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Chapter 15: Regulation of Health Carriers

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Chapter Outline

15.1 Chapter Summary

This chapter describes the statutory and regulatory framework governing health carriers[1] in the State of Washington. Although a detailed explanation of federal regulations is beyond the scope of this chapter, they are addressed to the extent they are enforced by the Insurance Commissioner or are formally incorporated into state law. In addition to a description of relevant statutes and regulations, the role of the Office of Insurance Commissioner is addressed.

15.2 Overview of the Insurance Code

The Washington Insurance Code (Title 48 RCW) and Insurance Commissioner Regulations (Title 284 Washington Administrative Code) are not organized in a useful manner. This results from the fact that the Insurance Code was last recodified in 1947. Together with the ongoing adoption of regulations by the Office of the Insurance Commissioner, this means a single issue may be addressed in multiple chapters of Title 48 RCW and Title 284 WAC, as well as applicable federal law.

15.3 Federal Law and the Affordable Care Act

Notwithstanding the McCarran-Ferguson Act (15 USC § 1011 *et seq.*), which cedes insurance regulation to the states, there are several federal provisions preempting state insurance law, notably: the Patient Protection and Affordable Care Act (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act (Public Law 111-152) ("ACA"), ERISA (29 USC § 1001 *et seq.*), the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 42 USC 201 *et seq.* and 45 CFR Parts 160 and 164), and the Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343).

Title I of the ACA in particular undertook significant reform of the commercial health insurance market. Title I of the ACA preempts state law, but only to the extent that state law is incompatible with the requirements of the Act. As a result, one portion of a particular RCW may be preempted, while another portion remains valid law. Similarly, certain portions of the Insurance Code remain valid law for "grandfathered" health plans issued prior to March 23, 2010, but have otherwise been preempted by the ACA.[2] Moreover, Washington has incorporated many provisions of the ACA by reference into state law and regulations, and the enforcement of many of the Act's provisions are delegated to state insurance regulators. This has resulted in a rapidly evolving complex regulatory landscape as state regulators attempt to reconcile and implement both state and federal law.

15.4 Office of the Insurance Commissioner

The Insurance Commissioner is an elected official. The Office of the Insurance Commissioner has seven divisions each headed by a deputy appointed by the Commissioner. The divisions are: Company Supervision,[3] Rates and Forms,[4] Consumer Protection,[5] Legal Affairs and Enforcement,[6] Policy and Legislative Affairs[7], Operations,[8] and Public Affairs.[9]

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[1] "Health carriers," is used as defined at RCW 48.43.005(25) and includes commercial disability insurers, healthcare service contractors and health maintenance organizations. The definition also includes "issuers" as defined in the ACA. However, this definition is somewhat circular, as the ACA defines issuers as an "insurance company, insurance service, or insurance organization (including a health maintenance organization) which is licensed to engage in the business of insurance in a State and which is subject to state law which regulates insurance."

[2] RCW 48.43.005(20). As there are relatively few "grandfathered" health plans remaining in Washington, this chapter focuses on the laws and regulations governing non-grandfathered plans.

[3] Financial Examinations, Market Conduct Examinations, Financial Analysis, Holding Company Law compliance and Company Licensing.

[4] Life and Disability, Property and Casualty, and Health Care Actuarial Services and Form Compliance.

[5] Consumer Advocacy, Investigation, Examinations, Producer Licensing and Education, Holocaust, and SHIBA.

[6] Penal Action Against Licensees.

[7] Policy, Rules Coordination and Legislative Review.

[8] HR, IS, Public Records, Facilities, Fiscal, Telecommunications.

[9] Press Relations, Social Media and Web Site Maintenance.

15.5 Overview of Disability Insurers, Health Care Service Contractors ("HCSC") and Health Maintenance Organizations ("HMO")

There are three types of health carriers: disability (accident and health) insurers, health care service contractors, and health maintenance organizations.[10] Each is governed by a separate chapter in the Insurance Code and all are subject to Chapter 48.43 RCW.

- Disability insurers are regulated under Chapters 48.20, 48.21 and 48.43 RCW.
- Health care service contractors are regulated under Chapter 48.44 and Chapter 48.43 RCW.
- Health maintenance organizations are regulated under Chapters 48.46 and 48.43 RCW.

Historically, disability insurers offered pure indemnity plans, health care service contractors offered indemnity and participating provider plans, and health maintenance organizations offered comprehensive health care services through employed positions (staff model) or participating providers (network model). This distinction has blurred over time with all three types of carriers offering health benefit plans utilizing provider networks. Disability insurers are commercial insurers. HCSCs and HMOs may be for profit or not for profit and are generally prohibited by federal antitrust law from being governed by providers – at least with respect to provider contracting and provider payment.[11]

15.6 Disability Insurers

Disability insurers issue "contracts of insurance" or policies providing coverage against bodily injury, disablement or death by accident or illness.[12]

15.6.1 Formation and Authorization of Disability Insurers

Any domestic, foreign (domiciled in the United States other than in the State of Washington) or alien (domiciled outside the United States) insurer must obtain a certificate of authority before it can transact insurance in the state. A certificate of authority is issued by the Office of the Insurance Commissioner ("OIC").[13] The OIC has the authority to suspend or revoke an insurer's certificate of authority under defined circumstances.[14]

15.6.1.1 Solicitation Permits

Formation of an insurer in Washington State requires a solicitation permit issued by the OIC. The application for the solicitation permit requires disclosure of information about the persons involved in the formation of the insurer, third-party verification of their general trustworthiness and competence, and information concerning the manner in which funds will be solicited, the solicitation plan, articles and bylaws, securities to be issued, advertising of the solicitation, prospectuses and insurance contracts.[15] The applicant for a solicitation permit must file a $50,000 bond or cash deposit with the OIC.[16]

15.6.1.2 Regulation of Disability Insurer Financial Condition.

A disability insurer must have initial paid-in-capital stock or basic surplus of $2,000,000[17] and an additional surplus of $2,000,000. Every health carrier must file an annual report with the Commissioner demonstrating that its risk-based capital ("RBC") levels meet required levels.[18] All health carriers are required to file an RBC report with the National Association of Insurance

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[10] Accountable Care Organizations ("ACO's") are not listed under the statutory definition of health carriers and are not currently regulated as a separate type of carrier by the OIC. However, to the extent that an ACO is structured in a way to otherwise meet the definition of a health carrier, it may be regulated by the OIC.
[11] *Arizona v. Maricopa County Medical Society*, 457 U.S. 332, 102 S. Ct. 2466, 73 L. Ed. 2d 48 (1982).
[12] RCW 48.11.030 and 48.21.010.
[13] RCW 48.05.030 and 48.05.040 and 48.05.110 through 140.
[14] *See* RCW 48.05.140.
[15] RCW 48.06.040.
[16] RCW 48.06.110.
[17] RCW 48.05.340.
[18] *See* RCW 48.05.030(11).

Commissioners ("NAIC").[19] Inadequate RBC will trigger a "company action level event" which places the company under OIC scrutiny and requires submission of an RBC plan containing proposals for corrective action.[20] Further deterioration of a disability insurer's RBC will trigger a "regulatory action level event" requiring a revised RBC plan and resulting in a financial examination of the insurer by the OIC.[21] More serious RBC shortfalls trigger "authorized control level" events and "mandatory control level events." The former may involve the Commissioner in the operation of the disability insurer;[22] the latter mandates it.

Only certain types of assets constitute recognized assets of the insurer.[23] Generally accepted accounting principles do not control when in conflict with the statutory accounting principles set forth in Chapter 48.13 RCW.

