

No. 68726-3-I

DIVISION I, COURT OF APPEALS
OF THE STATE OF WASHINGTON

A.G., by and through his parents, J.G. and K.G.,

Plaintiff-Respondent,

v.

PREMERA BLUE CROSS and LIFEWISE OF WASHINGTON,
Washington corporations,

Defendants-Appellants.

ON NOTICE OF DISCRETIONARY REVIEW FROM
KING COUNTY SUPERIOR COURT
(Hon. Michael Trickey)

**PREMERA BLUE CROSS AND LIFEWISE OF WASHINGTON'S
REPLY IN SUPPORT OF MOTION FOR
DISCRETIONARY REVIEW**

Barbara J. Duffy, WSBA No. 18885
Gwendolyn C. Payton, WSBA No. 26752
Ryan P. McBride, WSBA No. 33280
*Attorneys for Premera Blue Cross and
Lifewise of Washington*

LANE POWELL PC
1420 Fifth Avenue, Suite 4100
Seattle, Washington 98101-2338
Telephone: 206.223.7000
Facsimile: 206.223.7107

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COURT OF APPEALS
DIVISION I
CLERK OF COURT
JENNIFER L. HARRIS

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I. INTRODUCTION

A.G. urges this Court to deny discretionary review because “every court” to examine the issue has concluded that the Parity Act forbids blanket exclusions of neurodevelopmental therapy benefits. The reality is that A.G.’s counsel obtained a favorable order from a federal district court and, thereafter, asked the court below and another Washington state court to follow the federal court’s ruling—which they did. But while the federal court was convinced it was right, the state courts were not. Both Judge Trickey and Judge Erlick concluded that the threshold issue in these cases—whether the legislature intended the Parity Act to supersede the Neurodevelopmental Therapy Mandate—is a novel, difficult and publicly important one that merits immediate appellate consideration. Both courts agreed that the issue should be certified for interlocutory review. This Court should defer to that view and accept review on this basis alone.

Even absent certification, discretionary review is warranted on the grounds of obvious or probable error. There is a conflict between the Parity Act and the Neurodevelopmental Therapy Mandate; under the trial court’s construction, the Act would forbid what the Mandate allows, *i.e.*, exclusion of neurodevelopmental therapy in an individual health plan. That conflict cannot be reconciled, and there is nothing in the legislative history, agency record or otherwise to suggest that the legislature intended the generic terms of the Parity Act to control over the specific terms of the Mandate—especially where, as here, evisceration of the Mandate will likely result in an increase in the cost of health plans in the individual

market. This potentially dispositive, and clearly significant, issue provides ample bases to depart from the usual policy against interlocutory review.

II. ARGUMENT

A. **This Court Should Defer To Judge Trickey’s (And Judge Erlick’s) Conclusion That Discretionary Review Is Warranted.**

For the most part, A.G. does not argue that the Order fails to satisfy RAP 2.3(b)(4)’s criteria for discretionary review. Rather, A.G. argues that certification “does not compel the Court of Appeals to accept review.” Opp. at 8. That is true, but it is well-settled and common sense that this Court “should give great weight and deference to the opinion of the very experienced trial judge” who takes the unusual step of certifying his or her own ruling for interlocutory review. *In re Coord. Pre-Trial Proceedings in Petroleum Prod. Antitrust Litig. M.D.L. No. 150*, 761 F.2d 710, 712 (Temp. Em. App. 1985); Wright & Miller: Fed. Prac. & Proc. § 3929, Permissive Interlocutory Appeals—Section 1292(b) (2d ed. 2012). This is particularly true here because not just one but two “experienced trial judges” have now certified the same issue for discretionary review.

As Premera noted in the Motion (Mot. at 7 n. 2), A.G.’s counsel filed an identical action against Regence BlueShield seeking to invalidate Regence’s neurodevelopmental therapy exclusion. *O.S.T. v. Regence BlueShield*, No. 11-2-34187-9-SEA, Oct. 19, 2012 Hearing (attached as Exhibit A) at pp. 7-9. Regence also argued that the Neurodevelopment Therapy Mandate permitted the exclusion. *Id.* Following Judge Trickey’s (erroneous) reasoning, Judge Erlick found that the exclusion violated the

Parity Act. *Id.*, pp. 33-35. Critically, however, Judge Erlick also concluded that the issue was sufficiently novel, complex and important to warrant immediate interlocutory appeal and, like Judge Trickey, agreed to certify his ruling for discretionary review. *Id.*, pp. 29-30, 40-41.¹

Judge Trickey and Judge Erlick understood that there can be, and in this instance is, a “substantial ground for a difference of opinion” under RAP 2.3(b)(4), even though they (and the federal court in *Z.D. v. Group Health Coop.*, 829 F. Supp. 2d 1009 (W.D.Wash. 2011)) ruled the same way. “A substantial ground for difference of opinion exists where reasonable jurists might disagree on an issue’s resolution, not merely where they have already disagreed.” *Reese v. BP Exploration (Alaska), Inc.*, 643 F.3d 681, 688 (9th Cir. 2011). That is often the case where, as here, the issues are novel and difficult. *Id.*; *Klinghoffer v. S.N.C. Achille Lauro*, 921 F.2d 21, 25 (2nd Cir. 1990). A.G. does not dispute that this is an issue of first impression in Washington that affects the entire insurance industry. This Court should accept Judge Trickey’s and Judge Erlick’s experienced and considered determination that the issue is a difficult and close one that warrants immediate appellate guidance.²

¹ Judge Erlick has not yet entered a formal order certifying the issue and, thus, no notice or motion for discretionary review has been filed in the *Regence* matter. Judge Erlick expressed his belief, however, that consolidation of the two appeals may be appropriate. Exh. A, pp. 20-21.

² A.G. points out that Judge Lasnik refused to certify his ruling. Opp. at 2. With all due respect to Judge Lasnik—who considered this state law issue on a different record—the Washington courts disagree. Indeed, A.G.’s counsel asked Judge Trickey to follow Judge Lasnik in *refusing* certification, but Judge Trickey believed certification was needed.

B. The Neurodevelopmental Therapy Mandate Permits Premera To Exclude Neurodevelopmental Therapy Benefits.

A.G. argues that the “sole legal issue certified by the trial court is whether the Mental Health Parity Act mandates coverage of medically necessary neurodevelopmental therapies to treat DSM-IV conditions[.]” Opp. at 9. Not exactly. The issue here is not the scope of the Parity Act, but the interplay between the Act and the Neurodevelopmental Therapy Mandate; did the later-enacted Parity Act “implicitly repeal, supersede and/or abrogate” the earlier-enacted Mandate? Certification Order (AE 17). There is no dispute that the Mandate expressly permits Premera to exclude neurodevelopmental therapy from A.G.’s individual health plan. A.G. therefore claims that the legislature intended the general provisions of the Parity Act to trump the specific provisions of the Mandate where, as here, the individual seeking neurodevelopmental therapy benefits has a DSM-IV condition. The legislature, however, had no such intent.

The Neurodevelopmental Therapy Mandate was enacted in 1989. Insurers have relied on the Mandate to offer individual health plans both with and without neurodevelopmental therapy benefits—the latter being less expensive and, thus, more affordable to those who may not otherwise have insurance. Tedford Decl. (AE 12), ¶ 3. It was just such a plan, with an express neurodevelopmental therapy exclusion, that A.G.’s parents chose. The Parity Act was enacted in 2005, and first applied to individual plans in 2008. If, as the trial court found, the Act now requires insurers to cover neurodevelopmental therapy, despite the Mandate, the market for

individual health plans will be altered dramatically. The cost of providing this additional coverage will cause the price of some plans to go up.

