

Chapter 284-46 WAC
HEALTH MAINTENANCE ORGANIZATIONS

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WAC

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DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

284-46-010	Assessments for examination costs. [Statutory Authority: RCW 48.46.200. WSR 84-08-002 (Order R 84-2), § 284-46-010, filed 3/22/84.] Repealed by WSR 91-07-053 (Order R 91-1), filed 3/19/91, effective 4/19/91. Statutory Authority: RCW 48.02.060.
284-46-020	Form for reporting number of persons entitled to services. [Statutory Authority: RCW 48.46.200. WSR 84-08-002 (Order R 84-2), § 284-46-020, filed 3/22/84.] Repealed by WSR 98-04-005 (Matter No. R 97-3), filed 1/22/98, effective 2/22/98. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243.
284-46-060	Requirement to file annual statement—Form of annual statement—Requirement to file quarterly statements—Authority to require filing of monthly financial statements—Compliance with NAIC instructions required. [Statutory Authority: RCW 48.02.060(3) and 48.46.200. WSR 92-22-094 (Order R 92-19), § 284-46-060, filed 11/3/92, effective 12/4/92.] Repealed by WSR 96-17-079 (Matter No. R 95-18), filed 8/21/96, effective 9/21/96. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200.
284-46-575	Participating provider contracts. [Statutory Authority: RCW 48.46.200, 48.46.243 and 48.02.060. WSR 92-09-044A (Order R 92-3), § 284-46-575, filed 4/10/92, effective 5/11/92.] Repealed by WSR 98-04-005 (Matter No. R 97-3), filed 1/22/98, effective 2/22/98. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243.

WAC 284-46-015 Discretionary clauses prohibited. (1) No contract may contain a discretionary clause. "Discretionary clause" means a provision that purports to reserve discretion to a health maintenance organization, its agents, officers, employees, or designees in interpreting the terms of a contract or deciding eligibility for benefits, or requires deference to such interpretations or decisions, including a provision that provides for any of the following results:

(a) That the carrier's interpretation of the terms of the contract is binding;

(b) That the carrier's decision regarding eligibility or continued receipt of benefits is binding;

(c) That the carrier's decision to deny, modify, reduce or terminate payment, coverage, authorization, or provision of health care service or benefits, is binding;

(d) That there is no appeal or judicial remedy from a denial of a claim;

(e) That deference must be given to the carrier's interpretation of the contract or claim decision; and

(f) That the standard of review of a carrier's interpretation of the contract or claim decision is other than a de novo review.

(2) Nothing in this section prohibits a carrier from including a provision in a contract that informs an insured that as part of its routine operations the carrier applies the terms of its contracts for making decisions, including making determination regarding eligibility, receipt of benefits and claims, or explaining its policies, procedures, and processes.

[Statutory Authority: RCW 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.200, 48.02.060, 48.18.110, 48.44.020, and 48.46.060. WSR 09-16-128 (Matter No. R 2008-25), § 284-46-015, filed 8/5/09, effective 9/5/09.]

WAC 284-46-025 General contents of all rate or forms of contract filings. Each filing made of a rate or contract form shall be submitted with the filing transmittal form prescribed by and available from the commissioner. Use of a standardized transmittal form makes it easier for the commissioner to identify filings, issuers, and other important identifying information; permits more efficient tracking of filings; and makes it less difficult to provide status reports of filings to persons outside the office. The form will include the name of the filing entity, its address, identification number, the type of filing being submitted, the form name or group name and number, and other relevant information.

[Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.18.100, 48.19.040, 48.19.050, 48.19.070, 48.20.012, 48.21.045(2), 48.29.140, 48.43.055, 48.44.023(2), 48.44.040, 48.44.070, 48.46.030, 48.46.060, 48.46.066(2), 48.46.243, 48.96.025, 48.102.020. WSR 96-11-004 (Matter No. R 96-1), § 284-46-025, filed 5/2/96, effective 6/2/96.]