15.6.2 Individual and Group Contract Filing Requirements

Disability insurance policies are "prior approval" products, i.e., policy forms cannot be offered to Washington consumers until they are filed with and approved by the OIC.[24] However, if the form is certified by the disability insurer's chief executive or qualified actuary, the insurer may use the form upon filing subject to the Commissioner's later disapproval.[25] Noncertified filings are "deemed" approved 30 days after filing if the OIC does not affirmatively disapprove the form.[26] The Commissioner may extend the approval period for 15 days.[27] The Commissioner may withdraw approval at any time for cause.[28]

Certain standard provisions are required in all policies. For example, claim forms, claim payments, grace periods for payment of premium, and mandated benefits are subject to uniformity requirements.[29] A "patient bill of rights" procedure must be filed with the OIC.

15.6.3 Provider Contracting

Initially, disability insurers provided only indemnity plans. Currently, they often contract with providers but are not required to do so. Benefits payable under a participating provider policy are paid to the provider. Benefits payable under an indemnity plan are payable jointly to the covered person and the provider.[30]

15.6.4 Stop Loss Insurance and ERISA Preemptions

The Employee Retirement Income Security Act of 1974 ("ERISA") preempts state laws relating to employee benefit plans.[31] However, under the "savings clause" ERISA does not preempt state insurance regulation.[32] Large employers may "self-insure" and retain the risk. In such circumstances, the employer typically purchases stop loss insurance to protect against catastrophic loss. Purchase of a stop loss policy by a self-insured plan does not render the plan subject to state regulation.[33] However, if the excess policy "attaches" below a threshold, it is treated as an insured plan.[34] Stop loss insurance attaching below the statutory threshold is subject to state regulation.[35]

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[19] RCW 48.05.435 and 48.43.300 *et seq.*
[20] RCW 48.05.440.
[21] RCW 48.05.445.
[22] RCW 48.05.450 and 48.05.455.
[23] Chapter 48.13 RCW.
[24] RCW 48.18.100.
[25] RCW 48.18.100(2).
[26] RCW 48.18.100(3).
[27] RCW 48.18.100(3).
[28] RCW 48.18.100(3).
[29] *See, for example,* Chapter 48.20 RCW and Chapter 284-50 WAC regarding individual disability insurance contracts. See also § 15.7.3.3 and §15.9 of this Chapter.
[30] RCW 48.21.110.
[31] 29 U.S.C. § 1144(a).
[32] *See Washington Physicians Service Ass'n v. Gregoire*, 147 F.3d 1039 (9th Cir. 1998).
[33] *See UFCW and EE Arizona Health and Welfare Trust v. Pacyga*, 801 F.2d 1157 (9th Cir. 1986; and *Moore v. Provident Life,* 786 F.2d 922 (9th Cir. 1986).
[34] RCW 48.21.015.
[35] RCW 48.21.015.

15.6.5 Other Regulations of Disability Insurers

Mergers and insolvencies of insurers are governed by Chapter 48.31 RCW. Transactions involving related companies, one of which is an insurer, are subject to the reporting requirements of Chapter 48.31B RCW. Disability insurer insolvency is further subject to the Washington Life and Disability Insurance Guaranty Association Act ("WLDIGA").[36] The WLDIGA is funded by assessments on life and disability insurers.[37]

Taxes and fees applicable to disability insurers are set forth in Chapter 48.14 RCW. The regulation of insurance producers (agents and brokers), including their obligations to disability insurers, are regulated pursuant to Chapter 48.17 RCW and Chapter 284-12 WAC.

15.7 Health Care Service Contractors

Health care service contractors are primarily regulated under Chapter 48.44 RCW. The statutory definition of a health care service contractor is "any corporation, cooperative group or association which is sponsored by or otherwise intimately connected with a provider or group of providers, who or which not otherwise being engaged in the insurance business, accepts prepayment for health care services from or for the benefit of persons or groups of persons as consideration for providing such persons with health care services."[38] This statutory definition is somewhat antiquated. The "intimately connected" language is an artifact of the medical bureaus that evolved into health care service contractors. Antitrust considerations have resulted in the dilution of provider control over HCSCs. The general rule is that HCSCs are not subject to state insurance law.[39] However, many insurer provisions in the Insurance Code and OIC regulations are made applicable to health care service contractors including Chapter 48.43 RCW.

HCSCs are almost exclusively participating provider organizations but can offer one or more indemnity benefits as part of the benefit contract. Pure indemnity products offered by HCSCs would not be permitted, as the HCSC would require a Certificate of Authority as a Disability Insurer.[40]

15.7.1 Formation and Registration Requirements

HCSCs must meet formation and registration requirements. Operating as a HCSC without a certificate of registration is a criminal[41] act, although it is typically dealt with by an OIC Cease and Desist Order and fine.[42]

15.7.1.1 Solicitation Permit

HCSCs are typically corporations but may take other forms.[43] An HCSC must be registered with the OIC. The process for obtaining a solicitation permit for the formation of a health care service contractor is expressly made subject to Chapter 48.06 RCW.[44] Accordingly, the solicitation process is the same as that for disability insurers.[45]

15.7.1.2 Registration

An HCSC must register with the Insurance Commissioner and apply for a certificate of registration.[46] Detailed information is required to obtain registration.[47] Master lists of the HCSC's participating providers must be filed with the Commissioner and updated on a monthly basis.[48]

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[36] Chapter 48.32A RCW.
[37] RCW 48.32A.085.
[38] RCW 48.44.010(9).
[39] RCW 48.44.020(1).
[40] RCW 48.05.030(2).
[41] RCW 48.44.016(3).
[42] RCW 48.44.016(5).
[43] RCW 48.44.010(9).
[44] RCW 48.44.015(2).
[45] *See* 15.6.1.1, *supra.*
[46] RCW 48.44.015(1).
[47] RCW 48.44.040.
[48] RCW 48.44.080.

The HCSC is subject to initial examination and subsequent examination at the pleasure of the Commissioner.[49]

A certificate of registration may be revoked on one of the bases identified in RCW 48.44.160. Due process is provided by way of administrative hearing.[50]

15.7.1.3 Capitalization and Insolvency Plan Requirements

An HCSC must maintain a minimum net worth of $3,000,000 or 2% of annual earned premium, whichever is greater.[51] A grandfather provision has lower requirements for health care service contractors registered prior to July 27, 1997.[52] Health carrier solvency and financial strength are determined in accordance with a risk-based capital formula.[53]

HCSCs must have a plan that provides for a continuation of benefits for the balance of the contract period notwithstanding insolvency of the HCSC.[54] Participating providers must agree to look solely to the HCSC for payment and are forbidden from billing enrollees.[55] The OIC must approve the HCSC's insolvency plan if it relies on insurance, letters of credit, or bonds.[56]

15.7.2 Rate and Form Filing Requirements

HCSCs are subject to financial reporting requirements including annual reports.[57] HCSCs may be required to file updates to their registration statements. HCSC forms and rates with some exceptions are "file and use" products, which may be used after they are filed with the OIC.[58] Individual rate filings are "deemed" approved 60 days after filing if the OIC does not affirmatively disapprove the form.[59] The Insurance Commissioner regulates both individual and small group contracts and rates and may disapprove any contract if the benefits provided are unreasonable in relation to the amount charged for the contract.[60] Carriers filing individual rates for grandfathered health plans must provide each individual plan rate schedule and certification that individual contract rates satisfy a loss ratio of 74% minus premium tax.[61] Non-grandfathered individual and small group products are subject to a federal medical loss ratio of 80% pursuant to the ACA.[62] Carriers filing small group rates must file base rates and annual base rate changes for each small group plan.[63] When filing rates all carriers must provide a description of their rate-making methodology and actuarially determined estimates and justifications for projected incurred claims.[64]

15.7.3 Enrollee Contract Requirements

The Insurance Code, federal law and OIC regulations specify various requirements for health care service contracts. This includes not only the format and certificate delivery requirements, but also substantive provisions addressing preexisting conditions, guaranteed renewability, conversion contract availability, and mandated benefits.