If the legislature intended the Parity Act to mark a sea-change on the market for individual health plans, it certainly did not say so. As A.G. correctly points out, under the “plain meaning” rule, legislative intent is first derived from statutory language. Opp. at 13 (*citing Dep’t of Ecology v. Campbell & Gwinn, LLC*, 146 Wn.2d 1, 43 P.3d 4 (2002)). This rule is of no help here. Nothing in the language of the Parity Act shows that the legislature intended the Act’s generic reference to “mental health services” to include the specific “neurodevelopmental therapies” referenced in the Mandate. A.G. next argues that the “*actual* legislative history indicates that the Legislature knew that it was covering all mental health services under the Parity Act[.]” *Id.* (emphasis in original). Here too, A.G. cannot point to a single reference to neurodevelopmental therapy or the Mandate in a bill report, budget analysis, committee hearing, bill file or other aspect of the Parity Act’s legislative history. There is no such reference.

Indeed, as Premera explained, legislative efforts *after* enactment of the Parity Act confirm that the Act does not apply to neurodevelopmental therapy, and the legislature wants to keep it that way. Mot. at 14-15. Several bills would have required insurers to cover neurodevelopmental therapy as a treatment for autism—laws that would be wholly unnecessary if the Parity Act already required such coverage. *See* Duffy Decl. (AE 9), Exh. G, H & I. A.G. has no explanation for this subsequent legislative history, other than to avoid it entirely on the purported grounds that it “is

not evidence of legislative intent.” Opp. at 13 n. 4. Wrong. In *Impecoven v. Dep’t of Revenue*, 120 Wn.2d 357, 841 P.2d 752 (1992), the Supreme Court construed RCW 82.04.255 to determine whether it applied to both real estate and insurance agents. The Court observed:

To the contrary, the legislative history supports treating insurance agents differently from real estate agents. The Legislature limited the application of RCW 82.04.255 to real estate agents and has not enacted legislation allowing a similar deduction for insurance agents. Rather, legislation seeking similar partial exemptions for insurance agents for amounts paid to other agents has failed. *See* Senate Bill 5078, 51st Legislature (1989) (died in Senate Ways and Means Committee; *see* 1 Legislative Digest (1989–90), at 40); House Bill 1063, 51st Legislature (1989) (died in House Revenue Committee; *see* 2 Legislative Digest (1989–90), at 33–34); Senate Bill 5210, 52d Legislature (1991) (died in Senate Ways and Means Committee; *see* 1 Legislative Digest (1991–92), at 99–100). ...

Id. at 362. As in *Impecoven*, that the legislature considered and rejected bills that would have required insurers to cover neurodevelopmental therapy for autism, a DSM-IV condition, is relevant “legislative history” showing that the Parity Act does not currently require such coverage.

A.G. similarly tries to discount agency statements recommending *expanding* the Parity Act to require insurers to cover neurodevelopmental therapy for individuals with autism and other DSM-IV conditions. Mot. at 15-17. Again, A.G. cannot explain why such action is necessary if, as A.G. believes, the Parity Act already mandates such coverage. A.G. also ignores that the OIC repeatedly reviewed Premera’s health plans, and has never disapproved the neurodevelopmental therapy exclusion. A.G.

argues that “[i]naction is not an agency interpretation” (Opp. at 15), but this is not mere *inaction*; this implicit *approval*. Cf. *Leingang v. Pierce County Medical Bureau, Inc.*, 131 Wn.2d 133, 153-54, 930 P.2d 288 (1997) (policy was not unfair and deceptive where OIC reviewed and did not disapprove challenged provision). In sum, A.G. can point to nothing in the legislative history or agency record to support the trial court’s conclusion that the Parity Act applies to neurodevelopmental therapy.

C. Recent Proposed Rulemaking Also Confirms That The Parity Act Does Not Apply To Neurodevelopmental Therapy.

A.G. points out that the OIC has recently announced its intention to promulgate rules related to the Parity Act. Opp. at 15 (*citing* Wash. St. Reg. 12-22-070 (Nov. 7, 2012)). If nothing else, this proposed rulemaking dispels A.G.’s argument that the Parity Act is “plain and unambiguous.” Further, and carefully ignored by A.G., OIC has already promulgated proposed rules defining the mandated “essential health benefits” that all Washington non-grandfathered individual and small group plans must cover beginning on January 1, 2014 pursuant to the federal Affordable Care Act. Wash. St. Reg. 12-21-136 (Oct. 24, 2012) (attached hereto as Exhibit B). These proposed rules—which must comport with existing state mandates, including the Parity Act—further show that OIC does not view neurodevelopmental therapy as a mental health service.

The proposed rules define “mental health ... services” and “habilitative services” as separate health benefits. Exh. B. Tracking the Parity Act, the mental health benefit includes “medically necessary care,

treatment and services for” most disorders listed in DSM-IV. *Proposed* WAC 284-43-877(5). Among the “[s]ervices specifically classified under this category” are “[b]ehavioral treatment,” but not neurodevelopmental treatment. *Id.* The benefit for habilitative services, however, covers:

... the range of medically necessary health care services ... designed to assist an individual in partially or fully developing, learning and retaining developed or learned age appropriate skills and functioning, within the individual’s environment or to compensate for a person’s progressive physical, cognitive and emotional illness and that ... [t]arget measurable, specific treatment goals appropriate for the person’s age, and physical and mental condition; ...

Id. (Proposed WAC 284-43-877(7)(b)). This habilitative benefit, which precisely describes the neurodevelopmental treatment A.G. seeks, includes “speech, physical and occupational therapy”—the same therapies covered by the Neurodevelopmental Therapy Mandate. *See* RCW 48.44.450(2). In short, while Premera may have to provide *some* neurodevelopmental therapy as a “habilitative benefit” in *some* plans beginning in 2014, it was not required to do so in A.G.’s individual plan under existing state law.

D. Discretionary Review Will Promote Judicial Efficiency.

A.G. asks this Court to ignore the Certification Order, arguing that “judicial economy is not served” where “interlocutory appeal will only address part of the substantive legal questions presented about the effect of the Mental Health Parity Act[.]” *Opp.* at 16. A.G. points to his recently filed motion for partial summary judgment, in which he asks the trial court to declare that the “Parity Act prevents Premera from imposing annual visit limits on neurodevelopmental therapies to treat DSM-IV conditions”

(the “Visit Limit Issue”). *Id.* at 17 (*citing* P.A. 16-35). Even though the trial court has not decided the Visit Limit Issue, and isn’t even scheduled to hear the issue until after this Court decides this Motion, A.G. argues that this Court should deny review because the Order and Visit Limit Issue are “so intertwined that both should be decided together.” *Id.* Not quite.

A.G.’s entreaty to judicial economy omits two crucial points. One, if this Court accepts review and reverses the Order, all of A.G.’s claims will be dismissed, ending further litigation on the Visit Limit Issue, class certification and trial. That would be the most efficient outcome, and why immediate review “may materially advance the ultimate termination of the litigation.” RAP 2.3(b)(4). Two, the Order and Visit Limit Issue are not “intertwined.” Review of the Order requires the Court to resolve the conflict between the Neurodevelopmental Therapy Mandate and the Parity Act; it does not require interpretation or application of any provision of the Act or Premera’s health plans. Review of the Visit Limit Issue, on the other hand, will require interpretation of the Act’s parity language and a factual determination as to whether Premera’s plans or practices violate that language. The issues are not legally and factually related.

