

**ANALYST CHECKLIST
HEALTH CARE SERVICE CONTRACTORS (HCSC)
SMALL/LARGE GROUP PRODUCTS**

Carrier: _____

Contract Form Number: _____

Date(s) of Review: _____

GENERAL REVIEW REQUIREMENTS
Authority to Review Contract – RCW 48.44.040 & RCW 48.44.309

*All pages referenced are from the
certificate of coverage unless
otherwise noted.*

Topic	Sub topic	Reference Specific Issue(s)*	Specific Issue	Location
Chemical Dependency	<i>Mandated Benefit</i>	Washington Administrative Code (WAC) 284-53-010 Revised Code of Washington (RCW) 48.44.240	Required \$14,000 Minimum benefit (2008) per 24 consecutive months. Includes treatment and supporting services. Consecutive 24 month period begins with the contract start date, not first treatment date. Note: 2009 minimum benefit is \$14,500.	
	<i>Detoxification Services</i>	RCW 48.43.093 WAC 284-53-010	Detox services are covered under the emergency statute RCW 48.43.093. Detox costs do not count toward dollar limits if not currently under chemical dependency treatment. Pre-notification for detox is not reasonable. Note: Pre-notification for non-detox services allowed if applied consistently as with other chronic illnesses.	
	<i>Definitions (Required)</i>	RCW 48.44.245 WAC 284-53-010	Certificates of Coverage (COC) that provide coverage for chemical dependency must define "chemical dependency" consistent with the definitions contained in Title 48.	
	<i>General Services</i>	WAC 284-53-010	Extends coverage to all enrollees, not just the insured. Point of Service (POS) cost-sharing provisions may be incorporated. Restrictive contractual provisions not permitted if pertinent to chemical dependency treatment.	
Colorectal Cancer	<i>Mandated Benefit</i>	RCW 48.43.043	Effective 7-1-2008 COC must provide benefits for colorectal cancer exams and laboratory tests as follows: <ul style="list-style-type: none"> • At least fifty (50) years of age OR less than 50 with high risk. • Cost shares may not be greater than those for similar benefits 	
Congenital Anomalies	<i>Mandated Benefit</i>	RCW 48.44.212	COCs must provide coverage from the moment of birth for a child afflicted with a congenital disease or anomaly	
Conscience Clause		RCW 48.43.065	No individual health care provider or religiously sponsored health carrier may be required by law or contract to participate in the provision of or payment for a specific service if they object to so doing for reason of conscience or religion.	

Topic	Sub topic	Reference Specific Issue(s)*	Specific Issue	Location
Contents of Filing		RCW 48.44.040	• Contract	
		WAC 284-43-920	• COC	
		WAC 284-43-925	• Enrollment Form	
			• Group Master Application	
			• Association, member governed group or trust paperwork (if trust, association, or MET, etc.)	
			• Rates	
Continuation of Care During Enrollee Absence	<i>Labor Dispute</i>	RCW 48.44.250	<p>COCs must allow for the employee to pay premiums directly to the contract holder, not to exceed 6 months, in the event that the employee's compensation is suspended as the result of a strike, lock-out or other labor dispute.</p> <ul style="list-style-type: none"> • Applies whether employer pays all or part of premium • All three actions – strike, lockout, other labor dispute – must appear in description of provision • After the self pay period the employee must be given the opportunity to purchase an individual policy per the RCW. 	
Continuation Options Upon Termination	<i>Continuation of Coverage Mandated Group Offering</i>	RCW 48.44.360	<p>The group master application must include a continuation option that offers to extend coverage for an agreed upon time period and rate paid to employer.</p> <p>Please note, after continuation is exhausted the person can purchase a conversion plan.</p>	
	<i>Conversion Offered</i>	RCW 48.44.370 RCW 48.44.380 WAC 284-52	<p>COCs must provide notice of the right to convert to a conversion contract upon termination from the group contract.</p> <ul style="list-style-type: none"> • The carrier must have at least three approved conversion contracts on file with the OIC. • The conversion option must provide continuous coverage, without a lapse. • The contract must reflect that in the event an employee is denied a conversion contract due to misconduct, his or her spouse and dependents must be offered a conversion contract. 	
	<i>Conversion Statement</i>	Centers for Medicare and Medicaid Services (CMS) Insurance Standards Bulletin 01-01	COCs must contain a statement that says, "If you accept conversion coverage at the end of coverage under this group health plan you will not qualify as a HIPAA eligible individual."	
Contract Examination and Standards	<i>Certificate of Coverage</i>	WAC 284-44-030 WAC 284-44-050 Fitfro v. Lincoln Natl	<ul style="list-style-type: none"> • Group certificates, also known as Evidence of Coverage (EOC) or COC, must be furnished to each member of a group under a health contract and contain the essential features of the health benefit plan. • If there is a conflict in language between the contract and certificate the certificate governs. 	
	<i>Examination/ Disapproval</i>	RCW 48.44.020	The filing must not contain any inconsistent, ambiguous or misleading clauses, or exceptions and conditions, which unreasonably or deceptively affect the risk, purported to be assumed in the general coverage of the contract.	