15.7.3.1 General Contract Requirements

A health care service contract (or "enrollee contract") may be disapproved by the OIC if it contains "inconsistent, ambiguous or misleading clauses or exceptions and conditions which

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[49] RCW 48.44.145(4).
[50] RCW 48.44.160.
[51] RCW 48.44.037(1).
[52] RCW 48.44.037(2).
[53] *See* 15.6.1.2 *supra* and RCW 48.43.300 *et seq.*
[54] RCW 48.44.055.
[55] RCW 48.44.010(14), 48.44.055(2) and 48.44.020(4).
[56] RCW 48.44.055.
[57] WAC 284-44-350.
[58] RCW 48.44.020(3); WAC 284-43-920.
[59] RCW 48.44.020(3).
[60] RCW 48.44.022; RCW 48.44.023; RCW 48.44.020(3); 42 U.S.C. §300gg.
[61] WAC 284-43-930; RCW 48.44.017(2).
[62] 42 U.S.C. 300gg-18.
[63] WAC 284-43-930.
[64] WAC 284-43-930.

unreasonably or deceptively affect the risk" purported to be assumed.[65] Other grounds for OIC disapproval of an enrollee contract include: (a) deceptive advertising; (b) unreasonable benefits in relation to the rates charged; (c) unreasonable restrictions on the treatment of patients; or (d) lack of "hold harmless" language that states the enrollee is not liable to the provider if the HCSC fails to pay for covered services.[66]

The Code includes specific requirements relating to coverage of dependents, newborns, and adopted children.[67] All non-grandfathered contracts which provide coverage for dependents must offer the option of covering any child under the age of twenty-six.[68] All grandfathered contracts which provide coverage for dependents must also offer the option of covering any child under the age of twenty-six unless the child is eligible to enroll in health coverage sponsored by the child's employer.[69] If a contract provides for termination of dependent coverage when the dependent reaches a specified age, the contract must also provide that there will be no termination if the child is incapable of self-sustaining employment by reason of developmental disability or physical handicap and chiefly dependent upon the subscriber for support and maintenance.[70] A contract that provides coverage for dependent children must cover newborn infants from birth, including coverage for congenital anomalies.[71] Adopted children must be covered: (a) upon being physically placed with the subscriber; and (b) upon the subscriber's assumption of financial responsibility for the child's medical expenses.[72]

Individual contracts must give the enrollee the right to cancel coverage within ten days of the contract's delivery. Upon such cancellation, the HCSC must return the enrollee's premium.[73]

Contracts that exclude or limit benefits for experimental or investigational treatments must include a definition of "experimental or investigational." The definition must identify the authorities that will determine whether the service is experimental or investigational. If the HCSC or an affiliate makes the determination, the contract must also identify the criteria upon which the decision will be based. The HCSC must respond to enrollee appeals of such decisions within twenty working days.[74]

15.7.3.2 Preexisting Conditions and Coverage Limits

No group or individual health plan issued or renewed after January 1, 2014 may deny or limit coverage based on a preexisting condition even if the plan is otherwise grandfathered under the ACA.[75] A "preexisting condition" is any medical condition, illness or injury that existed before the effective date of coverage.[76] A plan may still implement a waiting period unrelated to enrollee health status but it may not exceed 90 days.[77]

Health carriers, including HCSCs, may not impose lifetime coverage limits on any non-grandfathered health plan.[78] For plans issued or renewed beginning January 1, 2014, all annual

[65] RCW 48.44.020.
[66] RCW 48.44.020(2).
[67] RCW 48.44.210; 212; 420 and 450.
[68] RCW 48.44.215.
[69] RCW 48.44.215(3).
[70] RCW 48.44.200; 210.
[71] RCW 48.44.212.
[72] Federal law also imposes certain requirements with respect to coverage of children. 29 U.S.C. § 1169(a).
[73] RCW 48.44.230.
[74] WAC 284-44-043.
[75] 42 U.S.C. §300gg-3; WAC 284-170-252.
[76] RCW 48.43.005(21).
[77] 42 U.S.C. §300gg-7.
[78] 45 C.F.R. §147.126 (a).

dollar limits on coverage of essential health benefits are also prohibited.[79] Carriers may still place annual limits on benefits that do not constitute essential health benefits.[80]

15.7.3.3 Mandated Benefits[81]

Under the ACA, all small group and individual plans issued by a carrier after January 1, 2014 must provide ten "essential health benefits": ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventative and wellness services and chronic disease management; and pediatric services, including oral and vision care.[82] The scope of essential health benefits is defined according to a state-specific benchmark plan. At this time, Washington has selected the Regence BlueShield Innova small group plan as the state benchmark plan.[83]

In addition, all non-grandfathered individual and small group health plans, other than catastrophic health plans, must conform with one of four metallic actuarial value tiers: bronze, silver, gold or platinum. Bronze level plans must provide a level of coverage that provides benefits that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan; silver level plans must provide benefit coverage that is actuarially equivalent to 70 percent of the full actuarial value; and so on.[84] A carrier offering a bronze plan in the individual or small group market outside of the Exchange must also offer both a silver and gold plan in the individual or small group market outside of the Exchange.[85]

All health plans must fully cover preventive services delivered by network providers as recommended by the United States Preventive Services Task Force with respect to the enrollee involved.[86] A carrier may not impose any cost-sharing requirements for any preventive services and must post a list of the specific preventive services covered on its website.[87]

Chapters 48.43 and 48.44 RCW and regulations require that an HCSC offer a number of mandated benefits.[88] These mandates include mammography,[89] post-mastectomy reconstructive breast surgery,[90] prostate and colorectal cancer screening,[91] temporomandibular joint disorders,[92] alternative providers treating defined conditions,[93] home, health and hospital care in group contracts,[94] chemical dependency,[95] nurse and nurse practitioner care of conditions covered if treated by a medical or osteopathic physician,[96] chiropractic care,[97] podiatry,[98] diabetes

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[79] 45. C.F.R. §147.126 (b).
[80] 45 C.F.R. §147.126(b).
[81] Interested persons should be aware that additional mandates are introduced in virtually every legislative session and frequently adopted. Chapters 48.43 and the relevant chapter for the type of health carrier should be reviewed for new mandates.
[82] 42 U.S.C. §300gg(6)(a); RCW 48.02.060; WAC 284-43-865.
[83] WAC 284-43-865.
[84] RCW 48.43.705; 42 U.S.C. §18022 (d).
[85] RCW 48.43.700.
[86] WAC 284-43-882(4).
[87] WAC 284-43-882(4).
[88] State law currently exempts certain limited benefit small group plans from these mandates. RCW 48.44.023(1)(b). However, the continued issuance of limited benefit small group plans appears to be preempted by the ACA for all non-grandfathered plans.
[89] RCW 48.44.325 and 330.
[90] RCW 48.44.330
[91] RCW 48.43.043 and 48.44.327.
[92] RCW 48.44.460.
[93] RCW 48.43.045(1).
[94] RCW 48.44.320.
[95] RCW 48.44.240 and 245.
[96] RCW 48.44.290.
[97] RCW 48.44.310 and 48.43.190.
[98] RCW 48.44.300.

pharmaceuticals if the contract has a pharmacy benefit,[99] prescribed, self-administered anticancer medication if the contract has a chemotherapy benefit,[100] home health and hospice care,[101] phenylketonuria,[102] neurodevelopmental therapies,[103] and denturist services.[104]

Additionally, all carriers, including HCSC's, must cover all medically necessary treatment for mental disorders recognized in the DSM-IV-TR (with limited exceptions) to the same extent a contract covers medical and surgical services.[105]

It is possible that a plan that is exempt from providing coverage for certain treatments under a particular state law mandate must still provide coverage for the treatment in order to comply with the essential health benefits requirement or other benefit parity requirements.[106] Interested parties should carefully review all potentially applicable benefit mandates and exemptions.