At bottom, A.G. voices the same concern that exists in any interlocutory appeal; in the unlikely event this Court affirms the Order, the effect will be delay in the proceedings and the possibility of a second appeal. But that risk is present whenever discretionary review is accepted, and part of the balancing of interests the trial court considered in certifying the Order under RAP 2.3(b)(4), and this Court must consider under that

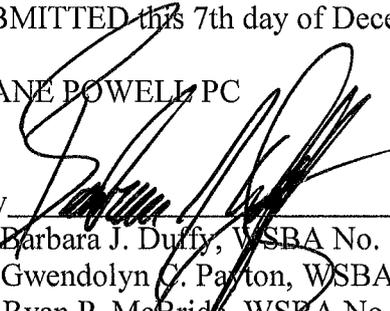
rule and RAP 2.3(b)(1) & (2). Even though interlocutory review is not favored, where those provisions are satisfied, discretionary review is warranted. *Sea-Pac Co., Inc. v. United Food and Comm. Workers Local Union 44*, 103 Wn.2d 800, 802, 699 P.2d 217 (1985). For all the reasons described in Premera's Motion and above, the balance tips decidedly in Premera's favor on this novel, difficult and potentially dispositive issue.

III. CONCLUSION

This Court should grant Defendants' motion for discretionary review under RAP 2.3(b)(4) and RAP 2.3(b)(1) & (2).

RESPECTFULLY SUBMITTED this 7th day of December, 2012.

LANE POWELL PC

By 

Barbara J. Duffy, WSBA No. 18885

Gwendolyn C. Payton, WSBA No. 26752

Ryan P. McBride, WSBA No. 33280

*Attorneys for Appellants Premera Blue Cross
and Lifewise of Washington*

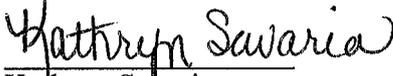
CERTIFICATE OF SERVICE

I hereby certify under penalty of perjury under the laws of the State of Washington that on December 7, 2012, I caused to be served a copy of the foregoing **Reply in Support of Motion for Discretionary Review** on the following person(s) in the manner indicated at the following addresses:

Richard E. Spoonemore
Eleanor Hamburger
Sirianni Youtz & Spoonemore
999 Third Ave., Suite 3650
Seattle, WA 98104

- by CM/ECF
- by Electronic Mail
- by Facsimile Transmission
- by First Class Mail
- by Hand Delivery
- by Overnight Delivery

DATED this 7th day of December, 2012 at Seattle, Washington


Kathryn Savaria

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STATE OF WASHINGTON
2012 DEC -7 PM 1:38

EXHIBIT A

1 IN THE SUPERIOR COURT OF THE STATE OF WASHINGTON
2 IN AND FOR THE COUNTY OF KING

3 O.S.T. by and through his parents,)
4 G.T. and E.S., and L.H., by and)
5 through his parents, M.S. and K.H.,)
6 each on his own behalf and on)
7 behalf of all similarly situated)
8 individuals,)
9 PLAINTIFFS,) CASE NO.
10)
11 VERSUS) 11-2-34187-9SEA
12)
13 REGENCE BLUESHIELD, a Washington)
14 Corporation,)
15 DEFENDANT.)

10 Proceedings Before Honorable JOHN P. ERLICK

11 KING COUNTY COURTHOUSE
12 SEATTLE, WASHINGTON

13 DATED: OCTOBER 19, 2012

14
15 A P P E A R A N C E S:

16 FOR THE PLAINTIFFS:

17
18 BY: ELEANOR HAMBURGER, ESQ.,
19 RICHARD SPOONEMORE, ESQ.,

20 FOR THE DEFENDANT:

21 BY: TIMOTHY PARKER, ESQ.,
22 MEDORA MARISSEAU, ESQ.

23 ALSO PRESENT:

24 GLENN THOMAS
25

09:42:10 1 plaintiff asks this court to determine three things.
09:42:14 2 First, that O.S.T. developmental disabilities are DSM
09:42:19 3 IV conditions covered by the Parity Act; secondly,
09:42:24 4 that his neurodevelopmental therapy services are
09:42:27 5 mental health services required to treat his
09:42:31 6 developmental disabilities, and, thirdly -- third,
09:42:36 7 that neurodevelopmental therapies can be medically
09:42:41 8 necessary and, therefore, Regence's blanket exclusion
09:42:45 9 violates the provisions of the Parity Act and is void.

09:42:54 10 Regence brought a motion to dismiss O.S.T.,
09:43:00 11 because he cannot prove one of the elements of his
09:43:04 12 claim.

09:43:05 13 To go back, I think that the court had
09:43:07 14 found as a matter of law that O.S.T. was not eligible
09:43:11 15 to bring injunctive relief, because his parents are
09:43:16 16 not current enrollees, therefore, he does lack
09:43:19 17 standing to request injunctive relief.

09:43:23 18 But in the element of damages, which would
09:43:26 19 give him standing for purposes of declaratory relief,
09:43:36 20 as well as a potential class representative, Regence
09:43:44 21 sought to dismiss O.S.T. as a plaintiff.

09:43:50 22 Regence has taken the position that O.S.T.
09:43:53 23 cannot establish that Regence neurodevelopmental
09:43:58 24 therapy exclusion is invalid, that Regence has ever
09:44:02 25 denied O.S.T.'s claims based on the exclusion, or that

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09:44:50
09:44:53
09:44:56
09:44:59
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Regence has ever determined that the claims brought -- excuse me, the claims submitted by O.S.T. were for medically necessary services.

I would like to quote from Judge Lasnik's decision in the Z.D. versus Group Health Cooperative case in a motion to dismiss that was brought before him, because I think that it provides some guidance to this court, as well as to the parties on Regence's motions.

"There are reasons why people might be sent to the speech therapy, physical therapy or occupational therapy that don't stem from diagnosed mental illness under the DSM.

"It is not like we are saying that every speech therapy that is recommended or every OT or PT that is recommended will be covered.

"We are saying if the underlying reason for such -- reasons for that is a mental disease or defect that is in the DSM, which it seems that Z. D. has such a diagnosis, from the documents that were submitted to me -- not necessarily the complaint, but the other documents -- why shouldn't that be swept in by the Mental Health Parity Act without damaging the other statute?"

The other statute was the

09:45:46 1 Neurodevelopmental Statute that Regence has relied
09:45:49 2 upon as controlling here.

09:45:51 3 This court has carefully reviewed the
09:45:56 4 briefing submitted to it -- extensive briefing
09:45:59 5 submitted to it -- and the evidence that it has to
09:46:01 6 consider in the pending motions.

09:46:06 7 In considering Regence's motion to dismiss
09:46:08 8 this court will first consider the initial contention
09:46:12 9 of O.S.T. as to whether O.S.T.'s developmental
09:46:17 10 disabilities are DSM IV conditions covered by the
09:46:21 11 Parity Act.

09:46:22 12 The record shows that in May of 2006,
09:46:26 13 Regence denied coverage for speech therapy for
09:46:29 14 O.S.T.'s feeding difficulties. Denial was based on
09:46:33 15 Regence's position that the contract, quote, does not
09:46:37 16 cover neurodevelopmental therapy, end of quote.