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	<i>Exclusions, Limitations, and Reductions</i>	WAC 284-44-030 RCW 48.44.305	<ul style="list-style-type: none"> The COC must contain a listing of exclusions, reductions, and limitations which must either be included with the benefit provisions, or under an appropriate caption. The COC cannot exclude services when the injury was sustained because of the insured being intoxicated or under the influence. 	
	<i>Required Format</i>	WAC 284-44-030	<ul style="list-style-type: none"> The style, arrangement, and over-all appearance of the contract shall give no undue prominence to any portion of the text. A form number in the lower left-hand corner of the page shall identify each form including riders & endorsements. 	
	<i>Required Standards</i>	WAC 284-44-040	COCs cannot unreasonably limit benefits to a specified period of time.	
COCs must provide that reasonable benefits will be restored upon each renewal of the contract or upon a calendar year basis				
COCs cannot unreasonably restrict or delay the payment of benefits. Delays are not justified because the expenses incurred, or the services received, resulted from an act or omission of a third party.				
There must be a grace period of not less than 10 days following the due date for the payment of the subscriber's dues, fees or premium.				
Coordination of Benefits		Chapter 284-51 WAC	The chapter does not require the use of coordination of benefit provisions. However, if a plan contains any provision for the reduction of benefits payable because of other insurance, it must be consistent with the requirements of the chapter.	
	<i>Definitions</i>	WAC 284-51-195	Definitions in the COB provision must be consistent with the section.	
	<i>Allowable Expense</i>	WAC 284-51-195(1)	The definition of "allowable expense" should be clear that when coordinating benefits, any secondary plans must pay an amount which, together with the primary plan, totals the higher of the allowable expenses.	
	<i>Plan</i>	WAC 284-51-195(12)(a)	Plans coordinating benefits must state the types of coverage that will be considered in applying the COB contract provisions.	
	<i>Time Limit</i>	WAC 284-51-215	Time limits for payment of claims may not be unreasonably delayed due to COB. Time limits for primary and secondary plans may be no less favorable than as set forth in this section.	
	<i>Required in COB Provision</i>	WAC 284-51-220 WAC 284-51-225 WAC 284-51-235	<ul style="list-style-type: none"> Facility of payment. Right of recovery. Notice to covered persons. 	
	<i>Appendix A – Model COB contract provisions.</i>	WAC 284-51-255	Model for use in contracts. Carriers need not use the specific words and format provided. Editing changes may be made to fit the language and style of the rest of the contract and differences among plans. Modifications may be made provided they do not conflict with the requirements of the chapter.	