WAC 284-46-100 PKU formula coverage requirements. (1) The purpose of this section is to effectuate the provisions of section 4, chapter 173, Laws of 1988, by establishing the requirements with respect to coverage for the formulas necessary for the treatment of phenylketonuria (PKU), applicable to health maintenance organizations.

(2) Any agreement for health care services delivered or issued for delivery or renewed in this state on or after September 1, 1988, shall provide coverage for the formulas necessary for the treatment of phenylketonuria, subject to the following exceptions:

(a) A contract that is subject to chapter 48.66 RCW and provides medicare supplemental insurance need not provide the PKU formula coverage;

(b) A contract that is subject to chapter 48.84 RCW and provides long-term care insurance need not provide the PKU formula coverage;

(c) A contract that is governed by 5 U.S.C. chapter 89 or 42 U.S.C. section 1395mm need not provide the PKU formula coverage; and

(d) In response to the written request of a health maintenance organization, other contracts may exclude coverage for the PKU formula with the written consent of the commissioner upon a finding that such coverage would be inappropriate.

(3) The amount charged by a health maintenance organization shall be no greater to a family or individual receiving benefits under the PKU formula coverage, by reason thereof, than to a family or individual under the same agreement form or group agreement who is not receiving such benefits.

(4) Preexisting condition provisions shall not be used with respect to PKU formula coverage, and no health maintenance organization shall cancel or decline to renew any contract, or restrict, modify, exclude, or reduce the amount of benefits payable or type of coverage provided in any contract, because an applicant or covered person has phenylketonuria.

(5) For purposes of section 4, chapter 173, Laws of 1988, and this section, an agreement is "renewed" when it is continued beyond the earliest date after September 1, 1988, upon which, at the health maintenance organization's sole option:

(a) The agreement's termination could have been effectuated, for other than nonpayment of premium; or

(b) The agreement could have been amended to add the PKU formula coverage, with, if justified, an appropriate rate increase for any increased cost in providing the PKU formula coverage under the contract.

The failure of the organization to take any such steps does not prevent the agreement from being "renewed." The intent of this subsection is to bring the PKU formula coverage under the maximum number of agreements possible at the earliest possible time, by permitting the health maintenance organization to exclude such coverage from only those agreements as to which there exists a right of renewal on the part of an enrollee without any change in any provision of the agreement.

(6) Coverage for the formulas may be made subject to deductibles, copayments, coinsurance or other reductions only to the extent that such deductibles, copayments, coinsurance or other reductions do not exceed those applicable to common sicknesses or disorders in the particular contract.

[Statutory Authority: RCW 48.02.060 (3)(a), 48.44.050 and 48.46.200. WSR 88-16-065 (Order R 88-7), § 284-46-100, filed 8/1/88.]

WAC 284-46-110 Mammography coverage. (1) The purpose of this regulation is to effectuate the provisions of RCW 48.43.076, by requiring coverage and prohibiting cost-sharing for certain types of mammography services.

(2) Except as provided in subsection (3) of this section, for nongrandfathered health plans issued or renewed on or after January 1, 2024, that include coverage of supplemental and diagnostic breast examinations, health carriers may not impose cost-sharing for such examinations.

(3) For a health plan that provides coverage of supplemental and diagnostic breast examinations and is offered as a qualifying health plan for a health savings account, the health carrier shall establish the plan's cost-sharing for the coverage of the services described in this section at the minimum level necessary to preserve the enrollee's ability to claim tax exempt contributions from their health savings account under Internal Revenue Service laws and regulations.

(4) For purposes of this section:

(a) "Diagnostic breast examination" means a medically necessary and appropriate examination of the breast, as defined in RCW 48.43.076. Diagnostic breast examinations are used to evaluate an abnormality either seen or suspected from a breast cancer screening examination, or detected by another means of examination.

(b) "Supplemental breast examination" has the meaning set forth in RCW 48.43.076.