09:46:41 17 For purposes of this motion, the court
09:46:44 18 accepts O.S.T.'s contention that his reading disorder
09:46:49 19 was characterized as a DSM IV diagnosis under 307.59.
09:46:57 20 At the time of the denial, because of the status of
09:47:00 21 O.S.T.'s insurance coverage under the individual
09:47:03 22 policy, the Mental Health Parity Act was not effective
09:47:08 23 until after that submittal until January 2008.

09:47:13 24 Following the effective date in January
09:47:17 25 2008 for coverage of the Mental Health Parity Act to

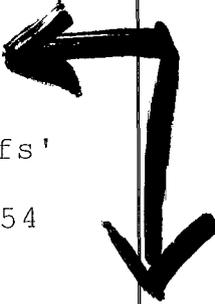
10:04:15 1 days.

10:04:16 2 MR. SPOONEMORE: The problem here, Your
10:04:17 3 Honor, is that you have in front of you here today is
10:04:19 4 the big boys at the insurance company. Everybody is
10:04:21 5 looking to see what happens to Regence, because nobody
10:04:24 6 -- none of the carriers wants to be take an adverse
10:04:26 7 selection. They don't want to have coverage, when
10:04:29 8 nobody else does. Everybody is looking to see what
10:04:32 9 happens here to Regence, in terms of how the industry
10:04:34 10 is going to either follow or not follow in terms of
10:04:36 11 the court rulings.

10:04:37 12 That is why we are concerned, I think,
10:04:39 13 about putting this off too long. Because really
10:04:43 14 people are looking to this case and what happens to
10:04:45 15 Regence in terms of the discussions that are going on
10:04:48 16 with Group Health and Premera. That is why the
10:04:52 17 Premera process is taking so long.

10:04:54 18 THE COURT: I want to hear from Mr. Parker.
10:04:57 19 But I will tell you with whatever my ruling would
10:05:04 20 be -- since I have the pending cross motion of summary
10:05:15 21 judgment -- if I grant Regence's motion and declare
10:05:26 22 the provision valid, that may be immediately
10:05:30 23 reviewable.

10:05:32 24 On the other hand, if I grant plaintiffs'
10:05:34 25 relief, it is not. Then we would be looking at a 54



10:05:44 1 (b), if parties thought that that would be
10:05:49 2 instructive.

10:05:49 3 From my perspective, it would be only in
10:05:54 4 the sense that it might make the Court of Appeals --
10:06:00 5 depends upon when I make my ruling.

10:06:02 6 It the might make the Court of Appeals look
10:06:05 7 more closely at the 54 (b) issue. They would, in other
10:06:10 8 words, consolidate A.G. with our case and then make
10:06:14 9 its ruling, whatever it might be.

10:06:21 10 MR. SPOONEMORE: That is an option. And I
10:06:22 11 think that it gives validity to that because, frankly,
10:06:24 12 it gives Regence its chance to make its argument, with
10:06:28 13 the Court of Appeals, rather than having one start
10:06:29 14 before the other.

10:06:31 15 Here is our concern, of the plaintiffs.
10:06:31 16 With the respect to the plaintiffs with respect to the
10:06:33 17 preliminary injunction, we didn't move with the
10:06:35 18 preliminary injunction with the previous motions.

10:06:39 19 THE COURT: Sorry, jumped the gun.

10:06:41 20 MR. SPOONEMORE: A little bit.

10:06:42 21 We didn't develop that record. They moved
10:06:44 22 to dismiss all of our claims. We never moved for a
10:06:47 23 preliminary injunction.

10:06:48 24 What our plans is -- I will be very candid
10:06:52 25 here. We are concerned with getting class-wide

10:14:49 1 grant plaintiffs' motion and say, it is invalid and
10:14:53 2 void.

10:14:56 3 If I grant Regence motion. The case is
10:14:58 4 over; automatic right of appeal.

10:15:00 5 If I grant plaintiffs' motion, then they
10:15:05 6 will seek class certification.

10:15:10 7 I am not overly keen about that because --
10:15:27 8 well, case law is clear that class certification ought
10:15:33 9 to be considered independently of the merits. You
10:15:36 10 don't decide the merits in making the determination of
10:15:40 11 the class certification.

10:15:41 12 The reason that I am saying that I am not
10:15:43 13 too keen on that is because it is a little bit of
10:15:46 14 which is the horse and which is the cart.

10:15:49 15 If the Court of Appeals says that legally,
10:15:53 16 I mean, my preference would be to get the legal
10:15:56 17 decision from the Court of Appeals and then decide the
10:15:59 18 class certification issue. So we have clarity on what
10:16:03 19 the issues are. That said, that precludes plaintiffs
10:16:08 20 from seeking injunctive relief before the court.

10:16:14 21 So, procedurally, I think that the best way
10:16:21 22 to proceed is to decide the declaratory issue, to
10:16:27 23 address the class certification issue, to address the
10:16:33 24 injunctive relief issue, that I would certify my
10:16:39 25 ruling, if I grant plaintiffs' declaratory relief.



10:16:47 1 That would allow Regence to join --
10:16:50 2 actually, both sides, if they want. I think that it
10:16:53 3 is in the plaintiffs' interests to get a determination
10:16:56 4 as much as it is to the defendants' interests to get a
10:17:03 5 ruling out of the Court of Appeals.

10:17:05 6 We are getting way ahead of ourselves. But
10:17:13 7 if the timing were right, then, I think that we would
10:17:20 8 consider whether to stay this matter, if cert is
10:17:26 9 accepted, if the certification is accepted.

10:17:32 10 MR. PARKER: I am concerned I am getting on
10:17:35 11 a slippery slope on an injunction here, Your Honor,
10:17:37 12 when there is no showing.

10:17:38 13 THE COURT: You are not. We are not even
10:17:42 14 warm. We are not even warm. Because before I can
10:17:47 15 consider injunctive relief, one, Mr. Spoonmore has to
10:17:52 16 set it up procedurally. That is number one. I should
10:17:57 17 say plaintiffs. It has to be set up procedurally.

10:18:02 18 First thing that I have to do is rule on
10:18:04 19 the declaratory relief. If I grant your motion,
10:18:07 20 Mr. Parker, the case is over.

10:18:13 21 Then, we have to consider class cert and I
10:18:20 22 don't -- I think somewhat to my embarrassment, I
10:18:27 23 jumped the gun on the injunctive relief ruling. I
10:18:31 24 conflated standing versus substantive ruling.

10:18:40 25 I guess we don't need to address the

10:21:48 1 minute recess and I will make a ruling on cross
10:21:55 2 motions for summary judgment.

10:21:57 3 Thank you.

10:21:58 4 MR. PARKER: There would be no argument on
10:22:00 5 the class certification today?

10:22:03 6 THE COURT: No. I think that both sides
10:22:05 7 think that we should put it off. I will give you a
10:22:07 8 date and a briefing schedule.

10:22:09 9 Thank you. The court is in recess.

10:22:10 10 (Court was recessed.)

10:42:03 11 (Open court.)

10:42:04 12 THE BAILIFF: All rise. Court is back in
10:42:06 13 session.

10:42:10 14 THE COURT: Please be seated.

10:42:20 15 The following is the court's ruling on
10:42:22 16 cross motions for summary judgment, Plaintiffs' motion
10:42:27 17 for summary judgment for declaration of coverage under
10:42:32 18 the Regence policy and Regence's cross motion for
10:42:37 19 summary judgment of dismissal.

