections of the Affordable Care Act, and the federal regulations and guidance in effect as of January 1, 2017, including, but not limi-

ted to, those issued by the U.S. Department of Health and Human Services Office of Civil Rights and federal regulations implementing 42 U.S.C. Sec. 18116 (Sec. 1557 of the Affordable Care Act) as set forth in 81 Fed. Reg. 31375 et seq. (2016).

AMENDATORY SECTION (Amending WSR 20-24-040, filed 11/23/20, effective 12/24/20)

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

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

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

(4) When a treatment or service is gender affirming treatment, as defined in RCW 48.43.0128, a health carrier may not:

(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

(b) Apply blanket exclusions; or

(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.

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

AMENDATORY SECTION (Amending WSR 21-01-094, filed 12/11/20, effective 1/11/21)

WAC 284-170-260 Provider directories. (1) For each carrier that uses a provider network, the carrier must make information about that network available to the general public, prospective enrollees and enrollees, in the form of an easily accessible and searchable online provider directory.

Easily accessible for the purposes of this section means:

(a) The general public is able to view all of the current providers for each plan in the provider directory on the carrier's public website through a clearly identifiable link or tab and without creating or accessing an account or entering a policy number; and

(b) If a carrier maintains multiple provider networks, the carrier must post the current provider directory for each plan so the general public is able to easily discern which providers participate in which plans and which provider networks.

(2) Carriers must make a printed copy of the current provider directory available to an enrollee upon request as required under RCW 48.43.510 (1)(g). The printed directory must contain the carrier's telephone number, including a TTY/TTD number, and any other contact information to enable the enrollee to obtain information about providers in the health plan network.

(3) Printed and online provider directories must be made available to the general public, prospective ((~~enrollee's~~)) enrollees and ((~~enrollee's~~)) enrollees in a manner that accommodates individuals with limited-English proficiency or disabilities.

(4) Printed and online provider directories must be updated for accuracy at least monthly. To ensure accuracy:

(a) Each provider directory must include clear instructions about how a consumer or an enrollee can report inaccurate information in the provider directory to the carrier.

(b) Carriers must have an easily available method for providers to report changes to their provider directory information, in addition to any reports associated with initial or renewed credentialing used by the carrier.

(c) Carriers must investigate reported inaccuracies from providers and consumers, and if verified, correct inaccuracies as part of the carrier's monthly updates.

(d) Carriers must establish processes and procedures to confirm the accuracy of provider directory information, including processes and procedures to ensure that changes are made when inaccuracies are verified. Carriers must provide the processes and procedures and any associated records, including the provider directories, to the commissioner upon request for review.

(5) Printed and online provider directories must include the following information for each provider:

(a) The provider's location and telephone number;

(b) The specialty area or areas for which the provider is licensed to practice and included in the network;

(c) Any in-network institutional affiliation of the provider, such as hospitals where the provider has admitting privileges or provider groups with which a provider is a member;

(d) Whether the provider may be accessed without referral;

(e) Any languages, other than English, spoken by the provider; and

(f) If a provider offers mental health or substance use disorder treatment services, identify in the directory that the provider is contracted to deliver mental health or substance use disorder treatment services.

(6) A carrier must include in its printed and online provider directories a notation of any primary care, chiropractor, women's health care provider, mental health provider, substance use disorder provider, or pediatric provider whose practice is closed to new patients.

(7) Printed and online provider directories must include information about any available telemedicine services, including any audio-only telemedicine services that are available, and specifically describe the services and how to access those services.

(8) Printed and online provider directories must include information about any available interpreter services, communication and language assistance services, and accessibility of the physical facility, and the mechanism by which an enrollee may access such services.

(9) Printed and online provider directories must include information about the network status of emergency providers as required by WAC 284-170-370.

(10) In both printed and online provider directories, the carrier must indicate that, if an enrollee is unable to locate a gender affirming treatment provider, the carrier must identify a gender affirming treatment provider.