(5) Coverage of mammograms may be subject to standard contract provisions, other than the cost-sharing provisions prohibited by RCW 48.43.076, which may be applicable to other diagnostic X-ray benefits.

[Statutory Authority: RCW 48.02.060, 48.43.735, 48.44.050, 48.46.200, 48.200.040, and 48.200.900. WSR 23-24-034 (Matter R 2023-07), § 284-46-110, filed 11/30/23, effective 1/1/24.]

WAC 284-46-500 Alternative care—General rules as to minimum standards. (1) As an alternative to hospitalization or institutionalization of an insured and with the intent to cover placement of the insured patient in the most appropriate and cost-effective setting, every individual or group agreement of a health maintenance organization issued, amended, or renewed on or after January 1, 1995, which provides coverage for hospitalization or other institutional expenses to a resident of this state shall include substitution of home health care, provided in lieu of hospitalization or other institutional care by home health, hospice and home care agencies licensed under chapter 70.127 RCW at equal or lesser cost, or by employees of the health maintenance organization.

(2) In addition, such expenses may include coverage for durable medical equipment which permits the insured to stay at home, care provided in Alzheimer's centers, adult family homes, assisted living facilities, congregate care facilities, adult day health care, home health, hospice, or home care, or similar alternative care arrangements which provide necessary care in less restrictive or less expensive environments.

(3) Substitution of less expensive or less intensive services shall be made only with the consent of the insured and upon the recommendation of the insured's attending physician or licensed health care provider that such services will adequately meet the insured patient's needs. The decision to substitute less expensive or less intensive services shall be determined based on the medical needs of the individual insured patient.

(4) A health maintenance organization may require that home health agencies or similar alternative care providers have written treatment plans which are approved by the insured patient's attending physician or other licensed health care provider.

(5) Coverage may be limited to no less than the maximum benefits which would be payable for hospital or other institutional expenses under the agreement, and may include all deductibles and coinsurances which would be payable by the insured under the hospital or other institutional expense coverage of the insured's agreement.

(6) This section shall not apply to long-term care or medicare supplement insurance contracts. This section shall not apply to guaranteed renewable agreements issued prior to January 1, 1995.

[Statutory Authority: RCW 48.01.030, 48.02.060, 48.44.050, 48.44.020, 48.46.200 and 48.46.060. WSR 94-19-015 (Order R 94-16), § 284-46-500, filed 9/9/94, effective 10/10/94.]

WAC 284-46-506 Temporomandibular joint disorders—Specified offer of coverage required—Terms of specified offer defined—Proof of offer must be maintained—Discrimination prohibited—Terms defined.

(1) Pursuant to RCW 48.46.530, each offer of new or renewal group and individual coverage made on or after January 1, 1993, must include one or more offers of optional coverage for the treatment of temporoman-

dibular joint disorders. Health maintenance organizations are encouraged to exercise broad flexibility in designing benefits for these optional temporomandibular joint disorder coverage offerings. However, compliance with the statute shall be demonstrated only when one of the optional temporomandibular joint disorder coverage offerings provides benefits as follows:

(a) Offers limited to only medical coverage shall provide coverage for medical services related to the treatment of temporomandibular joint disorders in the amount of one thousand dollars per covered individual, after the application of deductibles, coinsurance, and copayments, in any calendar year, and a lifetime benefit of five thousand dollars per covered individual, after the application of deductibles, coinsurance, and copayments. Other than the benefit amount, coverage for medical services shall be the same as are generally provided in the health maintenance agreement for other injuries or musculoskeletal disorders. The coverage provisions may require:

(i) That services either be rendered or referred by the covered individual's primary care physician; and

(ii) A second opinion, provided that the covered individual shall not be financially responsible for any costs relating to this second opinion and that such costs shall be in excess of the required benefit levels; and

(iii) Prenotification or preauthorization.

Except that the coverage provisions shall not require either a second opinion or prenotification or preauthorization for treatment commencing within forty-eight hours, or as soon as is reasonably possible, after the occurrence of an accident or trauma to the temporomandibular joint.

