

COURT OF APPEALS  
STATE OF WASHINGTON  
2017 DEC 01 10 03 35

NO. 68726-3-I

IN THE COURT OF APPEALS  
OF THE STATE OF WASHINGTON  
DIVISION I

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PREMERA BLUE CROSS and  
LIFEWISE OF WASHINGTON,

Petitioners-Defendants,

v.

A.G., by and through his parents, J.G. and K.G.,  
on his own behalf and on behalf of  
all similarly situated individuals,

Respondent-Plaintiff.

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**RESPONDENT'S STATEMENT OF ADDITIONAL AUTHORITY  
IN OPPOSITION TO MOTION FOR DISCRETIONARY REVIEW**

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ORIGINAL

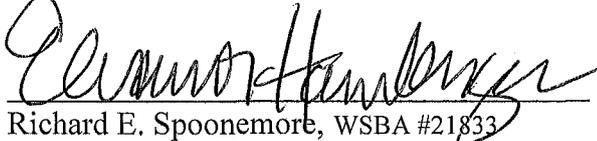
On December 20, 2012, the Office of the Insurance Commissioner issued a revised draft of proposed rulemaking regarding coverage of Essential Health Benefits. That draft is attached as Appendix 1 and provides in pertinent part:

When habilitative services are delivered to treat a mental health diagnosis categorized in the most recent version of the DSM, the mental health parity requirements apply and supersede any rehabilitative services parity limitations permitted by this subsection.

Appendix A, p. 17. The draft rule also defines “habilitative services” to include “speech therapy, occupational therapy, physical therapy and aural therapy.” *Id.* p. 18.

DATED: December 31, 2012.

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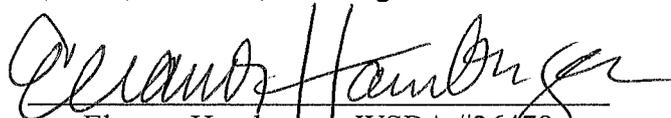
**CERTIFICATE OF SERVICE**

I certify, under penalty of perjury under the laws of the State of Washington, that on December 31, 2012, a true copy of the foregoing RESPONDENT'S STATEMENT OF ADDITIONAL AUTHORITY IN OPPOSITION TO MOTION FOR DISCRETIONARY REVIEW was served upon counsel as indicated below:

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DATED: December 31, 2012, at Seattle, Washington.

  
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# Appendix A

**From:** King, Adriana (OIC)  
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**Subject:** Essential Health Benefits Exposure draft  
**Date:** Thursday, December 20, 2012 4:39:14 PM  
**Attachments:** Exposure Draft 12-20-12.doc.doc

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*Sent on behalf of Meg Jones:*

A new exposure draft is attached for your review and comment. Please remember that we hope to file the substitute CR102 with new text on January 2, 2012. In order to finish our work internally, I need your thoughts/reactions to this draft not later than December 28, 2012.

Don't worry if you can't get comments to me before then. The public comment period applies to this next filing, and there will be a public hearing as well. All comments received before the end of the date of the public hearing will be carefully considered. If you testify at the hearing, you do not need to reiterate your comments in writing in order for them to be considered.

As always, call or email with questions you may have.

Meg

**Meg Jones**

Policy & Rules Manager

Policy & Legislative Affairs

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## Essential Health Benefits subchapter

### NEW SECTION

**WAC 284-43-849**                      **Purpose and scope**      For plan years beginning on or after January 1, 2014, each nongrandfathered health benefit plan offered, issued, amended or renewed to small employers or individuals, both inside and outside the Washington health benefit exchange, must provide coverage for a package of essential health benefits, pursuant to RCW 48.43.715. This subchapter explains the regulatory standards related to this coverage, establishes supplementation of the base-benchmark plan, consistent with PPACA and RCW 48.43.715, and the final parameters for the state EHB-benchmark plan.

(1) This subchapter does not apply to a health benefit plan that provides excepted benefits as described in Section 2722 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-21), or a health benefit plan that qualifies as a grandfathered health plan as defined in RCW 48.43.005.

(2) This subchapter does not require provider reimbursement at the same level negotiated by the base-benchmark plan's issuer for their plan.

(3) This subchapter does not require a plan to exclude the services or treatments from coverage that are excluded in the base-benchmark plan.

### NEW SECTION

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

"Base-benchmark plan" means the small group plan with the largest enrollment, as designated in WAC 284-43-850(1), prior to any adjustments made pursuant to RCW 48.43.715.

"EHB-benchmark plan" means the standardized set of essential health benefits that must be met by a qualified health plan offered through the health benefit exchange or by an

issuer in the individual or small group market in Washington state.

"Health benefit" unless defined differently pursuant to federal rules, regulations or guidance issued pursuant to Section 1302(b) of PPACA, means coverage for health care items or services for injury, disease, or a health condition, including a behavioral health condition.