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Delivery of Hospital and Institutional Care in an Alternative Setting		WAC 284-44-500	Must include a process for accessing alternative care with consent of insured upon recommendation of physician. Must provide care in the most appropriate and cost effective setting.	
Dental	<i>General Dental Anesthesia</i> <i>Mandated Benefit</i>	RCW 48.43.185	Health Plans that provide hospital, medical or ambulatory surgery services must offer medically necessary dental anesthesia coverage in a hospital or ambulatory surgery center when the patient is: <ul style="list-style-type: none"> • under age 7 • developmentally delayed, with a dental condition that cannot be safely and effectively treated in a dental office. Group health plans that provide coverage for dental services must cover medically necessary dental anesthesia in a dental office when the patient is: <ul style="list-style-type: none"> • under age 7 • developmentally delayed 	
	<i>Temporomandibular Joint (TMJ)</i> <i>Mandated offering</i>	RCW 48.44.460 WAC 284-44-042	<ul style="list-style-type: none"> • If group declines \$1,000/\$5,000 may then negotiate benefit either up or down. • The scope of services, coinsurance, and Pre Existing Condition (PEC) must be same as other common conditions. • These benefits must also be offered on dental only coverage. 	
Dependent Enrollment Requirements	<i>21 Day Newborn Coverage</i>	RCW 48.43.115 Erin Act	Coverage for the newly born child must be no less than the coverage of the child's mother for no less than three (3) weeks, even if there are separate hospital admissions.	
	<i>Disabled Child over Age Limit</i> <i>Mandated Benefit</i>	RCW 48.44.210	COCs must continue coverage for a child beyond the limiting age when a child is incapable of employment and chiefly dependent for support and maintenance provided proof of the incapacity is provided by the enrollee to the plan within 31 days of the child's attainment of the limiting age and no more frequently than annually after first 2 years of attainment	
	<i>Newborn Child Enrollment</i>	RCW 48.01.235 RCW 48.44.212 Health Insurance Portability and Accountability Act (HIPAA)	<ul style="list-style-type: none"> • COCs cannot limit the application period to 60 days unless additional premium is required. • There must be no waiting period for initial coverage or any service. • COCs cannot deny enrollment to newborn because other dependents not enrolled. 	
	<i>Adoptive Child Enrollment</i>	RCW 48.01.180 RCW 48.01.235 RCW 48.44.212 RCW 48.44.420 HIPAA	COCs must meet the requirements with respect to eligibility and enrollment of children who are physically placed with the subscriber for the purposes of adoption and for whom the subscriber has assumed financial responsibility for total or partial support; <ul style="list-style-type: none"> • Coverage must be on same basis as other dependents • Coverage begins when subscriber assumes responsibility, not physical placement in the home. • COCs cannot limit application period to 60 days unless additional premium is required. 	

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	<i>Newborn and Adoptive Child Enrollment</i>	RCW 48.01.235	COCs can not place unreasonable requirements on the enrollment of a dependent child, including; <ul style="list-style-type: none"> • Requiring the child to be Internal Revenue Service (IRS) dependent • Requiring proof of paternity • Denying dependent coverage because child does not live or physically reside with parent. • Denying dependent coverage because the child was born out of wedlock. 	
	<i>Option To Cover Dependents Under Age Twenty-Five</i> <i>Member Option</i>	RCW 48.44.215	Effective 01/01/2009, plans that cover dependents must have language allowing the member to pay the premium to cover dependents under the age of 25.	
Diabetes	<i>Mandated Benefit</i>	RCW 48.44.315	The COC must provide benefits for any person with diabetes as defined in the statute. COCs without drug (Rx) benefits must provide self-management training & education when ordered by a M.D.	
	<i>DME Mandated Benefit</i>	RCW 48.44.315(2)	COCs with Rx benefits , must provide self-management training & education when ordered by a M.D and appropriate and medically necessary equipment and supplies, including but not limited to: <ol style="list-style-type: none"> 1. Insulin 2. Syringes 3. Injection aids 4. Blood glucose monitors 5. Test strips for blood glucose monitors 6. Visual reading and urine test strips 7. Insulin pumps and accessories to the pumps 8. Insulin infusion devices 9. Prescriptive oral agents for controlling blood sugar levels 10. Foot care appliances for prevention of complications associated with diabetes. 11. Glucagon emergency kits. 	
Disclosure Statements	<i>Confidentiality</i>	RCW 48.43.500(6) RCW 48.43.505 WAC 284-43-820 WAC 284-04-500	COCs must contain a statement of the carrier's policies for protecting the confidentiality of health information.	
	<i>Written Information</i>	RCW 48.43.510 WAC 284-43-820	COCs must contain a statement on how to request written information regarding any health care plan it offers.	