10:42:39 20 Given the broad mandate regarding mental
10:42:44 21 health services, and the Mental Health Parity Act, RCW
10:42:50 22 48.44.341, pursuant to Washington's Declaratory Act,
10:42:58 23 RCW 7.24, the court grants plaintiffs' motion for
10:43:07 24 summary judgment regarding declaratory relief and
10:43:13 25 denies defendant's motion for summary judgment of

10:43:16 1 dismissal.

10:43:17 2 Plaintiffs O.S.T. and L.H. are entitled to
10:43:22 3 a declaration, that the exclusion in the defendant
10:43:28 4 Regence's policy for: "Treatment for
10:43:34 5 neurodevelopmental therapies, violates both Washington
10:43:39 6 public policy as well as its Mental Health Parity Act
10:43:43 7 under 48.43.341."

10:43:47 8 Accordingly, this court declares that the
10:43:53 9 neurodevelopmental therapy exclusion is void and
10:43:57 10 unenforceable in this case.

10:43:58 11 Under the Mental Health Parity Act,
10:44:02 12 defendant, Regence, must provide coverage for all
10:44:04 13 medically necessary: "Mental health services," to the
10:44:11 14 same extent that they provide such coverage for other
10:44:14 15 medical or surgical services.

10:44:17 16 Neurodevelopmental therapies are mental
10:44:22 17 health services and designed to treat expressive
10:44:25 18 language disorder, feeding disorders, and phonological
10:44:31 19 disorders and autism, to the extent that such mental
10:44:36 20 disorders are listed under DSM IV.

10:44:40 21 Since more neurodevelopmental therapies may
10:44:45 22 be necessary to treat all of these conditions,
10:44:47 23 defendants may not, and cannot use a blanket exclusion
10:44:50 24 under its policy to deny coverage for these therapies.

10:45:00 25 Although the defendant, Regence, has

10:45:07 1 requested that the court do so, this court does not
10:45:10 2 have to supersede or void the provisions of RCW
10:45:18 3 48.44.450, the Neurodevelopmental Therapy Act to reach
10:45:23 4 its ruling.

10:45:24 5 Under rules of statutory construction,
10:45:28 6 courts do not interpret statutes in isolation. Courts
10:45:32 7 interpret statutes in pari materia, considering all
10:45:39 8 statutes on the same subject, taking into account all
10:45:43 9 that the legislature has said on that subject and
10:45:47 10 attempting to create a unified whole, Hallauer versus
10:45:52 11 Spectrum Properties, Inc., 143 Wn.2nd 126, 2001
10:46:01 12 Supreme Court case.

10:46:04 13 Both the Neurodevelopmental Therapy Act and
10:46:10 14 the Mental Health Parity Act can be read together and
10:46:15 15 harmonized in considering the RCW 48.44.450. The
10:46:22 16 Neurodevelopmental Therapy Act only creates a minimum
10:46:25 17 level of required coverage.

10:46:29 18 Defendant Regence must meet the
10:46:33 19 requirements of both Acts, the Mental Health Parity
10:46:38 20 Act as well as the Neurodevelopmental Therapy Act,
10:46:41 21 accordingly, must provide coverage for
10:46:47 22 neurodevelopmental therapy for DSM diagnosed
10:46:51 23 conditions.

10:46:52 24 This is the ruling of the court. And
10:46:55 25 counsel is directed to prepare an appropriate order

10:57:00 1 THE BAILIFF: November 2nd, two weeks from
10:57:01 2 today?

10:57:08 3 THE COURT: Does that work for both sides?

10:57:10 4 MR. PARKER: That works for me, Your Honor.

10:57:15 5 MR. SPOONEMORE: That would work for us.

10:57:16 6 THE COURT: All right. 1:30 on November
10:57:20 7 2nd, 2012, supplemental briefing by plaintiff, if any.

10:57:33 8 Can you get it done by next Wednesday?

10:57:36 9 MR. SPOONEMORE: Yes; October 24th,
10:57:43 10 supplemental briefing.

10:57:46 11 THE COURT: Mr. Parker, the 30th of
10:57:52 12 October, does that work for you?

10:57:53 13 MR. PARKER: Yes, Your Honor, that would
10:57:55 14 work.

10:57:56 15 THE COURT: Then any reply by the 1st of
10:57:59 16 November. Can I put page limits on the supplemental
10:58:07 17 briefing?

10:58:08 18 MR. SPOONEMORE: I think that that would be
10:58:10 19 helpful.

10:58:11 20 THE COURT: 12, 12, 5 -- 12 plaintiff, 12
10:58:16 21 defense, five reply. So it is the 24th, the 30th and
10:58:30 22 the 1st, the briefing schedule, plaintiff, defense,
10:58:35 23 plaintiff.

10:58:36 24 Counsel, anything else?

10:58:37 25 MR. PARKER: Your HONor, I assume that Mr.



10:58:40 1 Spoonemore would include CR 54 (b) language on your
10:58:46 2 summary judgment?

10:58:46 3 THE COURT: Let me think about that for a
10:58:49 4 second. Yes, let's certify that. That was my intent

10:59:00 5 MR. SPOONEMORE: I will draft and circulate
10:59:02 6 to Mr. Parker.

10:59:05 7 THE COURT: You can send it by e-mail, if
10:59:07 8 you want. If Mr. Parker signs off on it, then he
10:59:11 9 doesn't need to sign it. Just say that this looks
10:59:14 10 fine and I will go ahead and enter it, if I can get
10:59:16 11 that within the next week, All right.

10:59:21 12 Counsel, thank you very much. I appreciate
10:59:25 13 it. I hope that everyone has a good weekend. The
10:59:28 14 court would be in recess.

10:59:30 15 THE BAILIFF: All rise. Court is in recess.

10:59:30 16

10:59:32 17 (Court was recessed.)

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EXHIBIT B



PROPOSED RULE MAKING

CR-102 (June 2012)

(Implements RCW 34.05.320)

Do NOT use for expedited rule making

Agency: Office of the Insurance Commissioner

Preproposal Statement of Inquiry was filed as WSR 12-12-064 ; or

Expedited Rule Making--Proposed notice was filed as WSR _____; or

Proposal is exempt under RCW 34.05.310(4) or 34.05.330(1).

Original Notice

Supplemental Notice to WSR 12-19-101
Continuance of WSR

Title of rule and other identifying information: Essential health benefits supplementation, scope and limitation requirements, and filing requirements

Insurance Commissioner Matter No. R 2012-17

Hearing location(s):

Training Room, T- 120
5000 Capitol Way S
Tumwater Washington

Submit written comments to:

Name: Meg L. Jones
Address: P.O. Box 40258
Olympia WA 98504
e-mail: rulescoordinator@oic.wa.gov
Fax: 360-586-3109

by (date) December 13, 2012

Date: December 14, 2012 Time: 10:00 a.m.

Assistance for persons with disabilities: Contact

Lorie Villaflores by December 10, 2012

TTY (360) 586-0241 or (360) 725-7087

Date of intended adoption: December 19, 2012

(Note: This is NOT the effective date)

Purpose of the proposal and its anticipated effects, including any changes in existing rules: The proposed rules will establish new sections in Subchapter C of chapter 284-43 RCW (health benefits), explaining the requirements associated with carrier inclusion of the essential health benefits package in non-grandfathered individual and small group plans for plans with coverage beginning January 1, 2014.