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

"Mandated benefit" and "required benefit" means a specific type of care, treatment or service, device or medical equipment that is required by either state or federal law. Required benefits do not include provider, definition, delivery method or health status based requirements.

"Meaningful health benefit" means a benefit that must be included in an essential health benefit category in order for the category to reasonably provide medically necessary services for an individual patient's condition on a non-discriminatory basis.

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

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

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

"Small group plan" includes any nongrandfathered health benefit plan offered, issued, amended or renewed by an admitted issuer in the state of Washington for the small group health benefit plan market to a small group, as defined in RCW 48.43.005, unless the certificate of coverage is issued to a small group pursuant to a master contract held by or

issued through an organization meeting the definition established in 45 CFR 144.103, and sections 3(5) and 3(40) of the Employee Retirement Income Security Act of 1974(29 USC 1001 et seq.).

"Stand-alone dental plan" means coverage for a set of benefits limited to oral care including, but not necessarily limited to, pediatric oral care, as referenced in RCW 43.71.065.

NEW SECTION

**WAC 284-43-860**

**Medical Necessity Determination**

(1) An issuer's certificate of coverage and the Summary of Coverage and Explanation of Benefits for the health plan must specifically explain any uniformly applied limitation on the scope, visit number or duration of a benefit, and state whether the uniform limitation is subject to adjustment based on the specific treatment requirements of the patient.

(2) An issuer's medical necessity determination process must:

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

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

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

(d) Ensure that when the interpretation of the medical purpose of interventions is part of the medical necessity decision-making, the interpretation standard can be explained in writing to an enrollee and providers, and is broad enough to address any of the services encompassed in the ten essential health benefits categories of care;

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

(f) Include consideration of the treating provider's clinical judgment and recommendations regarding the medical purpose of the requested service, and the extent to which the service is likely to produce incremental health benefits for the enrollee.

(4) An issuer's medical necessity determination process may include, but is not limited to, evaluation of the effectiveness and benefit of a service for the individual patient based on scientific evidence considerations, up-to-date and consistent professional standards of care, convincing expert opinion and a comparison to alternative interventions, including no interventions. Cost effectiveness may be criteria for determining medical necessity if it is not limited to lowest price.

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

#### NEW SECTION

**WAC 284-43-877 Plan Design** (1) A nongrandfathered individual or small group health benefit plan issued, renewed, amended, or offered on or after January 1, 2014, must provide coverage that is substantially equal to the EHB benchmark package, as described in WACs 284-43-878 and 284-43-879.

(a) For plans offered, issued, amended or renewed for a plan or policy year beginning on or after January 1, 2014, until January 31, 2014, an issuer must offer the EHB-benchmark plan without substituting benefits for those specifically identified in the EHB-benchmark plan.

(b) For plan or policy years beginning on or after January 1, 2015, an issuer may substitute benefits to the extent that the benefits are substantially equal to the EHB-benchmark plan.

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

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

(ii) The aggregate value of the benefits across all essential health benefit categories does not vary more than a de minimus aggregate value of the EHB-benchmark base plan; and

(iii) Within each essential health benefit category, the actuarial value of the category must not vary more than a de minimus amount from the actuarial value of the category for the EHB-benchmark plan.

(2) A carrier must classify covered services to an essential health benefits category consistent with WAC 284-43-878 and WAC 284-43-879 for purposes of determining actuarial value. An issuer may not use classification of services to an essential health benefits category for purposes of determining actuarial value as the basis for denying coverage under a health benefit plan.

(3) The base-benchmark plan does not specifically list all types of services, settings and supplies that can be classified to each essential health benefits category. Coverage for benefits that are not specifically listed in the base-benchmark plan document is determined under that plan based on medical necessity. For this reason, the plan document does not list each and every service, supply or covered benefit. An issuer may design its plan in this way and comply with the EHB-benchmark plan package requirements if each of the essential health benefit package categories is covered.

(4) An issuer is not required to exclude services excluded by the base-benchmark plan, but must not include those services as part of its calculation of actuarial value for a category to which those services are classified. A plan may not exclude a benefit that is specifically included in the base-benchmark plan.

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

(6) Telemedicine or telehealth services are considered provider services, and not a benefit for purposes of the essential health benefits package.

(7) Consistent with state and federal law, a health benefit plan must not contain an exclusion that unreasonably restricts access to medically necessary services for populations with special needs, including but not limited to a chronic condition caused by illness or injury, either acquired or congenital.

(8) Unless an age based reference limitation is specifically included in the base-benchmark plan or supplemental base-benchmark plan for a category set forth in WAC 284-43-878, a carrier's scope of coverage for those categories of benefits must cover both pediatric and adult populations.

