Sec. 1 WAC 284-170-130 Definitions.

Except as defined in other subchapters 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 issuer's designee utilization review organization that a request for a benefit under the health issuer's health benefit plan does not meet the health issuer'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 issuer or its designee utilization review organization of a covered person's eligibility to participate in the health issuer'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 issuer's denial of an application for coverage.

(2) "Authorization" or "certification" means a determination by the issuer 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) "Clinical review criteria" means the written screens, decision rules, medical protocols, or guidelines used by the issuer as an element in the evaluation of medical necessity and appropriateness of requested admissions, procedures, and services under the auspices of the applicable health plan.

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

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

(6) "Emergency medical condition" means the emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical 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) "Emergency services" has the meaning set forth in RCW 48.43.005.

(8) "Enrollee point-of-service cost-sharing" or "cost-sharing" means amounts paid to health issuers directly providing services, health care providers, or health care facilities by enrollees and may include copayments, coinsurance, or deductibles.

(9) "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) "Formulary" means a listing of drugs used within a health plan.

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

(12) "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) "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) "Health issuer" or "issuer" 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) "Health plan" or "plan" means any individual or group policy, contract, or agreement offered by a health issuer 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 issuer and subsequent written approval by the insurance commissioner.

(16) "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) "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) "Medically necessary" or "medical necessity" in regard to mental health services and pharmacy services is a issuer 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) "Mental health provider" means a health care provider or a health care facility authorized by state law to provide mental health services.

(20) "Mental health services" means in-patient or out-patient treatment, partial hospitalization or out-patient treatment to manage or ameliorate the effects of a mental disorder listed in the Diagnostic and Statistical Manual (DSM) IV published by the American Psychiatric Association, excluding diagnoses and treatments for substance abuse, 291.0 through 292.9 and 303.0 through 305.9.

(21) "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 issuer.

(22) "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 issuer to determine medical necessity for the particular service being rendered, as defined in Physicians Current Procedural Terminology, published by the American Medical Association.

(23) "Participating provider" and "participating facility" mean a facility or provider who, under a contract with the health issuer or with the issuer'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 issuer rather than from the covered person.

(24) "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) "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) "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 issuer to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person.

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

(28) "Premium" means all sums charged, received, or deposited by a health issuer 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 issuer 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) "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) "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 eligible employees.

(31) “Substance use disorder services” means items, services and treatment for illness characterized by a physiological or psychological dependency, or both, on a controlled substance regulated under chapter 69.50 RCW and/or alcoholic beverages. It is further characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially impaired or endangered or his or her social or economic function is substantially disrupted. Any disorder defined by the plan as being or as not being a substance use disorder must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the DSM, the most current version of the ICD, or state guidelines).

(32) "Substitute drug" means a therapeutically equivalent substance as defined in chapter 69.41RCW.

(33) "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.

Sec. 2 WAC 284-170-200 Network access—General standards.

(1) An issuer must maintain each provider network for each health plan in a manner that is sufficient in numbers and types of providers and facilities to assure that, to the extent feasible based on the number and type of providers and facilities in the service area, all health plan services provided to enrollees will be accessible in a timely manner appropriate for the enrollee's condition. An issuer must demonstrate that for each health plan's defined service area, a comprehensive range of primary, specialty, institutional, and ancillary services are readily available without unreasonable delay to all enrollees and that emergency services are accessible twenty-four hours per day, seven days per week without unreasonable delay.

(2) Each enrollee must have adequate choice among health care providers, including those providers which must be included in the network under WAC **284-170-270**, and for qualified health plans and qualified stand-alone dental plans, under WAC **284-170-310**.

(3) An issuer's service area must not be created in a manner designed to discriminate or that results in discrimination against persons because of age, gender, gender identity, sexual orientation, disability, national origin, sex, family structure, ethnicity, race, health condition, employment status, or socioeconomic status.

(4) An issuer must establish sufficiency and adequacy of choice of providers based on the number and type of providers and facilities necessary within the service area for the plan to meet the access requirements set forth in this subchapter. Where an issuer establishes medical necessity or other prior authorization procedures, the issuer must ensure sufficient qualified staff is available to provide timely prior authorization decisions on an appropriate basis, without delays detrimental to the health of enrollees.