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Durable Medical Equipment		RCW 48.44.315(2) RCW 48.44.320(2) Women's Health & Cancer Rights Act of 1998 WAC 284-43-822	COCs must define equitable durable medical equipment benefits in the following situations: <ul style="list-style-type: none"> • Durable medical equipment for diabetes when pharmacy benefits are offered (benefits cannot be capped for diabetes). • Prostheses and mastectomy bras after mastectomy. • Home Health and Hospice care when included in COC. • Contraceptive devices when pharmacy benefits are offered. 	
	<i>Fraud Statement</i>	RCW 48.135.080	Enrollment form must contain a statement similar to the following: <i>"It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits."</i>	
	<i>Genetic Exclusion</i>	Public Health Service Act (PHSA) 2701(b)(1)(B)	Under market rules exclusions cannot be applied because there is genetic information suggesting a particular condition. This contract may not contain PEC exclusion for genetic information.	
	<i>Group Size</i>	RCW 48.43.005 (10) RCW 48.43.005 (24)	The carrier's process of group size determination must be set forth in the application	
Eligibility	<i>Mandated Benefit Offering</i>	RCW 48.44.460 RCW 48.44.360 RCW 48.44.320 RCW 48.44.344	The group master application offer the following to groups for purchase: <ul style="list-style-type: none"> • TMJ services of at least one option containing \$1000 / \$5000 limitation • A continuation option that offers to extend coverage for an agreed upon time period and rate paid to employer. • Home Health and Hospice • Prenatal testing 	
	<i>Non-confinement Clause</i>	CMS Ins Standards Bulletin 00-01	A carrier may not use any health condition to delay the enrollment of an "eligible individual" or eligible persons under group market rules that is otherwise eligible for coverage. Policies may not delay coverage for persons who are confined to a hospital.	
	<i>Portability</i>	RCW 48.43.015	All medical contracts must conform to all portability standards. Creditable coverage must meet HIPAA definition for the first 63 day period, from 64 to 90 days "similar" coverage is defined by state law.	
	<i>Pre-existing Condition (PEC)</i>	RCW 48.43.025	All medical contracts must conform to all PEC standards. <ul style="list-style-type: none"> • Large groups (51+) have a maximum PEC waiting period of 3 months with a 3 month look-back. • Small groups (50-) have a maximum PEC waiting period of 9 months with a 6 month look-back. 	

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	<i>Special Enrollment Periods - Federal</i>	PHSA 2701(f)	COCs must explain what events trigger a special enrollment period. A special enrollment period can occur if a person with other health coverage loses that coverage or if a person becomes a new dependent through marriage, birth, adoption or placement for adoption, or a current plan's lifetime maximum benefits has been met. If a triggering event is a birth, adoption or placement for adoption, the child, the employee, and the employee's spouse are entitled to special enrollment, either individually or in any combination.	
	<i>Special Enrollment Periods - State</i>	RCW 48.43.008 RCW 48.43.517	COCs must contain language allowing enrollment when DSHS determines that it is cost effective to enroll a person eligible for medical assistance under chapter 74.09 RCW in an employer-sponsored health plan. The request for special enrollment of a child must be made by the department or participant within sixty (60) days of the department's determination that the enrollment would be cost-effective.	
	<i>Waiting Period for Defined Condition</i>	Fed Reg 12/2004	COCs must limit waiting periods for defined conditions to 12 months or less.	
Emergency Treatment	<i>Mandated Benefit</i>	RCW 48.43.005 RCW 48.43.093 WAC 284-43-130 WAC 284-44-040(5)	COCs must comply with emergency treatment requirements including; <ul style="list-style-type: none"> • Must not require prior authorization. • Emergency care definitions and provisions must be consistent with the law including incorporation of "prudent layperson" language. • Must not make sole determination of "emergency" situations. • Emergency out-of-network coverage must be consistent with scope of regular contract benefits. • Participating vs. non-participating cost sharing can be no greater than \$50 differential. 	
Grievance Procedures	<i>General</i>	WAC 284-43-130 RCW 48.43.530 WAC 284-43-620 WAC 284-43-630 WAC 284-43-615	Carriers must have comprehensive grievance processes. The carrier; <ul style="list-style-type: none"> • must provide an explanation of the process upon request, enrollment and annually to covered persons and subcontractors. • must register and respond to written and oral complaints and appeals in a timely and thorough manner. • must send written notification to the enrollee acknowledging receipt of complaints and appeals. • must comply with the 180-day timeframe to ask for an appeal in accordance with the Employee Retirement Income Security Act (ERISA). • may <u>not</u> impose any costs on a claimant as a condition for filing or appealing a claim. 	