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

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

(b) The benefits within an essential health benefit category are limited so that the coverage for the category is not a meaningful benefit; or

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

(10) An issuer must not impose annual or lifetime dollar limits on an essential health benefit, other than those permitted as reference based limitations pursuant to WAC 284-43-878 and 284-43-879.

#### NEW SECTION

#### **WAC 284-43-878**

#### **Essential Health Benefit Package Categories**

(1) A health benefit plan must cover "**ambulatory patient services.**" For purposes of determining a plan's actuarial value, an issuer must classify medically necessary services delivered to enrollees in settings other than a hospital or skilled nursing facility, which are generally recognized and accepted for diagnostic or therapeutic purposes to treat illness or injury, in a substantially equivalent manner to the base-benchmark plan as ambulatory patient services.

(a) A health benefit plan must include the following services, which are specifically covered by the base-benchmark plan, and classify them as ambulatory patient services:

(i) Home and out-patient dialysis services;

(ii) Hospice and Home health care, including skilled nursing care as an alternative to hospitalization, consistent with WAC 284-44-500, 284-46-500, and 284-96-500;

(iii) Provider office visits and treatments, and associated supplies and services, including

therapeutic injections and related supplies;

(iv) Urgent care center visits, including provider services, facility costs and supplies; and

(v) Ambulatory surgical center professional services, including anesthesiologist, assistant surgeon and surgeon services, surgical supplies and facility costs;

(vi) Diagnostic procedures including colonoscopies, cardiovascular testing, pulmonary function studies and neurology/neuromuscular procedures;

(vii) Provider contraceptive services and supplies, including but not limited to vasectomy, tubal ligation and insertion of IUD or Norplant, or extraction of FDA-approved contraceptive devices.

(b) A health benefit plan may include, but is not required to include the following services as part of the EHB-benchmark package. These services are specifically excluded by the base-benchmark plan, and should not be included in establishing actuarial value for this category.

(i) Infertility treatment and reversal of voluntary sterilization

(ii) Routine foot care for those that are not diabetic

(iii) Coverage of dental services following injury to sound natural teeth, but not excluding services or appliances necessary for or resulting from medical treatment if the service is (a) emergency in nature or (b) requires extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease. Oral surgery related to trauma and injury must be covered.

(iv) Private duty nursing for hospice care and home health care, to the extent consistent with state and federal law;

(v) Adult dental care and orthodontia delivered by a dentist or in a dentist's office;

(vi) Non-skilled care and help with activities of daily living;

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

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

(c) The base-benchmark base plan's establishes specific limitations on services classified

to the ambulatory patient services category that conflict with state or federal law as of January 1, 2014. The base-benchmark plan limits nutritional counseling to three visits per lifetime, if the benefit is not associated with diabetes management. This lifetime limitation for nutritional counseling is not part of the state EHB-benchmark plan. An issuer may limit this service based on medical necessity, and may establish an additional reasonable visit limitation requirement for nutritional counseling for medical conditions when supported by evidence based medical criteria.

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

- (i) 10 spinal manipulation services without referral
- (ii) 12 acupuncture services per year without referral
- (iii) 1 vision examination for adults per calendar year, with \$150 per year for hardware, including frames, contacts, lenses and tints
- (iv) 14 days respite care on either an inpatient or outpatient basis for hospice patients, per lifetime.

(v) 130 visits per year for home health care;

(e) State benefit requirements classified to this category are:

- (i) Chiropractic care (RCW 48.20.412, 48.21.142 and 48.44.310,);
- (ii) TMJ disorder treatment (RCW 48.21.320; 48.44.460, and 48.46.530);
- (iii) Diabetes-related care, exclusive of those supplies or prescribed drugs, medications and therapies covered under other categories (RCW 48.20.391; 48.21.143; 48.44.315; 48.46.272).

(2) A health benefit plan must cover "**emergency medical services.**" For purposes of determining a plan's actuarial value, an issuer must classify care and services related to an emergency medical condition to the emergency medical services category. (a) A health benefit plan must include the following services, which are specifically covered by the base-benchmark plan, and classify them as emergency services:

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

(ii) Emergency room based services, supplies and treatment, including professional charges, and outpatient charges for patient observation and medical screening exams required to stabilize a patient experiencing an emergency medical condition;

(iii) Prescription medications associated with an emergency medical condition, including those purchased in a foreign country.

(b) The base-benchmark plan does not exclude services classified to the emergency medical care category.

(c) The base-benchmark base plan does not establish specific limitations on services classified to the emergency medical services category that conflict with state or federal law as of January 1, 2014.

(d) The base-benchmark plan does not establish visit limitations on services in this category.

(e) State benefit requirements covered under this category include services necessary to screen and stabilize a covered person (RCW 48.43.093).

(3) A health benefit plan must cover "**hospitalization**" For purposes of determining a plan's actuarial value, an issuer must classify medically necessary medical services delivered in a hospital or skilled nursing setting, including but not limited to professional services, facility fees, supplies, laboratory, therapy or other types of services delivered on an inpatient basis, in a manner substantially equivalent to the base-benchmark plan as hospitalization services.