(b) Offers of both medical and dental coverage shall provide coverage for medical and dental services related to the treatment of temporomandibular joint disorders in the amount of one thousand dollars per covered individual, after the application of deductibles, coinsurance, and copayments, in any calendar year and a lifetime benefit of five thousand dollars per covered individual, after the application of deductibles, coinsurance, and copayments. Other than the benefit amount, coverage for medical and dental services shall be the same as are generally provided in the health maintenance agreement for other injuries, musculoskeletal disorders, or dental conditions. The coverage provisions may require:

(i) That services either be rendered or referred by the covered individual's primary care physician or dentist; and

(ii) A second opinion, provided that the covered individual shall not be financially responsible for any costs relating to this second opinion and that such costs shall be in excess of the required benefit levels; and

(iii) Prenotification or preauthorization.

Except that the coverage provisions shall not require either a second opinion or prenotification or preauthorization for treatment commencing within forty-eight hours or as soon as is reasonably possible, after the occurrence of an accident or trauma to the temporomandibular joint. This subsection applies only in those cases where the offeree has accepted any coverage.

(2) Offers of the optional coverage required by subsection (1) of this section shall be included on the health maintenance organization's application form(s) and retained by the health maintenance organization for five years or until the completion of the next examination of the health maintenance organization by the insurance commissioner, whichever occurs first. In those cases where there is no written application form, the health maintenance organization shall retain other written evidence of the offer of this optional coverage for temporomandibular joint disorders for the same period of time as required for application forms. This subsection applies only in those cases where the offeree has accepted any coverage.

(3) With respect to coverage of disorders of the temporomandibular joint, health maintenance organizations shall not engage in discriminatory practices against persons submitting claims for that coverage, nor shall they engage in discriminatory practices against licensed health care providers providing services within the scope of their licensure, for the treatment of disorders of the temporomandibular joint. This shall not prejudice the ability of the health maintenance organization to limit its coverage to its participating providers.

(4) For the purposes of the optional coverage for disorders of the temporomandibular joint required by subsections (1) through (3) of this section, the following definitions shall apply and shall be contained in the coverage contract:

(a) "Temporomandibular joint disorders" shall include those disorders which have one or more of the following characteristics: Pain in the musculature associated with the temporomandibular joint, internal derangements of the temporomandibular joint, arthritic problems with the temporomandibular joint, or an abnormal range of motion or limitation of motion of the temporomandibular joint.

(b) "Medical services" are those which are:

(i) Reasonable and appropriate for the treatment of a disorder of the temporomandibular joint, under all the factual circumstances of the case; and

(ii) Effective for the control or elimination of one or more of the following, caused by a disorder of the temporomandibular joint: Pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food; and

(iii) Recognized as effective, according to the professional standards of good medical practice; and

(iv) Not experimental or primarily for cosmetic purposes.

(c) "Dental services" are those which are:

(i) Reasonable and appropriate for the treatment of a disorder of the temporomandibular joint, under all the factual circumstances of the case; and

(ii) Effective for the control or elimination of one or more of the following, caused by a disorder of the temporomandibular joint: Pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food; and

(iii) Recognized as effective, according to the professional standards of good dental practice; and

(iv) Not experimental or primarily for cosmetic purposes.

(5) The requirements listed in the preceding subparagraphs of this section do not apply to those health maintenance agreements exempted by RCW 48.46.066 or 48.46.530(3), or other applicable law.

[Statutory Authority: RCW 48.46.530, 48.02.060 (3)(a) and 48.46.200. WSR 92-24-044 (Order R 92-22), § 284-46-506, filed 11/25/92, effective 12/26/92.]

WAC 284-46-507 Experimental and investigational prescriptions, treatments, procedures, or services—Definition required—Standard for definition—Written notice of denial required—Appeal process required.