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	<i>Adverse Determination and Independent Review Organization (IRO)</i>	RCW 48.43.530 RCW 48.43.535 WAC 284-43-620 WAC 284-43-630	<p>An enrollee or their representative may appeal an adverse determination. The carrier must:</p> <ul style="list-style-type: none"> notify the covered person of its decision within 14 days of receipt. The carrier may extend to 30 days if necessary and upon notification of the covered person. Longer than 30 days requires written consent of the covered person. If delay would jeopardize the covered person's life or health, the carrier shall expedite the process either a written or an oral appeal and issue a decision within 72 hours of receipt ERISA allows 2nd level of appeal. Timeframes must be reasonable under federal law. <p>A covered person may seek review by an IRO after exhausting the carrier's grievance process and receiving an unfavorable decision, or after the carrier has exceeded the timelines. A carrier may establish a process to bypass the grievance and allow the direct appeal to an IRO. The carrier:</p> <ul style="list-style-type: none"> must provide information to the IRO within 3 business days. implement the IRO determination promptly and pay the IRO's charges. continue to provide the health service if requested by the enrollee until a determination is made under this section. If the determination affirms the carrier's decision, the enrollee may be responsible for the cost of the continued health service. 	
	<i>Experimental and Investigative (E&I)</i>	WAC 284-43-620 (2) WAC 284-43-630	<ul style="list-style-type: none"> The definitions of E&I treatment must be included in the COC. <p>A denial due to E&I must be done in writing within 20 working days of receipt of a fully documented request. Extension of the review period beyond this period may only be done with the informed written consent of the individual.</p>	
Guaranteed Issue and Continuity of Coverage		RCW 48.43.035	<p>COCs may not terminate enrollee due to failure of provider-patient ability to establish care relationship.</p> <p>Enrollee may not be terminated for reasons other than those required by law without benefit of Grievance procedure protections.</p> <p>Association member groups must be allowed to purchase all association benefit health plans offered by the association. Smaller sized association member groups cannot be treated differently.</p>	
Home & Hospice Coverage <i>Mandated Benefit Offering</i>	<i>DME</i>	RCW 70.126.020 RCW 48.44.320	<p>If included in the COC, provisions must contain those services and supplies required by a Home Health Agency/Hospice.</p> <p>COCs may not impose additional cost restrictions which require enrollee to pay for equipment or rental of equipment. Must be covered at parity with inpatient DME benefits.</p>	
	<i>Home Health</i>	RCW 48.44.320	<p>Minimum of 130 visits for home healthcare, not to include non-care based visits</p> <p>May require written treatment plan approved by physician</p>	
	<i>Hospice Care</i>	RCW 48.44.320	Minimum of six months with an option for an additional six months	
	<i>Long-Term Care</i>	RCW 48.43.125	If the COC covers long term care, the member must be allowed to return to the same long term care facility after hospitalization.	