(a) A health benefit plan must include the following services, which are specifically covered by the base-benchmark plan, and classify them as hospitalization services:

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

(ii) Skilled nursing facility costs, including professional services and pharmacy services and prescriptions filled in the skilled nursing facility pharmacy;

(iii) Transplant services for donors and recipients, including the transplant facility fees performed in either a hospital setting or outpatient setting;

(iv) Dialysis services delivered in a hospital;

(v) Artificial organ transplants based on an issuer's medical guidelines and manufacturer recommendation;

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

(b) A health benefit plan may, but is not required to, include the following services as

part of the EHB-benchmark package. These services are specifically excluded by the base-benchmark plan, and should not be included in establishing actuarial value

(i) Hospitalization where mental illness is the primary diagnosis to the extent that it is classified under the mental health and substance use disorder benefits category;

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

(iii) Bariatric surgery and supplies, Orthognathic surgery and supplies unless due to Temporomandibular joint disorder or injury, sleep apnea or congenital anomaly, and Sexual reassignment treatment and surgery;

(iv) Reversal of sterilizations;

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

(c) The base-benchmark plan establishes specific limitations on services classified to the hospitalization services category that conflict with state or federal law as of January 1, 2014. The state EHB-benchmark plan requirements for these services are:

(i) The transplant waiting period must not be longer than ninety days, inclusive of prior creditable coverage, if an issuer elects to apply a limitation to the benefit.

(ii) Where transplant benefit services are delivered in a non-hospital setting, the same waiting period limitation may be applied.

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

(i) 60 inpatient days per calendar year for illness, injury or physical disability in a skilled nursing facility;

(ii) 30 inpatient rehabilitation service days per year. This benefit may be classified to this category for determining actuarial value or to the rehabilitation services category, but not to both.

(e) State benefit requirements covered under this category are:

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

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

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

(iv) Coverage at a long-term care facility following hospitalization (RCW 48.43.125).

(4) A health benefit plan must cover “**maternity and newborn**” services. For purposes of determining a plan’s actuarial value, an issuer must classify medically necessary care and services delivered to women during pregnancy and in relation to delivery and recovery from delivery, and to newborn children, in a manner substantially equivalent to the benchmark base plan to the maternity and newborn services category.

(a) A health benefit plan must cover the following services, which are specifically covered by the base-benchmark plan, and classify them as maternity and newborn services:

(i) In utero treatment for the fetus;

(ii) Vaginal or cesarean childbirth delivery in a hospital or birthing center, including facility fees;

(iii) Nursery services and supplies for newborns, including newly adopted children;

(iv) Infertility diagnosis;

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

(vi) Complications of pregnancy such as but not limited to fetal distress, gestational diabetes and toxemia; and

(vii) Termination of pregnancy.

(b) A health benefit plan may include, but is not required to include the following service as part of the EHB-benchmark package. This service is specifically excluded by the base-benchmark plan, and should not be included in establishing actuarial: Genetic testing of the child’s father.

(c) The base-benchmark plan establishes specific limitations on services classified to the maternity and newborn category that conflict with state or federal law as of January 1, 2014. The state EHB-benchmark plan requirements for these services are:

(i) Maternity coverage for dependent daughters must be included in the base-benchmark plan on the same basis that coverage is included for other enrollees.

(ii) Newborns delivered of dependent daughters must be covered to the same extent, and on the same basis, as newborns delivered to the other enrollees under the plan.

(d) The benchmark base plan’s limitations on services in this category include covering

home birth by a midwife or nurse midwife only for low risk pregnancy.

(e) State benefit requirements covered under this category include:

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

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

(iii) Prenatal diagnosis of congenital disorders by screening/diagnostic procedures if medically necessary (RCW 48.20.430, 48.21.244, 48.44.344, and 48.46.375).

(5) A health benefit plan must cover **“mental health and substance use disorder services, including behavioral health treatment.”** For purposes of determining a plan’s actuarial value, an issuer must classify medically necessary care, treatment and services for mental health conditions and substance use disorders categorized in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders, including behavioral health treatment for those conditions, in a manner substantially equivalent to the base-benchmark plan, as mental health and substance use disorder services, including behavioral health treatment.

(a) A health benefit plan must include the following services, when medically necessary, which are specifically covered by the base-benchmark plan, and classify them as mental health and substance use disorder services, including behavioral health treatment:

(i) In-patient, residential and outpatient mental health and substance use disorder treatment, including partial hospital programs or inpatient services;

(ii) Chemical dependency detoxification;

(iii) Behavioral treatment for a DSM category diagnosis;

(iv) Services provided by a licensed behavioral health provider for a covered diagnosis in a skilled nursing facility;

(v) Prescription medication prescribed during an in-patient and residential course of treatment.