(1) Every health maintenance agreement which excludes or limits, or reserves the right to exclude or limit, benefits for any treatment, procedure, facility, equipment, drug, drug usage, medical device, or

supply (hereinafter individually and collectively referred to as services) for one or more medical condition or illness because such services are deemed to be experimental or investigational must include within the agreement and any certificate of coverage issued thereunder, a definition of experimental or investigational.

(2) The definition of experimental or investigational services must include an identification of the authority or authorities which will make a determination of which services will be considered to be experimental or investigational. If the health maintenance organization specifies that it, or an affiliated entity, is the authority making the determination, the criteria it will utilize to determine whether a service is experimental or investigational must be set forth in the agreement and any certificate of coverage issued thereunder. As an example, and not by way of limitation, the requirement to set forth criteria in the agreement or any certificate of coverage thereunder may be satisfied by using one or more of the following statements, or other similar statements:

(a) "In determining whether services are experimental or investigational, the plan will consider whether the services are in general use in the medical community in the state of Washington, whether the services are under continued scientific testing and research, whether the services show a demonstrable benefit for a particular illness or disease, and whether they are proven to be safe and efficacious."

(b) "In determining whether services are experimental or investigational, the plan will consider whether the services result in greater benefits for a particular illness or disease than other generally available services, and do not pose a significant risk to health or safety of the patient."

The supporting documentation upon which the criteria are established must be made available for inspection upon written request in all instances and may not be withheld as proprietary.

(3) Every health maintenance organization that denies a request for benefits or that refuses to approve a request to preauthorize services, whether made in writing or through other claim presentation or preauthorization procedures set out in the agreement and any certificate of coverage thereunder, because of an experimental or investigational exclusion or limitation, must do so in writing within twenty working days of receipt of a fully documented request. The health maintenance organization may extend the review period beyond twenty days only with the informed written consent of the covered individual. The denial letter must identify by name and job title the individual making the decision and fully disclose:

(a) The basis for the denial of benefits or refusal to preauthorize services;

(b) The procedure through which the decision to deny benefits or to refuse to preauthorize services may be appealed;

(c) What information the appellant is required to submit with the appeal; and

(d) The specific time period within which the company will reconsider its decision.

(4)(a) Every health maintenance organization must establish a reasonable procedure under which denials of benefits or refusals to preauthorize services because of an experimental or investigational exclusion or limitation may be appealed. The appeals procedure may be considered reasonable if it provides that:

(i) A final determination must be made and provided to the appellant in writing within twenty working days of receipt of the fully

documented appeal. The health maintenance organization may extend the review period beyond twenty days only with the informed written consent of the covered individual;

(ii) The appeal must be reviewed by a person or persons qualified by reasons of training, experience and medical expertise to evaluate it; and

(iii) The appeal must be reviewed by a person or persons other than the person or persons making the initial decision to deny benefits or to refuse to preauthorize services.

(b) When the initial decision to deny benefits or to refuse to preauthorize services is upheld upon appeal, the written notice shall set forth:

(i) The basis for the denial of benefits or refusal to preauthorize services; and

(ii) The name and professional qualifications of the person or persons reviewing the appeal.

(c) Disclosure of the existence of an appeal procedure shall be made by the health maintenance organization in each agreement and any certificate of coverage issued thereunder which contains an experimental or investigational exclusion or limitations.

(5) Whenever a covered person appeals the decision of the health maintenance organization and delay would jeopardize the covered person's life or health, the health maintenance organization must follow the appeal procedures and time frames in WAC 284-43-4040(2).

[Statutory Authority: RCW 48.02.060. WSR 16-14-106 (Matter No. R 2016-11), § 284-46-507, filed 7/6/16, effective 8/6/16. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.43.055, 48.44.050, 48.46.100 and 48.46.200. WSR 99-24-075 (Matter No. R 98-17), § 284-46-507, filed 11/29/99, effective 12/30/99. Statutory Authority: RCW 48.02.060 (3)(a) and 48.46.200. WSR 92-21-098 (Order 92-14), § 284-46-507, filed 10/21/92, effective 11/21/92.]