(5) In any case where the issuer has an absence of or an insufficient number or type of participating providers or facilities to provide a particular covered health care service, the issuer must ensure through referral by the primary care provider or otherwise that the enrollee obtains the covered service from a provider or facility within reasonable proximity of the enrollee at no greater cost to the enrollee than if the service were obtained from network providers and facilities. An issuer must satisfy this obligation even if an alternate access delivery request has been submitted and is pending commissioner approval.

An issuer may use facilities in neighboring service areas to satisfy a network access standard if one of the following types of facilities is not in the service area, or if the issuer can provide substantial evidence of good faith efforts on its part to contract with the facilities in the service area. Such evidence of good faith efforts to contract will include documentation about the efforts to contract but not the substantive contract terms offered by either the issuer or the facility. This applies to the following types of facilities:

(a) Tertiary hospitals;

(b) Pediatric community hospitals;

(c) Specialty or limited hospitals, such as burn units, rehabilitative hospitals, orthopedic hospitals, and cancer care hospitals;

(d) Neonatal intensive care units; and

(e) Facilities providing transplant services, including those that provide solid organ, bone marrow, and stem cell transplants.

(6) An issuer must establish and maintain adequate arrangements to ensure reasonable proximity of network providers and facilities to the business or personal residence of enrollees, and located so as to not result in unreasonable barriers to accessibility. Issuers must make reasonable efforts to include providers and facilities in networks in a manner that limits the amount of travel required to obtain covered benefits.

(7) A single case provider reimbursement agreement must be used only to address unique situations that typically occur out-of-network and out of service area,

where an enrollee requires services that extend beyond stabilization or one time urgent care. Single case provider reimbursement agreements must not be used to fill holes or gaps in the network and do not support a determination of network access.

(8) An issuer must disclose to enrollees that limitations or restrictions on access to participating providers and facilities may arise from the health service referral and authorization practices of the issuer. A description of the health plan's referral and authorization practices, including information about how to contact customer service for guidance, must be set forth as an introduction or preamble to the provider directory for a health plan. In the alternative, the description of referral and authorization practices may be included in the summary of benefits and explanation of coverage for the health plan.

(9) To provide adequate choice to enrollees who are American Indians/Alaska Natives, each health issuer must maintain arrangements that ensure that American Indians/Alaska Natives who are enrollees have access to covered medical and behavioral health services provided by Indian health care providers.

Issuers must ensure that such enrollees may obtain covered medical and behavioral health services from an Indian health care provider at no greater cost to the enrollee than if the service were obtained from network providers and facilities, even if the Indian health care provider is not a contracted provider. Issuers are not responsible for credentialing providers and facilities that are part of the Indian health system. Nothing in this subsection prohibits an issuer from limiting coverage to those health services that meet issuer standards for medical necessity, care management, and claims administration or from limiting payment to that amount payable if the health service were obtained from a network provider or facility.

(10) An issuer must have a demonstrable method and contracting strategy to ensure that contracting hospitals in a plan's service area have the capacity to serve the entire enrollee population based on normal utilization.

(11) At a minimum, an issuer's provider network must adequately provide for mental health and substance use disorder treatment, including behavioral health therapy. An issuer must include a sufficient number and type of mental health and

substance use disorder treatment providers and facilities within a service area based on normal enrollee utilization patterns.

(a) Adequate networks must include crisis intervention and stabilization, psychiatric inpatient hospital services, including voluntary psychiatric inpatient services, and services from mental health providers.

(b) There must be mental health providers of sufficient number and type to provide diagnosis and medically necessary treatment of conditions covered by the plan through providers acting within their scope of license and scope of competence established by education, training, and experience to diagnose and treat conditions found in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* or other recognized diagnostic manual or standard.

(c) An issuer must establish a reasonable standard for the number and geographic distribution of mental health providers who can treat serious mental illness of an adult and serious emotional disturbances of a child, taking into account the various types of mental health practitioners acting within the scope of their licensure.

The issuer must measure the adequacy of the mental health network against this standard at least twice a year, and submit an action plan with the commissioner if the standard is not met.

(d) Emergency mental health and substance use disorder services, including crisis intervention and crisis stabilization services, must be included in an issuer's provider network.