(b) A health benefit plan may include, but is not required to include the following services as part of the EHB-benchmark package. These services are specifically excluded by the base-benchmark plan, and should not be included in establishing actuarial value.

(i) Counseling in the absence of illness, other than family counseling when the patient is

a child or adolescent with a covered diagnosis and the family counseling is part of the treatment for mental health services;

(ii) Mental health treatment for diagnostic codes 302- through 302.9 in the DSM-IV, or for "V code" diagnoses except for medically necessary services for parent-child relational problems for children five years of age or younger, neglect or abuse of a child for children five years of age or younger, and bereavement for children five years of age or younger;

(iii) Non-medically necessary court-ordered mental health treatment.

(c) The base-benchmark plan establishes specific limitations on services classified to the mental health and substance abuse disorder services category that conflict with state or federal law as of January 1, 2014. The state EHB-benchmark plan requirements for these services are:

(i) Coverage for eating disorder treatment must be covered for a diagnosis of a DSM-IV or DSM-V categorized mental health condition;

(ii) Chemical detoxification coverage must not be uniformly limited to 30 days. Medical necessity, utilization review and criteria consistent with federal law may be applied by an issuer in designing coverage for this benefit.

(iii) Mental health services and substance use disorder treatment must be delivered in a home health setting on parity with medical surgical benefits, consistent with state and federal law.

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

(i) For small group plans, a limit of four employee assistance program counseling sessions;

(ii) Court ordered treatment only when medically necessary.

(e) State benefit requirements covered under this category include:

(i) Mental health parity (RCW 48.20.580, 48.21.241; 48.44.341, and 48.46.285);

(ii) Chemical dependency detoxification services (RCW 48.21.180, 48.44.240, 48.44.245, 48.46.350, and 48.46.355,);

(iii) Services delivered pursuant to involuntary commitment proceedings (RCW 48.21.242; 48.44.342; 48.46.292).

(g) The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343) (MHPAEA) applies to a health benefit plan subject to this

section. Coverage of mental health and substance use disorder services, along with any scope and duration limits imposed on the benefits, must comply with the MHPAEA, and all rules, regulations and guidance issued pursuant to Section 2726 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26) where state law is silent, or where federal law pre-empts state law.

(6) A health benefit plan must cover “**prescription drug services.**” For purposes of determining actuarial value, an issuer must classify medically necessary prescribed drugs, medication and drug therapies, in a manner substantially equivalent to the base-benchmark plan as prescription drug services.

(a) A health benefit plan must include the following services, which are specifically covered by the base-benchmark plan, and classify them as prescription drug services:

(i) Those classes of drugs, and the specific drugs in the drug formulary, both generic and brand name, including self-administrable prescription medications;

(ii) Prescribed medical supplies, including diabetic supplies that are not otherwise covered as durable medical equipment under the rehabilitative and habilitative services category, including test strips, glucagon emergency kits, insulin and insulin syringes;

(iii) All FDA approved contraceptive methods, and prescription based sterilization procedures for women with reproductive capacity;

(iv) certain preventive medications, including but not limited to, aspirin, fluoride, iron and medications for tobacco use cessation, according to, and as recommended by, the United States Preventive Services Task Force, when obtained with a prescription order.

(b) A health benefit plan may include, but is not required to include the following services as part of the EHB-benchmark package. These services are specifically excluded by the base-benchmark plan as prescription drug or pharmacy benefit services, and should not be included in establishing actuarial value for this category:

(i) Insulin pumps and their supplies, which are classified to the rehabilitation and habilitation services category;

(ii) Weight loss drugs.

(c) The base-benchmark plan establishes specific limitations on services classified to the prescription drug services category that conflict with state or federal law as of January 1, 2014. The state EHB-benchmark plan requirements for these services are:

(i) Preauthorized tobacco cessation products must be covered consistent with state and federal law. Brand-name tobacco cessation products must be available pursuant to an issuer's formulary exception or substitution process;

(ii) Medication prescribed as part of a clinical trial that is not the subject of the trial must be covered in a manner consistent with state and federal law.

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

(i) Prescriptions for self-administrable injectable medication are limited to 30 day supplies at a time, other than insulin, which may be offered with more than a thirty day supply;

(ii) Teaching doses of self-administrable injectable medications are limited to 3 doses per medication per lifetime.

(e) State benefit requirements classified this category include:

(i) Medical foods to treat inborn errors of metabolism, including but not limited to formula for phenylketonuria (RCW 48.44.440, 48.46.510, 48.20.520, and 48.21.300);

(ii) Diabetes supplies ordered by the physician (RCW 48.44.315, 48.46.272, 48.20.391, and 48.21.143). Inclusion of this mandate does not bar issuer variation in diabetic supply manufacturers under its drug formulary;

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

(iv) Mental health prescription drugs to the extent not covered under the hospitalization or skilled nursing facility services, or mental health and substance use disorders categories (RCW 48.44.341, 48.46.291, 48.20.580, and 48.21.241).