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Mammogram Mandated Benefit	<i>Mandated Benefit</i>	RCW 48.44.325 WAC 284-44-046	COCs must provide benefits for screening and diagnostic mammography services when referred by a member's Medical Doctor (M.D.), Advanced Registered Nurse Practitioner (ARNP) , or Physician's Assistant (PA).	
Mastectomy	<i>Mastectomy (Reconstructive Surgery)</i> <i>Mandated Benefit</i>	RCW 48.44.330 Women's Health & Cancer Rights Act of 1998	COC must provide benefits for reconstruction following a mastectomy: <ul style="list-style-type: none"> Benefit restrictions such as "initial surgery" and "complications" can not be used to limit coverage for any stage of treatment All stages of surgery/reconstruction of the non-diseased breast to produce symmetrical appearance must be included. Mastectomy bras must be covered benefit under Women's Health & Cancer Rights Act of 1998 Prostheses & physical complication including lymphedemas must be covered 	
Master and Enrollment Application	<i>Certificate of Creditable Coverage</i>	PHSA 2701(e) 45 Code of Federal Register (CFR) 148.124 RCW 48.43.015	Enrollment application must ask for prior creditable coverage information or state that the following information can be used to prove prior coverage; <ul style="list-style-type: none"> Pay stubs that reflect a premium deduction; Explanation of benefit forms; A benefit termination notice from Medicare or Medicaid; and Verification by a doctor or your former health care benefits provider that you had prior health coverage. Certificate of Creditable Coverage 	
	<i>Creditable Coverage</i>	PHSA 2701(c) 45 CFR 146.113 RCW 48.43.015	The application, certificate, or contract must include a description of types of creditable coverage: <ul style="list-style-type: none"> A group health plan (includes Consolidated Omnibus Budget Reconciliation Act (COBRA)) Health insurance coverage (includes individual coverage, college or school insurance, short-term limited duration insurance) Medicare Part A or Part B Medicaid, Indian Health Service or tribal organization medical program A State health benefits risk pool TRICARE (military health care program for dependents & retirees) Federal Employees Health Benefit Plan A public health plan A health plan under the Peace Corps Act State Children's Health Insurance Act (SCHIP) 	
Maternity Benefits	<i>Direct Access to Services</i>	WAC 284-43-250	COCs may not impose a limitation on maternity services that would require all child birth to occur in a hospital.	
	<i>Access Mandate</i>		COCs may not impose requirement which requires a physician to conduct a delivery in lieu of midwives.	
			COCs must cover medically necessary supplies of a home birth.	
			Benefits must be provided at the same level as comparable services.	

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	<i>Length of Stay</i>	RCW 48.43.115	COCs must allow the health care provider <i>in consultation</i> with the mother to make decisions regarding care and length of stay in a hospital.	
		ERIN Act	If length of stay guideline is stated must be no less than: 48-hour normal birth/96 caesarian section birth.	
	<i>Mandated Benefit</i>	Newborns and Mothers Protection Act of 1996	The contract can not restrict follow-up care when ordered by the attending provider <i>in consultation</i> with the mother	
			The Carrier must provide notice to policyholders regarding this coverage yearly by January 1 st .	
	<i>Pregnancy</i>	RCW 48.43.025 PHSA 2701(d)(3)	There must be no pre-existing condition exclusion for pregnancy, no matter when pregnancy began and whether medical advice, diagnosis, care or treatment was recommended or received for the pregnancy. COCs may not contain a pre-existing exclusion for pregnancy even if the previous health plan did not cover pregnancy.	
	<i>Pregnancy Discrimination</i>	Title VII of the Civil Rights Act	A plan may not unreasonably discriminate against pregnant women.	
		Equal Employment Opportunity Commission (EEOC) Compliance Manual	Unreasonable discrimination includes: <ul style="list-style-type: none"> Restricting travel during pregnancy including the 3rd trimester. Charging higher premium for care. 	
<i>Federal Mandate</i>				
<i>Prenatal Testing Mandated benefit Offering</i>	RCW 48.44.344	The plan must offer prenatal testing for congenital disorders.		
Mental Health Coverage	<i>Mandated Benefit</i>	RCW 48.43.087 RCW 48.43.091 RCW 48.44.341 RCW 48.44.342	<ul style="list-style-type: none"> Must be inclusive of providers recognized by RCW 48.43.087. Preauthorization must be waived if person is involuntarily committed. Must be offered with lesser or the same copayment/coinsurance as other medical and surgical services offered. Effective January 1, 2008, if plan imposes maximum out-of-pocket limit, it must be a single stop loss for medical, surgical and mental health services. Must provide inpatient and outpatient services Does not need to provide care for substance abuse, life transition problems, Skilled Nursing Facility (SNF), home health, residential treatment, or custodial care, or court ordered unless medically necessary. Rx – to same extent covered under health benefit portion of plan. Benefits may not be reduced below those established in plans prior to July 1, 2002. COCs cannot prohibit the subscriber from contracting outside of the plan. 	
Neurodevelopmental Therapy Mandated Benefit		RCW 48.44.450	<ul style="list-style-type: none"> Must provide benefits for children up to and including age six Services covered must include testing, physical, speech, and occupational therapies. Benefits must be provided to restore and improve function, and to prevent deterioration. Benefits may be subject to annual or lifetime benefit limits. 	