Reasons supporting proposal: RCW 48.43.715 directs the Commissioner to designate by rule the small group plan with the largest enrollment as the benchmark plan for purposes of defining the essential health benefits package for non grandfathered individual and small group health benefit plans issued on or after January 1, 2014. The same legislation requires supplementation, and adjustment or establishment of scope and limitation requirements by the commissioner in order to ensure meaningful benefits and prevent bias based on health selection. Carriers require specific guidance in order to prepare plan filings for the Commissioner's review prior to health benefit exchange deadlines, and to ensure time to satisfy plan replacement requirements.

Statutory authority for adoption: RCW 48.02.060;
48.21.241;48.21.320;48.43.715; 48.44.460; 48.44.341;
48.46.291; 48.46.530

Statute being implemented: RCW 48.43.715

Is rule necessary because of a:

Federal Law? Yes No
Federal Court Decision? Yes No
State Court Decision? Yes No

If yes, CITATION: P.L. 111-148, §1302

DATE

October 24, 2012

NAME (type or print)

Mike Kreidler

SIGNATURE

TITLE

Insurance Commissioner

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: **October 24, 2012**

TIME: **10:35 AM**

WSR 12-21-136

(COMPLETE REVERSE SIDE)

Agency comments or recommendations, if any, as to statutory language, implementation, enforcement, and fiscal matters:
None

Name of proponent: (person or organization) Office of the Insurance Commissioner

Private
 Public
 Governmental

Name of agency personnel responsible for:

Name	Office Location	Phone
Drafting..... Meg Jones	P.O. Box 40258, Olympia WA 98504	360-725-7170
Implementation.... Beth Berendt	P.O. Box 40258, Olympia WA 98504	360-725-7117
Enforcement..... Carol Sureau	P.O. Box 40258, Olympia WA 98504	360-725-7050

Has a small business economic impact statement been prepared under chapter 19.85 RCW or has a school district fiscal impact statement been prepared under section 1, chapter 210, Laws of 2012?

Yes. Attach copy of small business economic impact statement or school district fiscal impact statement.

A copy of the statement may be obtained by contacting:

Name:

Address:

phone () _____

fax () _____

e-mail _____

No. Explain why no statement was prepared.

The entities that must comply with the proposed rule are not small businesses, pursuant to chapter 19.85 RCW.

Is a cost-benefit analysis required under RCW 34.05.328?

Yes A preliminary cost-benefit analysis may be obtained by contacting:

Name: Meg Jones

Address: P.O. Box 40258
Olympia WA 98504

phone (360) 725-7170

fax (360) 586-3109

e-mail:

rulescoordinator@oic.wa.gov

No: Please explain:

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. WAC 284-43-849 through 284-43-885 implements the requirements of RCW 48.43.715, establishing a benchmark base plan and the essential health benefit package required in Washington State for nongrandfathered individual and small group health benefit plans.

(1) The commissioner will implement this subchapter to the extent that federal law or policy does not require the state to defray the costs of benefits included within the definition of essential health benefits.

(2) 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, unless a plan is providing an essential health benefit for pediatric oral services within the exchange, or as a subcontractor to a health benefit plan.

(3) This subchapter does not require provider reimbursement at the same levels negotiated by the benchmark base plan's carrier for their plan.

(4) This subchapter does not require a plan to exclude the services or treatments from coverage that are excluded in the benchmark base plan. The benchmark base plan's exclusions are used to inform the calculation of the actuarial value of the benchmark essential health benefits package.

(5) This subchapter does not establish requirements regarding the choice of specific types of venues for delivery of outpatient treatment, services or supplies, nor the choice of specific approaches to therapy or treatment.

NEW SECTION

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

"Benchmark base plan" means the small group plan with the largest enrollment, as designated in WAC 284-43-865(1).

"Health benefits" unless otherwise defined pursuant to federal rules, regulations or guidance issued pursuant to Section 1302(b) of PPACA, means health care items or services for injury, disease, or a health condition, including a behavioral health condition. Cost sharing requirements are not included in the definition of health benefits for purposes of

this subchapter.

"Individual plan" means any nongrandfathered health benefit plan offered, issued, amended or renewed by an admitted carrier 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 C.F.R. 144.103, and sections 3(5) and 3(40) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.).

"Mandated benefit" means a health plan benefit for a specific type of service, device or medical equipment, or treatment for a specified condition or conditions that is required by either state or federal law.

"Meaningful health benefit" means the range of services or benefits within each of the ten essential health benefit categories identified in Section 1302 of PPACA, that are medically necessary to ensure enrollees covered access to clinically effective services, including services critical to the needs of those with chronic disease or those with special needs based on age or gender.

"Medical necessity determination process" means the process used by a health carrier to make a coverage determination about whether a medical item or service, which is a covered benefit, 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 a requirement applicable to a benefit that limits the duration of a benefit, the number of times coverage is available for the benefit, or imposes a legally permitted eligibility limitation on a specific benefit.

"Small group plan" means any nongrandfathered health benefit plan offered, issued, amended or renewed by an admitted carrier 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 C.F.R. 144.103, and sections 3(5) and 3(40) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.).

"Stand-alone dental plan" means a contract or agreement covering a set of benefits limited to oral care including, but not necessarily limited to, pediatric oral care.

NEW SECTION

WAC 284-43-860 Medical Necessity Determination

(1) A carrier may not apply its medical necessity determination process in a manner that results in a uniformly applied limitation on the scope, visit number or duration of a benefit that applies regardless of the specific treatment requirements of the patient, unless that uniform limitation is specifically explained in the certificate of coverage and the Summary of Coverage and Explanation of Benefits for the health plan.

(2) A carrier's medical necessity determination process must:

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

(b) Conducted fairly, and with transparency, 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 its process for interpretation of the medical purpose of interventions 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) Consider the 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) A carrier'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 284-43-875 Application of the definition and scope requirements for essential health benefit categories. (1) When calculating the actuarial value of a plan's essential health benefit package, each health benefit carrier must appropriately classify services covered by the plan consistent with WAC 284-43-877.

(2) A carrier 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. This obligation does not require a carrier to contract with any willing provider, nor is a carrier restricted from establishing requirements for credentialing of and access to providers within its network.

NEW SECTION

WAC 284-43-877 Essential Health Benefits Package Benchmark Parameters A carrier must classify its services to an essential health benefits category consistent with this section for purposes of determining actuarial value and the scope of coverage.

(1) When the commissioner determines that a health benefit plan's "ambulatory patient services" category covers 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, and which are not included in a more specifically defined essential health benefits category, in a substantially equivalent manner to the benchmark base plan, it provides a meaningful benefit in this category.

(a) The benchmark base plan specifically excludes the following services that would otherwise be included in this category:

(i) Infertility treatment and reversal of voluntary sterilization;

(ii) Routine foot care;

(iii) Dental services provided to prevent, diagnose or treat diseases or conditions of the teeth and adjacent supporting soft tissues, including treatment that restores the function of teeth are excluded;

(iv) Private duty nursing;

(v) Nonskilled care and help with activities of daily living;

(vi) 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;

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

(b) The benchmark base plan's limitation on nutritional counseling to three visits per lifetime is an unreasonable restriction on patient treatment. A carrier may establish a reasonable visit limitation requirement for nutritional counseling for medical conditions when supported by evidence based medical criteria.