15.7.3.4 Guaranteed Issue Cancellation, Continuation and Conversion

A health carrier offering a group or individual contract, including an HCSC, must accept for enrollment any state resident in the carrier service area, regardless of age, sex, family structure, ethnicity, race, health condition, geographic location, employment status, socioeconomic status, or preexisting health conditions, although a carrier may still restrict enrollment to open or special enrollment periods.[107] A health carrier must guarantee continuity of coverage absent special circumstances.[108] A carrier may not cancel or nonrenew an individual or group contract except for nonpayment of premium, failure to satisfy contract cost-sharing provisions such as deductibles or co-pays, fraud, illegality of the contract due to a change in state or federal law, or the discontinuation or termination of the product in a given service area.[109] A health carrier may modify a product at the time of renewal without running afoul of the guaranteed issue/guaranteed renewal provisions as long as the modifications are made uniformly among all small group or individual plans issued under that product. The modified product must also be offered by the same issuer, consist of the same type of network, serve the majority of the same service area and maintain the same cost-sharing structures and covered benefits.[110] Cancellation, renewal, and termination of a product are all subject to notification requirements.[111] A carrier is not required to give notice or obtain OIC approval to stop offering a certain product as long as existing enrollees' coverage is not terminated. At the state level, carrier withdrawal from the group and individual market is governed by RCW 48.43.035 and 48.43.038 respectively, although federal standards should be followed where there is a conflict. For example, unlike state law, federal regulations prohibit nonrenewal of enrollees who are eligible for Medicare on the basis that they have become eligible for Medicare.[112]

Carriers may be required to refile individual and small group products with the OIC each plan year.[113] Instructions on filing requirements are posted on the OIC website.[114]

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[99] RCW 48.44.315.
[100] RCW 48.44.323
[101] RCW 48.44.320.
[102] RCW 48.44.440.
[103] RCW 48.44.450.
[104] RCW 48.44.500 and 48.43.180.
[105] RCW 48.44.341; WAC 284-43-990 – 997.
[106] *See, e.g. O.S.T. ex rel. G.T. v. BlueShield*, 335 P.3d 416 (2014).
[107] 45 CFR § 147.104 (a); WAC 284-170-400.
[108] 45 CFR §147.106.
[109] RCW 48.43.035(3).
[110] 45 CFR §147.106(e).
[111] 45 CFR §147.106.
[112] 45 CFR § 147.106 (g)(2); RCW 48.43.035(3)(c) and 48.43.038 (2)(c)
[113] WAC 284-170-870.
[114] http://www.oic.wa.gov

Every HCSC that issues group coverage must offer enrollees who become ineligible for coverage the right to continue benefits for an agreed period of time. Federal law mandates specific time periods for continuation of coverage.[115]

Current state law requires a group contract to provide for a conversion contract providing equivalent benefits upon termination of the enrollee's eligibility for coverage under the group contract.[116] This law and its regulation have not been modified or repealed, even though it conflicts with the regulatory scheme under the ACA. Exceptions to the conversion contract mandate exist for persons terminated by their employer for cause,[117] but this does not permit a health carrier to deny a conversion contract to the terminated employee's spouse or dependents. Additionally, a conversion contract need not be offered to an enrollee eligible for Medicare[118] or a person who is covered under another group contract.[119] A health carrier is obligated to offer three mandated conversion plans: a basic medical plan,[120] a major medical plan,[121] and a comprehensive medical plan.[122] State regulations currently allow conversion contracts to exclude coverage for mental illness, alcoholism, drug addiction, pregnancy (except for complications of pregnancy) and illness treatment or medical condition arising out of war, suicide or aviation.[123] Additional conditions or treatments excludable in a conversion contract include: cosmetic surgery, certain foot care, dental, vision, custodial care, care provided in a government hospital or under a government program, and care outside the carrier's service area.[124] However, such exclusions may still be unlawful if the contract is subject to an additional state or federal benefit mandate.

15.7.4 Provider Contracting

Health care service contractors may provide services either through participating or nonparticipating providers.[125] Participating providers sign a written contract and agree not to balance bill or seek payment from the enrollee in the event of carrier insolvency.[126] HCSCs must file participating provider contracts 30 days before use.[127] Any subsequent provider contract or amendment that deviates from a filed agreement must also be filed 30 days before use.[128] Such contracts must set forth a schedule for the prompt payment of "clean claims" and must have a dispute resolution process.[129] Although the amount in terms of payment must be filed with the Insurance Commissioner, the Commissioner may not base disapproval of a participating provider contract on the amount of compensation between the carrier and the provider unless the compensation amount causes the underlying plan to be in violation of state or federal law.[130] Participating provider compensation agreements are proprietary information and are not subject to public inspection under the Public Records Act if filed in accordance with statutory confidential filing procedures.[131]

The HCSC Act provides limited regulation of the relationship between HCSCs and certain providers. This includes the "every category of provider" mandate[132] and other practitioner mandates. The requirement of "parity of reimbursement" in some practitioner mandates refers to the economic impact on the enrollee, *i.e.*,

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115 26 U.S.C. § 4980B; 29 U.S.C. § 1161-1168; 42 U.S.C. §§ 300bb-1-300bb-8.
116 RCW 48.44.370.
117 RCW 48.44.370(2)(a).
118 RCW 48.44.370(2)(b).
119 RCW 48.44.370(2)(c).
120 WAC 284-52-040.
121 WAC 284-52-050.
122 WAC 284-52-060.
123 WAC 284-52-070(1)-(3).
124 WAC 284-52-070(4)-(11).
125 RCW 48.44.030.
126 RCW 48.44.010(14) and 48.44.055(2) and WAC 284-43-320.
127 RCW 48.43.730; WAC 284-43-300, *et seq.*
128 RCW 48.43.730.
129 WAC 284-43-321 and 322.
130 RCW 48.43.730(3).
131 RCW 48.43.730(5).
132 RCW 48.43.045.

payment provisions that would financially penalize an enrollee for seeking a certain type of provider over another are prohibited in some instances. However, with the exception of chiropractors, a health carrier is not obligated to pay different types of providers the same for treatment of the same condition.[133] A health carrier may not pay a chiropractor any less for a particular treatment code than it pays any other type of licensed health care provider unless the difference pay is related to differences in network participation, geographic location or pay-for-performance methodologies.[134]

Health carriers are obligated to adopt policies and procedures protecting an enrollee's right to privacy.[135] A health carrier is obligated at the time the contract is offered for sale to provide a list of benefits, exclusions, premiums, enrollee cost-sharing requirements, an explanation of the carrier's appeal process for adverse benefit determinations and grievance process for dissatisfaction with care, a description of the availability of a point-of-service option if any, and a means of obtaining lists of participating primary and specialty care providers.[136] Additional disclosure and information-providing requirements are imposed on health carriers pursuant to the "patient bill of rights" adopted in 2000 and recent federal regulations.[137]

15.8 Health Maintenance Organizations

An HMO is an organization which provides comprehensive health care services to enrolled participants on either a group practice per capita prepayment basis or on a prepaid individual practice plan basis.[138] An HMO may charge co-payments, coinsurance and/or deductibles.[139] HMOs can provide services directly (employed providers) or through contracted providers. An HMO's activities are not subject to the insurance laws if the health care services are rendered directly by the HMO or by any provider that has a contract or other arrangement with the HMO to render health services to enrolled participants.[140]

15.8.1 Formation and Registration Requirements

HMOs are formed under general corporate law and are registered with the OIC. HMOs must satisfy specific requirements in the Code regarding formation and registration. Failure to register is a crime.