(f) An issuer's formulary is part of the prescription drug services category. The formulary filed with the commissioner must be substantially equal to the benchmark base plan formulary, both as to therapeutic classes covered and included drugs in each class.

(i) The benchmark formulary includes the following therapeutic classes: Anti-infectives, Cardiovascular, Cholesterol Lowering, Diabetes, Ear/Nose/Throat, Gastrointestinal, Hormones, Mental Health, Neurological, Ophthalmic, Pain and Inflammatory Disease, Respiratory, Skin, Women's Health.

(ii) An issuer must file its formulary with a representative product identifier code in each therapeutic class, when filing its rates and forms with the commissioner. Acceptable

product identifier codes include Generic Sequence Number (GSN), Generic Code Number (GCN), Generic Product Identifier (GPI), or National Drug Code (NDC).

(iii) An issuer complies with subsection (6)(f)(ii) by filing its product identifier codes through SERFF and noting in its actuarial filings any substitutions, with reference to both the therapeutic class and the drug being replaced.

(iv) An issuer may remove or add products to its formulary during the benefit year consistent with its policies for management of its formulary, and state and federal law. The removal of a product must not result in the elimination of access to any product in a therapeutic class, unless there is not a Food and Drug Administration approved product for that therapeutic class. An issuer must file its updated formulary with the commissioner each quarter and specifically note changes that have been made.

(v) An issuer may submit for the commissioner's review and approval a justification to exclude a drug from its formulary that is included in the base-benchmark plan formulary. The justification must be clearly described and include an evidence based, formal recommendation of the issuer's internal prescription formulary committee.

(vi) An issuer's formulary does not have to be substantially equal to the base-benchmark plan formulary in terms of formulary placement.

(7) A health benefit plan must cover "**rehabilitative and habilitative services.**" For purposes of determining a plan's actuarial value, an issuer must classify medically necessary services that help a person keep, restore or improve skills and function for daily living that have been lost or impaired because a person was sick, hurt or disabled, in a manner substantially equivalent to the benchmark base plan as rehabilitative services.

(a) A health benefit plan must include the following services, which are specifically covered by the base-benchmark plan, and classify them as rehabilitative services:

(i) Cochlear implants;

(ii) In-patient rehabilitation facility and professional services delivered in those facilities are limited to 30 days per year, unless those services are classified under the hospitalization category;

(iii) Outpatient physical therapy, occupational therapy and speech therapy are limited to 25 outpatient visits per year, on a combined basis, for rehabilitative purposes.

(iv) Braces, splints, orthopedic appliances and orthotic devices, supplies or apparatuses

used to support, align or correct deformities or to improve the function of moving parts;

(v) Durable medical equipment and mobility enhancing equipment used to serve a medical purpose, including sales tax.

(b) A health benefit plan may include, but is not required to include the following services as part of the EHB-benchmark package. These services are specifically excluded by the base- benchmark plan, and should not be included in establishing actuarial value.

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

(ii) Exercise equipment for medically necessary conditions;

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

(iv) Hearing aids other than cochlear implants

(c) The base-benchmark plan does not cover certain federally required services under this category. The state EHB-benchmark plan requirements for habilitative services are:

(i) For purposes of determining actuarial value, the issuer must classify the range of medically necessary health care services and health care devices designed to assist an individual in partially or fully developing, keeping and learning age appropriate skills and functioning, within the individual's environment or to compensate for a person's progressive physical, cognitive and emotional illness as habilitative services.

(ii) A health benefit plan must cover habilitative services in a manner consistent with RCW 48.43.045. An issuer must not exclude otherwise covered habilitative services provided by an individual who is directly supervised by a provider qualified pursuant to RCW 48.43.045.

(iii) An issuer may establish limitations on habilitative services at parity with those for rehabilitative services. A health benefit plan may include reference based limitations only if the limitations take into account the unique needs of the individual and target measurable, and specific treatment goals appropriate for the person's age, and physical and mental condition. When habilitative services are delivered to treat a mental health diagnosis categorized in the most recent version of the DSM, the mental health parity requirements apply and supercede any rehabilitative services parity limitations permitted by this subsection.

(iv) Absent a federal or state requirement to do so, this section does not require an issuer to coordinate its benefits in conjunction with services provided by a public or

government program. However, a health benefit plan must not limit an enrollee's access to covered services on the basis that some, but not all of the services are provided by a public or government program.

(v) An issuer may establish utilization review guidelines and practice guidelines for rehabilitative services that are recognized by the medical community as efficacious. The guidelines may not require a return to a prior level of function.