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

(i) Ten spinal manipulation services without referral;

(ii) Twelve acupuncture services per year without referral;

(iii) One vision examination per calendar year, with one hundred fifty dollars per year for hardware, including frames, contacts, lenses, and tints;

(iv) Fourteen days respite care on either an inpatient or outpatient basis for hospice patients, per lifetime. Where respite services are delivered on an inpatient basis in a hospital or skilled nursing facility, the benefit may be classified to the hospital category;

(v) One hundred thirty visits per year for home health care.

(d) Services specifically classified under this category that the benchmark base plan covers include, but are not limited to:

(i) Home and out-patient dialysis services;

(ii) Hospice and home health care;

(iii) Provider office visits and treatments;

(iv) Urgent care center visits.

(e) State mandates 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) Home health care and hospice services delivered in the home (RCW 48.21.220 and 48.44.320)'

(iv) 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) When the commissioner determines that a health benefit

plan's "emergency medical services" category covers care and services related to an emergency medical condition in a manner substantially equivalent to the benchmark base plan, the plan provides a meaningful benefit for this category.

(a) Benefits classified under this category include:

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

(ii) Emergency room based services and treatment.

(b) State mandates classified under this category include services necessary to screen and stabilize a covered person (RCW 48.43.093).

(3) When the commissioner determines that a health benefit plan's "hospitalization" category covers 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 benchmark base plan, the plan provides a meaningful benefit for this category.

(a) The benchmark base plan specifically excludes the following services that would otherwise be included in this category:

(i) 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;

(ii) Obesity surgery and supplies,

(iii) Orthognathic surgery and supplies unless due to Temporomandibular joint disorder or injury, sleep apnea or congenital anomaly'

(iv) Sexual reassignment treatment and surgery;

(v) Reversal of sterilizations;

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

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

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

(ii) Transplant services delivered prior to the end of a six month waiting period that is inclusive of prior creditable coverage. Beginning January 1, 2014, the waiting period may be no longer than ninety days.

(d) Covered services specifically classified under this category that the benchmark base plan covers include:

(i) Transplant services for donors and recipients, including the transplant facility fees;

(ii) Dialysis services delivered in a hospital;
(iii) Artificial organ transplants based on medical guidelines;

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

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

(e) State mandates covered under this category include:

(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).

(4) When the commissioner determines that a health benefit plan's "maternity and newborn" category covers 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, the plan provides a meaningful benefit for this category.

(a) The benchmark base plan's visit limitations on services in this category include home birth by a midwife or nurse midwife is covered only for low risk pregnancy.

(b) Services specifically classified under this category that the benchmark base plan covers include:

(i) In utero treatment for the fetus;

(ii) Delivery in a hospital or birthing center, including facility fees;

(iii) Professional and nursery services for newborns;

(iv) Infertility diagnosis;

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

(vi) Termination of pregnancy.

(c) State mandates classified under this category include:

(i) Women's health care services including maternity services performed by a midwife, M.D., D.O., or ARNP (RCW 48.42.100; 48.43.115);

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

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

(iv) 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,).

(d) The commissioner finds that the exclusion of maternity coverage for dependent daughters is an unreasonable restriction on patient treatment, and violates the women's wellness coverage requirements in PPACA. The limitation is not included as part of the benchmark base plan.

(f) The commissioner finds that the limitation on coverage for newborns delivered of dependent daughters, covering the newborn for seventy-two hours, is an unreasonable restriction on patient treatment, and is discriminatory. The limitation is not included as part of the benchmark base plan.

(5) When the commissioner determines that a health benefit plan's "mental health and substance use disorder services, including behavioral health treatment" category covers 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 benchmark base plan, the plan provides a meaningful benefit for this category.

(a) The benchmark base plan specifically excludes the following services that would otherwise be included in this category:

(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 in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders, 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.

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

(i) A limit of four employee assistance program counseling sessions;

(ii) Court ordered treatment only when medically necessary.

(c) Services specifically classified under this category that the benchmark base plan covers include:

(i) Inpatient, residential, and outpatient mental health treatment;

(ii) Chemical dependency detoxification;

(iii) Behavioral treatment;
(iv) Prescription medication prescribed during an inpatient and residential course of treatment; and
(v) Acupuncture services for treatment of chemical dependency, without visit limitation.

(d) State mandates classified 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).

(e) For purposes of this section, 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).

(6) When the commissioner determines that a health benefit plan's "prescription drug services" category covers medically necessary prescribed drugs, medication and drug therapies, in a manner substantially equivalent to the benchmark base plan, the plan provides a meaningful benefit for this category.

(a) The benchmark base plan's specifically excludes weight loss drugs under this benefit.

(b) The benchmark base plan's exclusion of coverage for medication prescribed as part of a clinical trial, that is not the subject of the trial, is an impermissible exclusion of coverage under state and federal law.

(c) The benchmark base plan applies the following limitations to coverage:

(i) Prescriptions for self-administrable injectible medication are limited to thirty-day supplies at a time;

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

(e) Services specifically classified under this category that the benchmark base plan covers include:

(i) Those classes of drugs, and the specific drugs in the drug formulary;

(ii) Prescribed medical supplies, including diabetic supplies that are not otherwise covered as durable medical equipment under the rehabilitative and habilitative services category;

(iii) All FDA approved contraceptive methods, sterilization

procedures for all women with reproductive capacity.

(f) A carrier's formulary is part of the prescription drug benefit category, and must be substantially equal to the benchmark base plan formulary, both as to therapeutic class and included drugs in the class. 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. A carrier 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).

(g) State mandates classified under this category include:

(i) Medical foods to treat inborn errors of metabolism, including PKU (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);

(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 (RCW 48.44.341, 48.46.291, 48.20.580, and 48.21.241).

(7) When the commissioner determines that a health benefit plan's "rehabilitative and habilitative services" category covers the following, the plan provides a meaningful benefit in this category:

(a) Medically necessary rehabilitative 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; and

(b) Habilitative services that include the range of medically necessary health care services and health care devices designed to assist an individual in partially or fully developing, learning and retaining developed or learned age appropriate skills and functioning, within the individual's environment or to compensate for a person's progressive physical, cognitive and emotional illness and that:

(i) Are provided in a manner consistent with RCW 48.43.045;

(ii) Take into account the unique needs of the individual;

(iii) Target measurable, specific treatment goals appropriate for the person's age, and physical and mental condition; and

(iv) Are consistent with the carrier's utilization review guidelines and practice guidelines recognized by the medical

community as efficacious, and do not necessarily require a return to a prior level of function, if the scope of the services complies with (g) of this subsection.

A carrier may limit the definition of health care devices under the habilitative services category to those that require Food and Drug Administration (FDA) approval, and a prescription to dispense the device.

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

(i) Hearing aid devices are limited to cochlear implants;

(ii) Inpatient rehabilitation facility and professional services delivered in those facilities are limited to thirty days per year;

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

(d) The benchmark base plan specifically classifies orthotics used to support, align or correct deformities or to improve the function of moving parts under this category.

(e) Services that would otherwise be classified under this category but the benchmark base plan specifically excludes are:

(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.

(f) State mandates classified 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);

(g) The scope of habilitative services must include, but is not limited to, the following requirements:

(i) The services and devices must be covered on not less than a parity basis to rehabilitative benefits. Habilitative services must not be limited to speech, physical and occupational therapy if medical necessity requires other types of habilitative services and devices that are consistent with the definition in (b) of this subsection;

(ii) Habilitative services and devices delivered pursuant to federal Individuals with Disabilities Education Act of 2004 (IDEA) requirements or other habilitative services delivered in an educational setting may be excluded from coverage;

(iii) Habilitative services must be covered both as to type of service and amount of the service. The phrase "the amount" refers to the number of services, subject to a carrier's medical necessity and utilization review determinations. A carrier may not exclude coverage for services delivered outside an educational setting on the basis that the enrollee is receiving some of the prescribed number of services in an educational

setting;

(iv) Rehabilitative services do not necessarily require a return to a prior level of function.