15.8.1.1 Solicitation Permit

Once registered, an HMO issuing, selling or offering for sale securities of its own issue (except nonprofit memberships) is subject to the solicitation permit requirements of Chapter 48.06 RCW, as if it were a domestic insurer.[141]

15.8.1.2 Registration and Governance Requirements

The HMO statute contains detailed eligibility requirements for a certificate of registration.[142] An HMO must be governed by a board elected by enrolled participants or otherwise provide its enrolled participants with a "meaningful role" in the policy making procedures of the organization.[143] The members of the governing body of an HMO must be nominated by the voting members or by the enrolled participants and providers and must be elected by the enrolled participants or voting members in accordance with the HMO's bylaws.[144] At least one-third of the governing body must consist of consumers who are substantially representative of the enrolled population of the organization.[145] Health carriers, including HMOs, must annually report the

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[133] *See* WAC 284-43-205.
[134] RCW 48.43.190.
[135] RCW 48.43.505.
[136] RCW 48.43.510.
[137] *See* RCW 48.43.510 – 550; Section 15.9, *infra*.
[138] RCW 48.46.020 (13).
[139] RCW 48.46.020(13).
[140] RCW 48.46.060.
[141] RCW 48.46.027. *See* § 15.6.1.1 of this Chapter.
[142] RCW 48.46.030 and 48.46.040.
[143] RCW 48.46.030(2).
[144] RCW 48.46.070(1).
[145] RCW 48.46.070(1)

names and addresses of all officers, directors and trustees and the amount of wages, expense reimbursements or other payments to such individuals.[146]

An HMO must provide to enrollees or make available for inspection at least annually, its financial statements disclosing assets, liabilities and the bases for proposed rate adjustments.[147] An HMO must also demonstrate to the satisfaction of the OIC that its facilities and personnel are reasonably adequate to provide comprehensive health care services to enrolled participants and that it is financially capable itself, through insurance or otherwise, of providing members with health services.[148]

15.8.1.3 Capitalization and Insolvency Plan Requirements

An HMO must maintain a funded reserve of $150,000. The reserve must be in the form of cash, eligible securities and/or an approved surety bond.[149] An HMO must maintain a minimum net worth equal to the greater of $3,000,000 or two percent of annual premium revenues on the first $150,000,000 of premiums and one percent of annual premiums on the premiums in excess of $150,000,000, or an amount equal to the sum of three months' uncovered expenditures.[150] Uncovered expenditures are costs to the HMO for health care services for which an enrollee would be liable in the event of the HMO's insolvency.[151] Each HMO must have a plan for handling insolvency that allows for continuation of benefits during the period for which premiums have been paid.[152] The insolvency plan must also allow for continuation of benefits to members who are confined on the date of insolvency in an inpatient facility until their discharge or expiration of their benefits.[153]

The OIC must approve the HMO's insolvency plan if it includes either: (a) insurance covering expenses for continued benefits after insolvency; (b) provider contract language requiring continued benefits as described above; (c) the use of insolvency reserves; (d) approved letters of credit or bonds; or (e) other arrangements approved by the OIC.[154]

15.8.2 Filing Requirements

An HMO must file copies of each type of health maintenance agreement to be issued to enrolled participants, a schedule of proposed rates of reimbursement to contracting health care facilities or providers, and a schedule of the proposed charges for enrollee coverage. With the exception of certain non-grandfathered individual, small group and Medicare Supplement products, HMOs are permitted to file and use health maintenance agreements.[155] New filing requirements established pursuant to the ACA generally restrict use of the individual and small group products until elements of the rate, form and required data templates are approved by the OIC.[156] All forms of health maintenance agreements or other marketing documents must comply with minimum standards deemed reasonable and necessary by the OIC. The documents must fully inform enrolled participants of the health care services to which they are entitled.[157]

15.8.3 Enrollee Contract Requirements

The Code specifies a number of requirements for individual and group health maintenance agreements. These include requirements relating to preexisting conditions, mandated benefits, continuation and conversion.

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[146] RCW 48.43.045(1)(b)
[147] RCW 48.46.030(4).
[148] RCW 48.46.030(5).
[149] RCW 48.46.240.
[150] RCW 48.46.235(1)(a)-(c).
[151] RCW 48.46.020(23).
[152] RCW 48.46.245.
[153] *Id.*
[154] *Id.*
[155] RCW 48.46.060 and 48.46.066.
[156] See, *e.g.* §15.9 and §15.11 of this Chapter.
[157] RCW 48.46.060(2).

15.8.3.1 General Contract Requirements

Any health maintenance agreement may be disapproved by the OIC if it contains "inconsistent, ambiguous or misleading clauses or exceptions or conditions which unreasonably or deceptively affect the risk purported to be assumed."[158] Other grounds for OIC disapproval of a health maintenance agreement include: (a) deceptive advertising; (b) unreasonable benefits in relation to the rates charged; (c) unreasonable restrictions on the treatment of patients; or (d) violation of any provision of the Code or any regulation adopted by the OIC.[159] The Code includes specific requirements relating to coverage of dependents and adopted children. If a contract provides for termination of dependent coverage when the dependent reaches a specified age, the contract must also provide that there will be no termination if the child is incapable of self-sustaining employment by reason of developmental disability or physical handicap and chiefly dependent upon the subscriber for support and maintenance.[160] A contract that provides coverage for dependent children must also cover newborn infants from birth, including coverage for congenital anomalies.[161]

Individual health maintenance agreements must give the enrollee the right to cancel coverage within ten days of the agreement's delivery.[162] Upon such cancellation, the HMO must return the subscriber's premium.

HMOs are also subject to the maternity length-of-stay legislation.[163] An HMO that provides maternity services must permit a mother's attending provider, in consultation with the mother, to make decisions on the length of inpatient stay and type and location of follow-up care. Decisions between the provider and the patient must be based on accepted medical practice. Covered eligible services may not be denied for inpatient care, post-delivery care or follow-up care, as ordered by the attending provider in consultation with the mother. Coverage for a newborn must be no less than the mother's coverage, for not less than three weeks, even if the newborn is separately admitted to the hospital. Carriers providing maternity coverage must notify policyholders of the coverage required by the maternity length-of-stay statute.

Like other health carriers, HMOs are required to disclose certain carrier policies to their enrollees.[164] Upon request, HMOs must provide information regarding: the availability of a point-of-service plan; any documents referred to in an enrollment agreement; procedures for consulting a provider other than the enrollee's primary care provider; any restrictions on prescribing drugs from a plan formulary; prior authorization procedures; circumstances under which the plan may retrospectively deny coverage for care that had prior authorization; and grievance procedures. Carriers must also disclose to enrollees, upon request, descriptions of provider reimbursement arrangements (including capitation, fee-for-service and health care delivery efficiency provisions) and descriptions and justifications for provider compensation programs, including any incentives or penalties that are intended to encourage providers to withhold services or minimize or avoid referrals to specialists.[165]

HMOs may not prohibit enrollees from obtaining coverage outside of their plan.[166] However, the HMO is not required to pay for services delivered outside the plan, with the exception of emergency services.[167]

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158 RCW 48.46.060(3)(a).
159 RCW 48.46.060(3) and (4).
160 RCW 48.46.320.
161 RCW 48.46.250.
162 RCW 48.46.260.
163 RCW 48.43.115.
164 RCW 48.43.510.
165 See §15.9 of this Chapter.
166 RCW 48.43.085.
167 *Id*.

15.8.3.2 Preexisting Conditions and Coverage Limitations

HMOs are subject to the same preexisting condition requirements as HCSCs. *See* § 15.7.3.2 *supra*.