(vi) Rehabilitative health care devices may be limited to those that require FDA approval and a prescription to dispense the device.

(vii) Consistent with the standards in this subsection (7) (c), speech therapy, occupational therapy, physical therapy and aural therapy are rehabilitative services. Day habilitation services designed to provide training, structured activities and specialized assistance to adults, chore services to assist with basic needs, vocational or custodial services are not are not classified as rehabilitative services.

(vii) An issuer must not exclude coverage rehabilitative services received at a school-based health care centers unless the rehabilitative services and devices are delivered pursuant to federal Individuals with Disabilities Education Act of 2004 (IDEIA) requirements pursuant to an individual educational plan (IEP).

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

(i) In-patient rehabilitation facility and professional services delivered in those facilities are limited to 30 days per year;

(ii) Outpatient physical therapy, occupational therapy and speech therapy are limited to 25 outpatient visits per year, on a combined basis, for rehabilitative purposes.

(e) State benefit requirements covered under this category include:

(i) State sales tax for durable medical equipment;

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

(f) An issuer must not classify services to the rehabilitative services category if the classification results in a limitation of coverage for therapies that is medically necessary for an enrollee's treatment for cancer, chronic pulmonary or respiratory disease, cardiac disease or other similar chronic conditions or diseases. For purposes of this subsection, an issuer may establish limitations on the number of visits and coverage of the rehabilitation

therapy consistent with its medical necessity and utilization review guidelines for medical/surgical benefits. Examples of these are, but are not limited to, breast cancer rehabilitation therapy, respiratory therapy, and cardiac rehabilitation therapy. Such services may be classified to the ambulatory patient or hospitalization services categories for purposes of determining actuarial value.

(8) A health plan must cover “**laboratory services.**” For purposes of determining actuarial value, an issuer must classify medically necessary laboratory services and testing, including those performed by a licensed provider to determine differential diagnoses, conditions, outcomes and treatment, and including blood and blood services, storage and procurement, and ultrasound, X-ray, MRI, CAT scan and PET scans, in a manner substantially equivalent to the base-benchmark plan as laboratory services.

(a) A health benefit plan must include the following services, which are specifically covered by the base-benchmark plan, and classify them as laboratory services:

(i) Laboratory services, supplies and tests, including genetic testing;

(ii) Radiology services, including X-ray, MRI, CAT scan, PET scan and ultrasound imaging;

(iii) Blood, blood products and blood storage, including the services and supplies of a blood bank.

(b) A health benefit plan may include, but is not required to include the following services as part of the EHB-benchmark package. These services are specifically excluded by the base-benchmark plan, and should not be included in establishing actuarial value: an enrollee’s non-medically indicated procurement and storage of personal blood supplies provided by a member of the enrollee’s family.

(c)- (e): Reserved.

(9) A health plan must cover “**preventive and wellness services, including chronic disease management**” For purposes of determining a plan’s actuarial value, an issuer must classify services that identify or prevent the onset or worsening of disease or disease conditions, illness or injury, often asymptomatic, services that assist in the multidisciplinary management and treatment of chronic diseases, services of particular preventive or early identification of disease or illness of value to specific populations, such as women, children and seniors, in a manner substantially equivalent to the benchmark

base plan, as preventive and wellness services, including chronic disease management.

(a) A health benefit plan must include the following services, which are specifically covered by the base-benchmark plan, and classify them as preventive and wellness services:

(i) Immunizations recommended by the Centers for Disease Control's Advisory Committee on Immunization Practices,

(ii) Screening and tests with A and B recommendations by the U.S. Preventive Services Task Force for prevention and chronic care, for recommendations issued on or before the applicable plan year;

(iii) Services, tests and screening contained in the U.S. Health Resources and Services Administration Bright Futures guidelines as set forth by the American Academy of Pediatrics

(iv) Services, tests, screening and supplies recommended in the U.S. Health Resources and Services Administration women's preventive and wellness services guidelines;

(v) Chronic disease management services.

(b) The base-benchmark plan does not exclude any services that could reasonably be classified to this category.

(c) The base-benchmark plan does not apply any limitations or scope restrictions that conflict with state or federal law as of January 1, 2014.

(d) The base-benchmark plan does not establish visit limitations on services in this category.

(e) State benefit requirements classified in this category are:

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

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

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

**NEW SECTION**

**WAC 284-43-879 Essential Health Benefit Category: Pediatric Services**

A health plan must include “pediatric services” in its essential health benefits package. The base-benchmark plan covers pediatric services for the categories set forth in WAC 284-43-878 (1) through (9) with the exception of pediatric oral services.

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

(2) If a health plan is a stand-alone dental plan offered through the health benefit exchange, then the requirements of this section are the sole essential health benefit requirements applicable to the plan.