(e). <u>An issuer’s network standards for mental health and substance use disorder benefit providers and facilities must designate covered mental health and substance use disorder treatments or services as either primary or specialty care, and monitor the time to an appointment for the services in conformance with (13)(b)(iii) and (13 (c)(ii) of this section.</u>

(f) An issuer must ensure that an enrollee can identify information about mental health services and substance use disorder treatment including benefits, providers, coverage, and other relevant information by calling a customer service representative during normal business hours, using the issuer’s transparency tool developed pursuant to RCW 48.43.007 and referring to the network provider directory.

(12) The provider network must include preventive and wellness services, including chronic disease management and smoking cessation services as defined in RCW 48.43.005 (38) and WAC 284-43-5640 (9) and 284-43-5642 (9). If these services are provided through a quit-line or help-line, the issuer must ensure that when follow-up services are medically necessary, the enrollee will have access to sufficient information to access those services within the service area. Contracts with quit-line or help-line services are subject to the same conditions and terms as other provider contracts under this section.

(13) For the essential health benefits category of ambulatory patient services, as defined in WAC 284-43-5640 (1) and 284-43-5642 (1), an issuer's network is adequate if:

(a) The issuer establishes a network that affords enrollee access to urgent appointments without prior authorization within forty-eight hours, or with prior authorization, within ninety-six hours of the referring provider's referral.

(b) For primary care providers the following must be demonstrated:

(i) The ratio of primary care providers to enrollees within the issuer's service area as a whole meets or exceeds the average ratio for Washington state for the prior plan year;

(ii) The network includes such numbers and distribution that eighty percent of enrollees within the service area are within thirty miles of a sufficient number of primary care providers in an urban area and within sixty miles of a sufficient number of primary care providers in a rural area from either their residence or work; and

(iii) Enrollees have access to an appointment, for other than preventive services, with a primary care provider within ten business days of requesting one.

(c) For specialists:

(i) The issuer documents the distribution of specialists in the network for the service area in relation to the population distribution within the service area; and

(ii) The issuer establishes that when an enrollee is referred to a specialist, the enrollee has access to an appointment with such a specialist within fifteen business days for nonurgent services.

(d) For preventive care services, and periodic follow-up care including, but not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological or imaging monitoring for recurrence of disease, the issuer permits scheduling such services in advance, consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice.

(14) The network access requirements in this subchapter apply to stand-alone dental plans offered through the exchange or where a stand-alone dental plan is offered outside of the exchange for the purpose of providing the essential health benefit category of pediatric oral benefits. All such stand-alone dental plans must ensure that all covered services to enrollees will be accessible in a timely manner appropriate for the enrollee's conditions.

(a) An issuer of such stand-alone dental plans must demonstrate that, for the dental plan's defined service area, all services required under WAC 284-43-5700 (3) and 284-43-5702 (4), as appropriate, are available to all enrollees without unreasonable delay.

(b) Dental networks for pediatric oral services must be sufficient for the enrollee population in the service area based on expected utilization.

(15) Issuers must meet all requirements of this subsection for all provider networks. An alternate access delivery request under WAC 284-170-210 may be proposed only if:

(a) There are sufficient numbers and types of providers or facilities in the service area to meet the standards under this subchapter but the issuer is unable to contract with sufficient providers or facilities to meet the network standards in this subchapter; or

(b) An issuer's provider network has been previously approved under this section, and a provider or facility type subsequently becomes unavailable within a health plan's service area; or

(c) A county has a population that is fifty thousand or fewer, and the county is the sole service area for the plan, and the issuer chooses to propose an alternative access delivery system for that county; or

(d) A qualified health plan issuer is unable to meet the standards for inclusion of essential community providers, as provided under WAC 284-170-310 (3).

Sec. 3 WAC 284-170-260 Provider directories.

(1) For each health plan that uses a provider network, an issuer must make information about that network available to consumers and enrollees in the form of a provider directory that permits a user to search by provider name, provider type or provider specialty.

(a) Provider directories must be updated at least monthly. New or corrected information about the network, a facility or a provider in the network must be included if it was received within five business days of the issuer's regularly scheduled update. An issuer must establish procedures to confirm the accuracy of provider directory information and provide them and any associated records to the commissioner upon request for review and approval.

(b) An issuer must post the current provider directory for each health plan online, and must make a printed copy of the current directory available to an enrollee upon request as required under RCW 48.43.510 (1) (g).

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

(2) For each health plan, the associated provider directory must include the following information for each provider:

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

(b) 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;

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

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

(e) office address, phone number and where applicable, electronic mail address.