15.8.3.3 Mandated Benefits

The HMO statute and regulations require that HMOs offer the same mandated benefits as other health carriers. *See* Section 15.7.3.3, *supra*.

15.8.3.4 Guaranteed Issue, Continuation and Conversion

An HMO, like an HCSC, must accept any group member who is a state resident within the HMOs service area, regardless of age, sex, family structure, ethnicity, race, health condition, geographic location, employment status, socioeconomic status, or preexisting health conditions.[168] An HMO must guarantee continuity of coverage and is subject to the same guaranteed issue/renewal provisions as an HCSC.[169] Thus, like an HCSC, an HMO may cancel coverage without OIC approval only in limited circumstances.[170]

Every HMO that issues group coverage must offer enrollees who become ineligible for coverage the right to continue benefits for an agreed period of time. Federal law mandates specific time periods for continuation of coverage.[171]

Under state law, health maintenance agreements must also provide that when continuation coverage terminates, the enrollee be offered a conversion contract.[172] This law and its regulations[173] have not been modified or repealed, even though it conflicts with the regulatory scheme under the ACA. A conversion contract need not be offered to a person whose coverage was terminated when the person's employment or membership was terminated for misconduct. However, a conversion policy must be offered to the spouse or dependents of such terminated member. In addition, an HMO need not offer a conversion agreement to a person who is eligible for federal Medicare coverage or a person who is covered under another group plan.[174] To obtain a conversion agreement, a person must submit a written application and first premium payment no later than 31 days after the person's eligibility for group coverage terminates or 31 days after the date the person received notice of termination of coverage, whichever is later.

15.8.4 Provider Contracting

HMOs provide services through participating providers, except for emergency care, out-of-area services, pediatric oral services which constitute essential health benefits and, in exceptional circumstances, services where the HMO is unable to negotiate reasonable and cost-effective contracts.[175] Participating providers must contract with HMOs in writing.[176] Participating providers must agree to look only to the HMO for payment for covered services and not to the individual subscriber.[177]

HMOs must file their participating provider contracts for approval with the OIC, at least 30 days prior to use.[178] Any subsequent provider contract or amendment that deviates from a filed agreement must also be filed 30 days before use.[179] Such contracts must set forth a schedule for the prompt payment of "clean

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[168] RCW 48.43.035(1); WAC 284-170-400.
[169] RCW 48.43.035(2) and 48.43.038(1). See also §15.7.3.4 of this Chapter.
[170] *See* § 15.7.3.4 of this Chapter.
[171] 26 U.S.C. § 4980B; 29 U.S.C. § 1161-1168; 42 U.S.C. §§ 300bb-1-300bb-8.
[172] RCW 48.46.450-460.
[173] Chapter 284-52 WAC.
[174] RCW 48.46.450.
[175] RCW 48.46.243.
[176] RCW 48.46.243.
[177] WAC 284-43-320
[178] RCW 48.46.243(3).
[179] RCW 48.43.730.

claims" and must have a dispute resolution process.[180] Although the amount and terms of payment must be filed with the Insurance Commissioner, the Commissioner may not base disapproval of a participating provider contract on the amount of compensation between the carrier and the provider unless the compensation amount causes the underlying plan to be in violation of state or federal law.[181] Participating provider compensation agreements are proprietary information and are not subject to public inspection under the Public Records Act if filed in accordance with SERFF confidential filing procedures.[182] Any contract form not affirmatively disapproved within 30 days of filing is deemed approved.[183] The participating provider contract form language prohibits the provider from billing the subscriber except for non-covered services, co-payments, coinsurance and deductibles.[184] Providers also must agree to provide covered services for the period during which premiums were paid or until the enrollee is discharged from an inpatient facility, if the HMO becomes insolvent.[185]

The HMO Act contains provisions regulating the relationship between HMOs and certain types of providers. For example, an HMO providing prescription drug coverage using nonresident pharmacies may only provide coverage from licensed nonresident pharmacies.[186] Benefits may not be denied for any service performed by a denturist covered by a health maintenance agreement if the services performed were within the scope of the denturist's licensure and benefits would have been paid for if the service was performed by a dentist.[187] An HMO may not discriminate against osteopaths solely because the practitioner was board certified or eligible under an approved osteopathic certifying board instead of board certified or eligible under an approved medical certifying board.[188]

HMOs, like other health carriers, may not preclude or discourage providers from informing patients of the care they require, including treatment options.[189] However, providers cannot by such discussions bind the HMO to pay for any services. HMOs may not penalize, prohibit or discourage providers who are otherwise practicing in compliance with law from advocating on behalf of a patient with an HMO. Further, HMOs may not prohibit or limit providers from participating in discussions with their patients as to the comparative merits of different health carriers, even if those discussions are critical of a carrier.

15.9 Mandatory Disclosures

All health carriers must provide a summary of benefits and coverage as well as a uniform glossary of health coverage-related and medical terms to all enrollees free of charge.[190] This summary and glossary must be provided in a uniform format in accordance with current federal guidance.[191]

All health carriers are required to disclose certain carrier policies to their enrollees.[192] Upon request, carriers must provide information regarding: the availability of a point-of-service plan; any documents referred to in an enrollment agreement; procedures for consulting a provider other than the enrollee's primary care provider; any restrictions on prescribing drugs from a plan formulary; prior authorization procedures; circumstances under which the plan may retrospectively deny coverage for care that had prior authorization; the review process for adverse benefit determinations; and grievance procedures. Carriers must also disclose to enrollees, upon request, descriptions of provider reimbursement arrangements (including capitation, fee-for-service and health care delivery efficiency provisions) and descriptions and justifications for provider compensation programs, including any incentives or penalties that are intended to encourage providers to withhold services or minimize or avoid referrals to specialists.

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[180] WAC 284-43-321 and 322.
[181] RCW 48.43.730(3).
[182] RCW 48.43.730(5).
[183] RCW 48.43.730 (2)..
[184] WAC 284-43-320.
[185] WAC 284-43-320
[186] RCW 48.46.540.
[187] RCW 48.46.570.
[188] RCW 48.46.575.
[189] RCW 48.43.510.
[190] 45 CFR §147.200.
[191] 45 CFR §147.200.
[192] RCW 48.43.510.

Pursuant to state and federal health reform, any carrier offering or renewing a health plan after January 1, 2016 must also offer "transparency tools" on its website which enable enrollees to make treatment decisions on cost, quality, and patient feedback for certain common treatments.[193] Carriers must provide a method by which enrollees may search for information on in-network providers and hospitals, including specialists, distance from the patient, provider's contact information and directions, and provider's education and credentials, including where to find information on malpractice history and disciplinary actions.[194] Carriers must also provide enrollees with health plan quality and performance information submitted to the federal Department of Health and Human Services (DHHS) as required by federal regulations.[195] A carrier must attest to the Insurance Commissioner its compliance with these transparency requirements within thirty days from its offer or renewal. [196]

The ACA requires carriers to submit to the Insurance Commissioner and DHHS information regarding claims payment policies and practices, periodic financial disclosures, data on enrollment, data on disenrollment, data on the number of claims that are denied, data on rating practices, information on cost sharing and payments with respect to any out-of-network coverage, and information on enrollee and participant rights. Carriers must also make such information publicly available. [197]

15.10 Approved Clinical Trials

Health plans may not deny enrollees participation in an approved clinical trial with respect to the treatment of cancer or another life-threatening condition. Nor may they deny or impose limitations or conditions on the coverage of routine patient costs for items and services furnished through participation in the trial or discriminate against the enrollee because of his or her participation in the trial.[198] This does not require a carrier to provide benefits for routine patient care services provided outside of the plan's provider network unless the plan provides for out-of-network benefits.[199] If one or more network providers are participating in a clinical trial, a carrier may require that the enrollee participate with the network providers.[200] However, carriers must still allow an enrollee to participate in an approved clinical trial that is conducted outside of Washington regardless of the provider's network status.[201]

15.11 Premiums and Community Rating

Premiums for individuals and small groups covered by non-grandfathered plans[202] must be calculated using federal community rating standards.[203] Community rating sets rates based on all similarly situated individuals with allowed adjustment for certain factors.