(h) The scope of rehabilitative services may not be applied in a manner that results in a limitation of coverage that is inconsistent with evidence based medical guidelines for therapies specific to disease recovery, other than on the basis of medical necessity. A health benefit plan must classify therapies specific to disease recovery to the ambulatory patient services category or, when delivered in an inpatient setting, the hospitalization category. Examples of these are, but are not limited to, breast cancer rehabilitation therapy, respiratory therapy, and cardiac rehabilitation therapy.

(8) When the commissioner determines that a health benefit plan's "laboratory services" category covers 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 benchmark base plan, the plan provides a meaningful benefit for this category.

(9) When the commissioner determines that a health benefit plan's "preventive and wellness services, including chronic disease management" category covers 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, the plan provides a meaningful benefit for this category.

(a) The benchmark base plan specifically covers preventive services recommended by the Centers for Disease Control's Advisory Committee on Immunization Practices, the U.S. Preventive Services Task Force A and B guidelines for prevention and chronic care, the U.S. Health Resources and Services Administration Bright Futures guidelines as set forth by the American Academy of Pediatricians.

(b) State mandates 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).

(10) When the commissioner determines that a health benefit

plan's "pediatric services" category covers persons who would otherwise be eligible for child only coverage under state law, in a manner substantially equivalent to the benchmark base plan in each of the essential health benefits categories, includes the pediatric vision benefits set forth in the Federal Employees Vision Plan with the largest enrollment and published by the U.S. Department of Health and Human Services at www.cciioo.cms.gov on July 2, 2012, and includes the pediatric oral benefits found in the Washington state CHIP plan, in a manner substantially equivalent to these supplemental benchmark plans, the plan provides a meaningful benefit for this category.

(a) The vision services included in the "pediatric" category are:

(i) Routine vision screening for children, including dilation and with refraction every calendar year, including dilation;

(ii) One pair of prescription lenses or contacts every calendar year, including polycarbonate lenses and scratch resistant coating;

(iii) One pair of frames every calendar year;

(iv) Low vision optical devices including low vision services, and an aid allowance with follow-up care when preauthorized.

(b) The pediatric vision benefits specifically exclude:

(i) Visual therapy;

(ii) Two pairs of glasses may not be ordered in lieu of bifocals.

(c) The oral benefits included in the "pediatric" category are:

(i) Diagnostic services;

(ii) Preventive care;

(iii) Restorative care;

(iv) Oral surgery and reconstruction to the extent not covered under the hospitalization benefit;

(v) Endodontic treatment;

(vi) Periodontics;

(vii) Crown and fixed bridge;

(viii) Removable prosthetics;

(ix) Medically necessary orthodontia.

(d) The pediatric oral benefits include the following scope and limitation requirements:

(i) Diagnostic exams once every six months, beginning before one year of age;

(ii) Bitewing X ray once a year;

(iii) Panoramic X rays once every three years;

(iv) Prophylaxis every six months beginning at age six months;

(v) Fluoride three times in a twelve month period for ages

six and under; two times in a twelve month period for ages seven and older; three times in a twelve month period during orthodontic treatment; sealant once every three years for occlusal surfaces only; oral hygiene instruction two times in twelve months for ages eight and under if not billed on the same day as a prophylaxis treatment;

(vi) Every two years for the same restoration (fillings);

(vii) Frenulectomy or frenuloplasty covered for ages six and under without prior authorization;

(viii) Root canals on baby primary posterior teeth only;

(ix) Root canals on permanent anterior, bicuspid and molar teeth, excluding teeth 1, 16, 17, and 32;

(x) Periodontal scaling and root planning once per quadrant in a two year period for ages thirteen and older, with prior authorization;

(xi) Periodontal maintenance once per quadrant in a twelve month period for ages thirteen and older, with prior authorization;

(xii) Stainless steel crowns for primary anterior teeth once every three years; if age thirteen and older with prior authorization;

(xiii) Stainless steel crowns for permanent posterior teeth once every three years;

(xiv) Metal/porcelain crowns and porcelain crowns on anterior teeth only, with prior authorization;

(xv) Space maintainers for missing primary molars A, B, I, J, K, L, S, and T;

(xvi) One resin based partial denture, replaced once within a three year period;

(xvii) One complete denture upper and lower, and one replacement denture per lifetime after at least five years from the seat date;

(xviii) Rebasing and relining of complete or partial dentures once in a three year period, if performed at least six months from the seating date.

(e) The pediatric oral benefit specifically excludes implants.

(f) State mandates classified under this category include:

(i) 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);

(ii) Congenital anomalies in newborn and dependent children (RCW 48.20.430, 48.21.155, 48.44.212, 48.46.250, and 48.21.155).

NEW SECTION

WAC 284-43-880 Plan design parameters. (1) A nongrandfathered individual or small group health benefit plan issued, renewed, amended, or offered on or after January 1, 2014, must cover the ten essential health benefits categories as set forth in the benchmark base plan, as supplemented by the commissioner, at least to the extent that the benefits and services included are medically necessary, and so that the benefits are substantially equal to the designated benchmark plan, as supplemented.

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

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

(b) The aggregate value of the benefits across all essential health benefit categories is not less than the aggregate value of the benchmark base plan as supplemented by the commissioner; and

(c) Within each essential health benefit category, the actuarial value of the category is not less than the actuarial value of the category for the benchmark base plan as supplemented by the commissioner.

(2) A carrier may not alter its health benefit plan design by transferring a service from the category assigned to it by the commissioner in WAC 284-43-877 if that transfer results in the elimination of a parity requirement.

(3) Nothing precludes a health carrier from including coverage for benefits in a health benefit plan that are in addition to the benchmark base plan's essential health benefit package, as supplemented by the commissioner. A carrier must identify in its rate filing those services substituted within a category as part of the essential health benefits package, if the carrier includes the service in calculating actuarial value of the essential health benefits package.

(4) To the extent that the benchmark base plan contains benefit limitations that conflict with requirements of PPACA, the benefit limitations must be amended to comply with PPACA's requirements.

(5) 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 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),

as amended, or Washington state law.

(6) Pediatric oral benefits must be included in a health benefit plan 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 benchmark base plan, as supplemented, is offered in the health benefit exchange for that benefit year.

(7) A carrier must not impose annual or lifetime dollar limits on an essential health benefit.

NEW SECTION

WAC 284-43-882 Plan cost sharing and benefit substitution of limitations (1) At the time a health benefit plan form is filed with the commissioner for approval, if a carrier elects to adjust specific services within any of the essential health benefit categories, or a quantitative limit for a service, a carrier must submit with its filing an actuarial opinion certifying the equivalence of the value of the plan's essential health benefits in the category, and overall, to the benchmark base plan as supplemented.

(2) 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.

(3) 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.

(4) A carrier may use reasonable medical management techniques to control costs, including promoting the use of appropriate, high value preventive services, providers and settings. A carrier'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.

(5) A carrier 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.

NEW SECTION

WAC 284-43-885 Representations regarding minimum essential coverage. A health carrier must not indicate or imply that a health benefit plan covers the essential health benefits unless the plan 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.