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Pharmacy	<i>Contraceptive Care</i>	WAC 284-43-822 <i>Erickson v. Bartell Drug Co.</i> , 141 F. Supp.2d 1266 (W.D. Wash. 2001)	<ul style="list-style-type: none"> It is unfair practice for any COC to restrict, exclude, or reduce coverage on the basis of sex Health plans which include Rx benefits shall not exclude coverage of contraceptive drugs and devices including associated medical services for prescribing, dispensing, delivery, distribution, administration and removal of contraceptive devices Benefit waiting period may not be more restrictive than those required of other Rx benefits COCs may limit to closed formulary but it shall cover each required type If excludes coverage for nonprescription drugs/devices it may also exclude for nonprescription contraceptive drugs/devices The Federal Drug Administration (FDA) approved prescription contraceptives shall include: contraceptive drugs, barrier methods, and emergency contraception 	
	<i>Disclosure (if offered)</i>	RCW 48.44.465 WAC 284-30-450	COCs that offer prescription drug coverage must: <ul style="list-style-type: none"> Upon request of (prospective) enrollee furnish information regarding drug formulary requirements A COC cannot exclude a drug solely because of lack of Federal Drug Administration (FDA) approval for the given use Carriers may not retract an issued authorization on a pharmacy claim. 	
	<i>Off Label Use of Drugs</i>	WAC 284-30-450	All COCs providing pharmacy coverage must provide coverage for FDA approved drugs that have many other beneficial uses as confirmed by other research studies, reference, compendium, or the Federal government.	
	<i>Pharmacy Services Statement of Right</i>	WAC 284-43-815	If a statement regarding "Your right to Safe and Effective Pharmacy Services" is included it must follow language in WAC 284-43-815.	
	<i>Prescription Drug Formulary</i>	RCW 48.43.510 WAC 284-43-820	COCs must inform member about how to obtain a listing of covered benefits including prescription drugs, a formulary and how a subscriber may be involved in decisions about benefits.	
	<i>Terms</i>	WAC 284-43-820	COCs must contain definitions of terms including formulary, generic versus brand name, medical necessity or other coverage criteria including policies regarding drug coverage.	
PHENYLKE-TONURIA (PKU) Mandated Benefit	<i>Mandated Benefit</i>	RCW 48.44.440 WAC 284-44-450	Formulas necessary for the treatment of PKU must be provided at the same cost share level as other benefits and must be exempt from PEC limitations.	
Prostate Cancer Screening Mandated Benefit	<i>Mandated Benefit</i>	RCW 48.44.327	COCs must provide prostate cancer screening ordered by physician, ARNP, or physician's assistant	