"Community rating" contemplates adjustments on a per-contract basis for a geographic area, family size, age and tobacco use.[204] A carrier must use the designated geographic rating areas promulgated by the OIC if it wishes to adjust rates geographically, and the premium ratio between the highest and lowest cost geographic rating area may not be more than 1.15.[205] Premium rates based on family size are determined by summing the premium for each individual family member, provided that with respect to family members under the age of 21, the premiums for no more than the three oldest covered children may be taken into account when determining the total family premium.[206] Rates may be adjusted based on one-year age bands for individuals age 21 through 63, but rates may not vary by more than a ratio of 3:1 for like individuals of a different age who are 21 or older.[207] An individual may be

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193 RCW 48.43.007(1).
194 RCW 48.43.007.
195 RCW 48.43.007(3); see also 42 U.S.C. §300gg-17.
196 RCW 48.43.007(4).
197 42 U.S.C. §300gg-15a.
198 42 U.S.C. §300gg-8.
199 42 U.S.C. §300gg-8(c).
200 42 U.S.C. §300gg-8(a)(3).
201 42 U.S.C. §300gg-8(a)(4).
202 Community rating by grandfathered health plans continues to be governed by RCW 48.44.022-23, 48.21.045 and 48.46.064-066.
203 42 U.S.C. §300gg
204 45 C.F.R. §147.102.
205 WAC 284-170-250.
206 45 C.F.R. §147.102(c)(1).
207 45 C.F.R. §147.102.

uprated based on attained age at the time of the policy renewal.[208] Rates may not vary for tobacco use by more than 1.5:1.[209] Rates cannot be changed more frequently than annually except to reflect changes in family size, benefit changes requested by the enrollee, or changes in government requirements affecting the health benefit plan.[210]

Prior to ACA, rates for health plans for small groups that purchased the plan as a member of an industry-related purchasing pool ("association health plans") were exempt from small group community rating under state law.[211] Instead, a carrier would issue the association a single, large group plan. Effective January 1, 2014, the statutory exemption was pre-empted by federal community rating requirements for all non-grandfathered plans. The OIC recently promulgated rules governing this transition. A carrier may no longer issue a plan for individuals or small groups to an association as a large group plan unless the association constitutes an "employer" within the meaning of ERISA.[212] The carrier must make a good faith effort to ensure that an association constitutes an "employer" prior to filing plan rates and forms with the OIC, and remains responsible for maintaining documentation supporting the association's status as an "employer."[213]

15.12 Reinsurance and Risk Adjustment Programs

Pursuant to the ACA, Washington established risk adjustment and transitional reinsurance programs designed to promote insurance market stability under health reform.[214]

All Washington health carriers and third-party administrators of health benefit coverage must make contributions to the transitional reinsurance program. Reinsurance payments will be paid to non-grandfathered plans in the individual market that cover individuals with high-cost conditions.[215] A carrier must report any reinsurance payments received as part of its annual rate filing.[216] Washington's program is operated by DHHS and will cease operation on June 30, 2017.[217]

All carriers that issue non-grandfathered individual or small group health plans must participate in a permanent risk adjustment program. Under the program, a non-grandfathered health plan will be assessed a charge if the total actuarial risk of its enrollees in a plan year is less than the average actuarial risk of all enrollees in all plans or coverage in Washington for that year. A health plan will receive a payment from the program if the actuarial risk of the enrollees is greater than the state average for that year.[218] Each carrier must report risk adjustments received or made as part of its annual rate filing.[219] The program will be administered by DHHS through the 2015 plan year, at which point the Insurance Commissioner must issue a statement of intent regarding whether the OIC or DHHS will administer the risk adjustment program for the following plan year.[220]

15.13 Provider Contracting

15.13.1 Every Category of Provider Mandate

The "every category of provider" mandate applies to services for conditions included in the Washington State Basic Health Plan or for services covered as essential health benefits for individual or small group plans.[221] The mandate applies to services for conditions included in the Washington State Basic Health Plan for plans other than individual and small group.[222] The provider must agree to abide by standards relating

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[208] 45 C.F.R. §147.102(a)(1)(iii).
[209] 45 C.F.R. §102.
[210] RCW 48.48.44.022(1)(f) and 48.21.045(3)(f).
[211] RCW 48.44.021(2).
[212] WAC 284-170-958; 29 U.S.C. § 1002(5),
[213] WAC 284-170-958.
[214] RCW 48.43.720.
[215] 45 C.F.R. §153.240; 45 C.F.R. §153.410.
[216] WAC 284-170-001(4).
[217] WAC 284-170-001.
[218] 42 U.S.C. § 18063.
[219] WAC 284-170-002(6).
[220] WAC 284-170-002.
[221] RCW 48.43.045, WAC 284-43.045(1).
[222] WAC 284-43-205(1).

to provision, utilization, review, cost containment and medical necessity.[223] OIC regulations permit health carriers to determine that particular services for particular conditions by particular categories of providers are not cost effective or clinically efficacious and permit health carriers to exclude such services within reason.[224] However, carriers may not decide that a particular category of licensed provider can *never* render any cost-effective or clinically efficacious services and attempt to exclude the category of provider completely from a health plan on that basis.[225] The OIC regulations further permit placing reasonable limits on licensed provider services; for example, the number of visits per contract year to a chiropractor.[226]

15.13.2 Women's Health Care Services

A health carrier that provides maternity services must permit a mother's attending provider, in consultation with the mother, to make decisions on the length of inpatient stay and type and location of follow-up care.[227] Decisions between the licensed provider and the patient must be based on accepted medical practice. Covered eligible services may not be denied for inpatient care, post-delivery care or follow-up care, as ordered by the attending provider in consultation with the mother.[228] Further, coverage for a newborn must be no less than the mother's coverage for not less than three weeks, even if the newborn is separately admitted to the hospital. Carriers providing maternity coverage must notify policyholders of the maternity length-of-stay statute's coverage requirements.[229]

Health carriers must ensure that enrolled female patients have direct access to timely and appropriate covered "women's health care services" from the type of licensed health care practitioner of their choice.[230] "Women's health care services" are inclusive of the women's preventive services mandated by the Health Resources and Services Administration of the U.S. Department of Health and Human Services, and include maternity care, reproductive health services including contraceptive services and pregnancy termination, gynecological care including testing and treatment for sexually transmitted diseases, general examination and preventive care as medically appropriate, and any medically appropriate follow-up visits for these services, as well as any appropriate health care service for other health problems that are discovered and treated during the course of visit to a women's health care practitioner for a women's health care service.[231]

Practitioners of "women's health care services" include, but are not limited to, any generally recognized medical specialty of practitioners licensed as osteopaths or physicians who provide "women's health care services," osteopathic physician's assistants and physician's assistants when providing "women's health care services," advanced registered nurse practitioner specialists in women's health, and midwives.[232] Carriers must include in each provider network a "sufficient number" of each type of licensed "women's health care practitioners."[233]

A carrier must provide enrollees seeking appropriate women's health care services with access to these types of providers without requiring a prior referral from another type of health care practitioner.[234] Nor may an issuer impose notification or prior authorization requirements upon women's health care practitioners or enrollees unless such requirements are also imposed upon other providers offering similar types of service.[235] A carrier may require enrollees to see only those health care practitioners who have signed participating provider agreements with the carrier.[236] However, under the OIC's regulations, a carrier must not exclude or limit access to covered women's health care services offered by a particular type