(3) A health benefit plan may include, but is not required to include the following services as part of the EHB-benchmark package. The supplemental base-benchmark plan specifically excludes oral implants, and an issuer should not include benefits for oral implants in establishing a plan’s actuarial value.

(4) The state EHB-benchmark plan requirements for pediatric oral benefits must be offered and classified consistent with the designated supplemental base-benchmark plan for pediatric oral services, the Washington State CHIP plan. The oral benefits included in the “pediatric” category are:

- (a) Diagnostic services
- (b) Preventive care
- (c) Restorative care
- (d) Oral surgery and reconstruction to the extent not covered under the hospitalization benefit;
- (e) Endodontic treatment
- (f) Periodontics
- (g) Crown and fixed bridge

- (h) Removable prosthetics
- (i) Medically necessary orthodontia

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

- (a) Diagnostic exams once every six months, beginning before one year of age;
- (b) Bitewing x-ray once a year;
- (c) Panoramic x-rays once every three years;
- (d) Prophylaxis every six months beginning at age 6 months
- (e) Fluoride three times in a twelve month period for ages six and under; two times in a 12 month period for ages seven and older; three times in a twelve month period during orthodontic treatment; sealant once every 3 years for Occlusal surfaces only; oral hygiene instruction two times in twelve months for ages 8 and under if not billed on the same day as a prophylaxis treatment;
- (f) Every 2 years for the same restoration (fillings);
- (g) Frenulectomy or frenuloplasty covered for ages six and under without prior authorization;
- (h) Root canals on baby primary posterior teeth only;
- (i) Root canals on permanent anterior, bicuspid and molar teeth, excluding teeth 1, 16, 17 and 32;
- (j) Periodontal scaling and root planning once per quadrant in a 2 year period for ages 13 and older, with prior authorization;
- (k) Periodontal maintenance once per quadrant in a 12 month period for ages 13 and older, with prior authorization;
- (j) Stainless steel crowns for primary anterior teeth once every 3 years; if age 13 and older with prior authorization;
- (l) Stainless steel crowns for permanent posterior teeth once every 3 years;
- (k) metal/porcelain crowns and porcelain crowns on anterior teeth only, with prior authorization;
- (j) Space maintainers for missing primary molars A, B, I, J, K, L, S and T
- (k) One resin based partial denture, replaced once within a 3 year period.
- (l) One complete denture upper and lower, and one replacement denture per lifetime

after at least 5 years from the seat date.

(m) Rebasement and relining of complete or partial dentures once in a 3 year period, if performed at least 6 months from the seating date

(6) State benefit requirements that are limited to those receiving pediatric services, but that are classified to other categories for purposes of determining actuarial value, are:

(a) Neurodevelopmental therapy to age six, consisting of physical, occupational and speech therapy and maintenance to restore or improve function based on developmental delay, which cannot be combined with rehabilitative services for the same condition (RCW 48.44.450, 48.46.520, and 48.21.310) (may be classified to ambulatory patient services or mental health and substance abuse disorder including behavioral health categories);

(b) Congenital anomalies in newborn and dependent children (RCW 48.20.430, 48.21.155, 48.44.212, 48.46.250, and 48.21.155) (may be classified to hospitalization, ambulatory patient services or maternity and newborn categories).

#### **NEW SECTION**

#### **WAC 284-43-882 Plan cost sharing and benefit substitution**

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

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

(3) An issuer may use reasonable medical management techniques to control costs, including promoting the use of appropriate, high value preventive services, providers and settings. An issuer's policies must accommodate enrollees for whom it would be medically inappropriate to have the service provided in one setting versus another, as determined by the attending provider, and permit waiver of an otherwise applicable copayment for the

service that is tied to one setting but not the preferred high-value setting.

(4) An issuer may not require cost-sharing for preventive services delivered by network providers, specifically related to those with an A or B rating in the most recent recommendations of the United States Preventive Services Task Force, women's preventive healthcare services recommended by the U.S. Health Resources and Services Administration (HRSA) and HRSA Bright Futures guideline designated pediatric services. An issuer must post on its website a list of the specific preventive and wellness services mandated by PPACA that it covers.

(5) An issuer must establish cost-sharing levels, structures or tiers for specific essential health benefit categories that are not discriminatory based on health status. "Cost-sharing" has the same meaning as set forth in RCW 48.43.005, and WAC 284-43-130(8).

(a) An issuer must not apply cost sharing or coverage limitations differently to enrollees with chronic disease or complex underlying medical conditions than to other enrollees, unless the difference provides the enrollee with access to care and treatment commensurate with the enrollee's specific medical needs without imposing a surcharge or other additional cost to the enrollee beyond normal cost-sharing requirements under the plan.

(b) An issuer must not establish a different cost-sharing structure for a specific benefit or tier for a benefit than is applied to the plan in general if the sole type of enrollee who would access that benefit or benefit tier is one with a chronic illness or medical condition.

#### NEW SECTION

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

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