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Provider Requirements	<i>Access to Providers for managed care plans only</i>	RCW 48.43.515 WAC 284-43-251	<ul style="list-style-type: none"> • COCs must permit changing PCP at any time. • The effective date must be no later than the beginning of the month following the request. 	
	<i>Any Category of Provider Mandated Benefit</i>	RCW 48.43.045	COCs must incorporate “every category of provider” language. Providers must treat within the scope of licensure.	
		RCW 48.43.005(16)	Providers can be required to conform with COC standards for cost-containment	
		RCW 48.44.299	COCs may exclude specific treatments for stated conditions by specific provider types, if they show the treatment is not cost-effective or efficacious.	
		RCW 48.43.515	Reasonable limits may be placed on individual services, but not on provider type.	
		RCW 48.44.225	COC can not impose composite annual dollar amount.	
		RCW 48.44.290	The services of a podiatrist and Registered Nurse (RN) must be covered on the same basis as services of a MD.	
		RCW 48.44.300	Chiropractic coverage must be covered on the same basis as other care.	
		RCW 48.44.310	COCs must provide direct access to a participating chiropractor without the necessity of prior referral. Managed care cost and containment techniques may be utilized.	
		WAC 284-43-205	For COCs offering dental coverage, dentist must be able to provide services within the scope of their license.	
	<i>Dentist Mandated Benefit</i>	RCW 48.43.180 RCW 48.44.500		
	<i>Continuation of Care Upon Provider Termination</i>	RCW 48.43.515(7) WAC 284-43-251	COCs must allow an enrollee whose PCP contract is being terminated from the plan to continue care under the terms of the contract for at least sixty (60) days following notice of termination to the enrollee.	
	<i>Participating Provider Definition (when provided)</i>	RCW 48.44.010 WAC 284-43-320(2)(d)	<ul style="list-style-type: none"> • The definition of “participating provider” must be consistent with the statutory and regulatory definitions. • Definition can not contain language that conflicts with provider agreement requirements, such as, Provider may not bill enrollee for covered services except for deductible, co-payments, or coinsurance. • If COCs offers multiple networks, i.e., participating, preferred, point-of-service; the definitions must be used consistently throughout the COC. 	
<i>Payment for Non-par Services</i>	RCW 48.44.026	If COCs contains a provision stating to whom benefits will be paid, it must follow the language in RCW 48.44.026.		
<i>Second Opinion</i>	RCW 48.43.515(6) WAC 284-43-251	Enrollee may seek a second opinion from any participating provider of the enrollee's choice regarding any medical diagnosis or treatment plan		
<i>Specialist Standing Referral (Managed Care Plans Only)</i>	RCW 48.43.515 WAC 284-43-251	COCs must explain that you may request a standing referral for specialist services if you have a complex or chronic medical condition.		

Topic	Sub topic	Reference Specific Issue(s)*	Specific Issue	Location
Retrospective Denial		RCW 48.43.525 RCW 48.44.465	<ul style="list-style-type: none"> • COCs cannot retrospectively deny coverage for emergency and non-emergency care that had prior authorization under the plan's written policies at the time the care was rendered. • COCs may not deny pharmacy benefits already approved and obtained by member. 	
Service Outside the Plan Allowed		RCW 48.43.085	COCs must allow for the enrollee to access services outside of the health plan.	
Subrogation		WAC 284-44-040 OIC Bulletin 79-4 Great-West Life & Annuity Ins v. Knudson Thiringer v. American Motors Ins.	<ul style="list-style-type: none"> • If COCs includes a subrogation provision, the provision must clearly notify enrollee of their right to be fully compensated. • The contract cannot unreasonably restrict or delay the payment of benefits. Delays are not justified because the expenses incurred, or the services received, resulted from an act or omission of a third party. 	
Timely Filing	<i>Negotiated Groups</i>	WAC 284-43-920	Must be filed within 30 working days of the completion of group negotiation <u>or</u> the date renewal premiums are implemented.	
	<i>Standard Master Contract</i>	WAC 284-43-920	Must be filed before being offered for sale to the public and within 30 days after the end of the 18 month approval period.	
Unfair and Discriminatory Practices		RCW 48.44.110 RCW 48.44.120 RCW 48.44.140 RCW 48.44.220 HIPAA	<ul style="list-style-type: none"> • No person shall make, publish, or disseminate any false, deceptive, or misleading representation or advertising on behalf of a HCSC. Nor shall the terms of a contract be misrepresented. • COCs cannot deny coverage to any person on account of a sensory, mental, or physical handicap. 	
	<i>Non-discrimination Clause</i>	45 CFR 146	Carrier's exclusion for specific disease, limitation or exclusion for a specific benefit, treatment or drugs must be applied uniformly to all similarly situated individuals, and not directed at individual participants or beneficiaries based on a health factor.	
Women's Direct Access	<i>Access Mandate</i>	RCW 48.42.100 WAC 284-43-250	<ul style="list-style-type: none"> • COCs must allow direct access to all women's health care providers (MD, Doctor of Osteopathic Medicine (DO), ARNP and Midwife) • Provider-types must be in the network and accessible to subscribers. • COCs may not require Primary Care Provider (PCP) prior referral. • May not impose discriminatory cost sharing provisions. 	