[223] RCW 48.43.045.
[224] WAC 284-43-205(3).
[225] WAC 284-43-205(2).
[226] WAC 284-43-205(3).
[227] RCW 48.43.115 (3).
[228] *Id.*
[229] RCW 48.43.115(5).
[230] RCW 48.42.100(4).
[231] RCW 48.42.100(3); WAC 284-43-250.
[232] RCW 48.42.100(2).
[233] WAC 284-43-250(3)(c)
[234] RCW 48.42.100(5)(a).
[235] WAC 284-43-250(1)(c).
[236] RCW 48.42.100(5)(c).

of women's health care practitioner or facility in a manner that would unreasonably restrict access to that type of practitioner, facility or covered service.[237] Carriers must also ensure that their participating providers do not limit access to a particular group subset of women's health care practitioners within a network.[238] No carrier can impose any cost-sharing or other barrier to a woman's exercise of the right of direct access that is not required for access to other primary care health care practitioners.[239] A carrier must include a written explanation of a woman's right to direct access and any permissible limitations on direct access in its enrollee handbook.[240]

15.13.3 Provider Network Access

Health carriers must maintain a provider network for each health plan that is "sufficient in numbers and types of providers and facilities" to assure that all health plan services provided to enrollees will be accessible in a timely manner.[241] If the carrier has an absence of or insufficient number or type of participating providers to provide a covered service, the carrier must ensure that the enrollee obtains the covered service from a provider within reasonable proximity of the enrollee at no greater cost to the enrollee than if the service were obtained from network providers.[242] Carriers must be able to demonstrate that the provider network is sufficient to serve the entire enrollee population based on normal utilization patterns. The OIC has promulgated standards that a carrier must meet to demonstrate sufficient network access to different types of providers.[243] A carrier must submit provider network materials demonstrating compliance with these standards prior to or at the time it files a newly offered health plan.[244]

A health carrier must make available an up-to-date directory of all health plan network providers. The directory must be updated on a monthly basis and posted online.[245] If the carrier maintains more than one provider network, the directories must make it reasonably clear to an enrollee which network is associated with a given health plan.[246] The carrier must file a report of all participating network providers on a monthly basis as well as certification that the provider directory posted on the carrier's website is accurate as of the last date of the prior month.[247]

Health carriers are obligated to cover, without prior authorization, emergency services "necessary to screen and stabilize a covered person if a prudent layperson acting reasonably would have believed that an emergency medical condition existed" regardless of the network status of the emergency services provider.[248] A health carrier may not impose differential cost-sharing arrangements for out-of-network providers of such emergency services.[249] However, an enrollee may be required to pay, in addition to the in-network cost sharing, the excess of the amount the out-of-network provider charges over the amount the carrier has negotiated with in-network providers for the emergency service furnished.[250]

15.14 Enrollee and Provider Grievances and Appeals

Carriers offering any health plan must offer all applicants, enrollees and providers a way to resolve grievances unrelated to a denial of benefits.[251] Each carrier must maintain a record of all grievances, which must be provided to the commissioner upon request.[252]

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[237] WAC 284-43-250(1)(b).
[238] WAC 284-43-250(3)(c).
[239] WAC 284-43-250(5).
[240] WAC 284-43-250(4).
[241] WAC 284-43-200(1)
[242] WAC 284-43-200(5).
[243] WAC 284-43-200; WAC 284-53-230.
[244] WAC 284-43-220(1).
[245] WAC 284-43-204.
[246] WAC 284-43-204(4).
[247] WAC 284-43-220(3).
[248] RCW 48.43.093
[249] 45 C.F.R. §147.138 (b)(3).
[250] 45 C.F.R. §147.138 (b)(3).
[251] WAC 284-43-721(1).
[252] WAC 284-43-721(2).

Carriers offering non-grandfathered[253] health plans must also have a separate and comprehensive process for the appeal of adverse benefit determinations.[254] Review of adverse benefit determinations must be conducted in compliance with mandated time frames.[255] Carriers may not require enrollees to file a complaint or grievance before seeking review of an adverse benefit determination.[256] Enrollees are entitled to an internal and external review of any adverse benefit determination.[257]

15.15 Health Benefit Exchange and Qualified Health Plans

Pursuant to the ACA, Washington has established an independent Health Benefit Exchange to allow individuals and small businesses to shop for and purchase health plans.[258] The OIC is charged with the regulation of health plans to be sold on the Washington State Health Benefit Exchange ("Exchange").[259] Although individual plans remain available for purchase out of the Exchange, individuals and families with lower incomes are eligible to receive tax credits or cost-sharing reductions when they purchase a plan on the Exchange.[260]

Disability insurers, health care service contractors and health maintenance organizations may all offer plans for sale on the Exchange provided the plan meets the requirements of a qualified health plan ("QHP") as determined by the OIC and as certified by the Health Benefit Exchange Board.

Catastrophic plans may only be sold through the Exchange.[261] However, a catastrophic plan enrollee is not eligible for tax credits or cost-sharing reductions.[262]

To be certified as a QHP, a health plan must comply with all other state and federal regulations governing the individual and small group market.[263] In addition, the plan must include a sufficient amount of federally designated "essential community providers" to provide reasonable access to medically underserved or low-income enrollees in the service area.[264] QHP issuers are also responsible for complying with federal regulations governing enrollment of Exchange applicants and for confirming enrollee eligibility for tax credits or cost-sharing reductions.[265]

Once the Commissioner finds that a health plan meets federal coverage requirements and state insuring requirements, the OIC approves it for certification to the board of the Exchange. The Exchange board must then certify the plan as a qualified health plan to the federal Department of Health and Human Services.[266]

15.16 OIC – Health Carrier Dispute Resolutions

Disputes between the OIC and health carriers arise variously. The OIC may disapprove a rate or form, may impose a fine or demand a change in practice following a financial or market conduct examination, or may issue a Cease and Desist Order prohibiting a health carrier's practice.

The exhaustion of administrative remedies rule denies health carriers the right to primary or de novo review by a court. The health carrier is limited to an administrative hearing.[267] OIC hearings are governed by the model rules of administrative procedure at Chapter 10-08 WAC. A "licensee," which is any entity or person regulated by the OIC, is entitled to have the initial hearing presided over by an independent ALJ from the Office of Administrative Hearings ("OAH"). No licensee's hearings will be presided over by the Insurance Commissioner's designee, including the in-house OIC hearing officer. Even in the event of a hearing before the OAH, however, the OIC has

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253 Grandfathered health plans must comply with the appeal procedures at WAC 284-43-611 – 630.
254 RCW 48.43.530; see also WAC 284-43-500 - 550.
255 RCW 48.43.530.
256 RCW 48.43.530(4)(c).
257 RCW 48.43.535
258 *See* 42 U.S.C. § 18031.
259 RCW 43.71.065.
260 26 U.S.C. §36B; 42 U.S.C. §18071
261 RCW 48.43.700 (3).
262 45 C.F.R. §156.440.
263 RCW 48.43.710.
264 WAC 284-43-222.
265 45 C.F.R. §§ 156.400-480.
266 RCW 43.71.065.
267 RCW 48.04.010(1)(b).

the right to reverse the initial order and issue a "final order." The final order is appealable to the Superior Court. Judicial review is influenced by deference to the agency.[268]

Legislation introduced in the 2015 session would remove all OIC hearings to the OAH, not just those directly involving licensees. The new legislation would also place the responsibility of issuing a "final decision" with the ALJ, appealable only to the Superior Court.[269]

[269] S.B. 5103, 2015 Regular Session.