(3) An issuer must include in its electronic posting of a health plan's provider directory a notation of any primary care, chiropractor, women's health care provider, mental health and substance use disorder provider or pediatrician whose practice is closed to new patients.

(4) If an issuer maintains more than one provider network, its posted provider directory or directories must make it reasonably clear to an enrollee which network applies to which health plan. Each directory must include all network providers for that network. If an issuer uses a subcontracted network, the providers from the subcontracted network may not be listed in a separate directory.

(5) Information about any available telemedicine services must be included and specifically described.

(6) A version of the directory must be offered to accommodate individuals with limited-English proficiency or disabilities. Information about any available interpreter services, communication and language assistance services, and accessibility of the physical facility must be identified in the directory, and the mechanism by which an enrollee may access such services.

(7) An issuer must include information about the network status of emergency providers as required by WAC 284-170-370.

Sec 4. NEW SECTION WAC 284-170-285 Mental Health and Substance Use Disorder Web page Model Format and Required Content

(1) Not later than January 1, 2020, an issuer must establish and maintain a web page entitled Important Mental Health and Substance Use Disorder Treatment Information that complies with the requirements in this section. A member must be able to link to the web page from their landing page if the issuer provides members with a portal. If an issuer does not provide members with a personal electronic portal, the issuer must place a link to the web page above the fold on the health plan's network information page.

(2) The information on the web page must also be available through the issuer's transparency tool(s) developed pursuant to RCW 48.43.007.

(3) By June 30 of each year, the commissioner shall post a report identifying, by issuer, the number of consumer complaints asserting that an inability to access mental health or substance use disorder services within 10 business days for primary care and 15 business days for specialty care, filed with the commissioner during the prior calendar year. An issuer's Important Mental Health & Substance Use Disorder Treatment Information webpage must include a link to this report, and must update

the link to the report not later than 30 calendar days after the commissioner posts the report.

(4) The web page must contain accurate information explaining the following information, based on the health plan network's standards for mental health and substance use disorder treatment and services:

(a) How an enrollee can find in-network mental health and substance use disorder treatment and services in their service area

(b) What an enrollee may do if covered services are not available in their service area or the enrollee cannot obtain an appointment from an in-network provider within ten business days for mental health and substance use disorder services covered as primary care and fifteen business days for those covered as specialty care.

(c) A chart of the health plan's covered mental health and substance use disorder treatment services identifying which services are covered as primary care services. The chart must have a banner stating that if a mental health or substance use disorder service is not listed as a primary care service, the enrollee's must be able to access a provider to schedule an appointment within 15 business days from an in-network provider, and that if the service is listed as a primary care service, the enrollee must be able to access a provider to schedule an appointment within 10 business days from an in-network provider.

(5) The web page must contain a section that explains what to do if the enrollee or their dependent is experiencing a mental health or substance use disorder emergency or crisis. The section must include links to the National Suicide Prevention hotline and other resources within the member's service area, and within Washington State to provide support and services for mental health or substance use disorder emergencies or crisis. This section must be above the fold and visually prominent.

(6) If the commissioner has disciplined the issuer for violating the network standards set forth in chapter 284-170 WAC or title 48.43 RCW, with regard to mental health or substance use disorder treatment and services within the prior calendar year, the

issuer must post a link to each order of enforcement or disciplinary action posted on the commissioner's website within 30 days of receipt of the order.

(a) An issuer may remove a link when the order is one year old or when the corrective action plan associated with the order has been completed, whichever occurs last. A market conduct continuum is not a disciplinary action for purposes of this section.

(b) An issuer may include an explanation of the actions it has taken to address the enforcement or disciplinary action.

(c) The information about disciplinary action may be posted below the fold on the webpage.

(7) The webpage must contain a section titled "How to File a Complaint with the OIC" and refer users to the OIC complaint form at https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status or the commissioner's toll-free insurance consumer hotline at 1-800-562-6900. This information may appear below the fold of the webpage.

(8) The commissioner may review the web page for accuracy and conformance with the requirements of this section when an enrollee complaint is received about access to mental health or substance use disorder services, or as the commissioner deems necessary to ensure the issuer is in compliance with the requirements of this chapter.

(9) Navigation to other webpages from this web page must be near the top of the page, unless the navigation is through a link within the page copy. Navigation from the page may be no more than three levels deep. An issuer may include its logo and identifying information on the webpage.