



RULE-MAKING ORDER

CR-103P (May 2009)
(Implements RCW 34.05.360)

Agency: Office of the Insurance Commissioner

Permanent Rule Only

Effective date of rule:

Permanent Rules

31 days after filing.

Other (specify) _____ (If less than 31 days after filing, a specific finding under RCW 34.05.380(3) is required and should be stated below)

Any other findings required by other provisions of law as precondition to adoption or effectiveness of rule?

Yes **No** If Yes, explain:

Purpose: This new rule allows health benefit plans to have optional plan designs that are compliant with the Affordable Care Act and include pediatric dental benefits as one of the ten essential health benefit designs.

Insurance Commissioner Matter No. R 2013-19

Citation of existing rules affected by this order:

Repealed:

Amended: 1

Suspended:

Statutory authority for adoption: RCW 48.02.060, 48.43.715

Other authority:

PERMANENT RULE (Including Expedited Rule Making)

Adopted under notice filed as WSR 14-06-098 on 03/05/2014.

Describe any changes other than editing from proposed to adopted version: None

If a preliminary cost-benefit analysis was prepared under RCW 34.05.328, a final cost-benefit analysis is available by contacting:

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Date adopted:

April 23, 2014

NAME (TYPE OR PRINT)

Mike Kreidler

SIGNATURE

TITLE

Insurance Commissioner

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: April 18, 2014

TIME: 4:56 PM

WSR 14-09-080

**Note: If any category is left blank, it will be calculated as zero.
No descriptive text.**

**Count by whole WAC sections only, from the WAC number through the history note.
A section may be counted in more than one category.**

The number of sections adopted in order to comply with:

Federal statute:	New	_____	Amended	_____	Repealed	_____
Federal rules or standards:	New	_____	Amended	_____	Repealed	_____
Recently enacted state statutes:	New	<u>3</u>	Amended	<u>1</u>	Repealed	_____

The number of sections adopted at the request of a nongovernmental entity:

New	_____	Amended	_____	Repealed	_____
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The number of sections adopted in the agency's own initiative:

New	3	Amended	<u>1</u>	Repealed	_____
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The number of sections adopted in order to clarify, streamline, or reform agency procedures:

New	_____	Amended	_____	Repealed	_____
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The number of sections adopted using:

Negotiated rule making:	New	_____	Amended	_____	Repealed	_____
Pilot rule making:	New	_____	Amended	_____	Repealed	_____
Other alternative rule making:	New	<u>3</u>	Amended	<u>1</u>	Repealed	_____

WAC 284-43-879 Essential health benefit category—Pediatric oral services. A health benefit plan must include "pediatric (~~oral services~~) dental benefits" in its essential health benefits package. Pediatric dental benefits means coverage for the oral services (~~are oral services~~) listed in subsection (3) of this section, delivered to those under age nineteen.

(1) For benefit years beginning January 1, 2015, a health benefit plan must (~~cover~~) include pediatric (~~oral services~~) dental benefits as an embedded set of (~~services~~) benefits, or through a combination of a health benefit plan and a stand-alone dental plan that includes pediatric dental benefits certified as a qualified dental plan. (~~If~~) For a health benefit plan (~~is~~) certified by the health benefit exchange as a qualified health plan, this requirement is met (~~for that benefit year for the certified plan~~) if a stand-alone dental plan (~~that covers pediatric oral services as set forth in the EHB-benchmark plan~~) meeting the requirements of subsection (3) of this section is offered in the health benefit exchange for that benefit year.

(2) The requirements of WAC 284-43-878 and 284-43-880 are not applicable to the stand-alone dental plan. A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. The supplemental base-benchmark plan specifically excludes oral implants, and an issuer should not include benefits for oral implants in establishing a plan's actuarial value.

(3) **Supplementation:** The base-benchmark plan covers pediatric services for the categories set forth in WAC 284-43-878, but does not (~~include~~) cover pediatric oral services. Because the base-benchmark plan does not (~~include~~) cover pediatric oral benefits, the state EHB-benchmark plan requirements (~~is~~) are supplemented for pediatric oral benefits. The Washington state CHIP plan is designated as the supplemental base-benchmark plan for pediatric (~~oral services. An~~) dental benefits. A health plan issuer must offer coverage for and classify the following (~~services as~~) pediatric oral services as pediatric dental benefits in a manner substantially equal to the supplemental base-benchmark plan:

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

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

- (a) Diagnostic exams once every six months, beginning before one year of age;
- (b) Bitewing X ray once a year;
- (c) Panoramic X rays once every three years;
- (d) Prophylaxis every six months beginning at age six months;

- (e) Fluoride three times in a twelve-month period for ages six and under; two times in a twelve-month period for ages seven and older; three times in a twelve-month period during orthodontic treatment; sealant once every three years for occlusal surfaces only; oral hygiene instruction two times in twelve months for ages eight and under if not billed on the same day as a prophylaxis treatment;
- (f) Every two years for the same restoration (fillings);
- (g) Frenulectomy or frenuloplasty covered for ages six and under without prior authorization;
- (h) Root canals on baby primary posterior teeth only;
- (i) Root canals on permanent anterior, bicuspid and molar teeth, excluding teeth 1, 16, 17 and 32;
- (j) Periodontal scaling and root planing once per quadrant in a two-year period for ages thirteen and older, with prior authorization;
- (k) Periodontal maintenance once per quadrant in a twelve-month period for ages thirteen and older, with prior authorization;
- (l) Stainless steel crowns for primary anterior teeth once every three years; if age thirteen and older with prior authorization;
- (m) Stainless steel crowns for permanent posterior teeth once every three years;
- (n) Metal/porcelain crowns and porcelain crowns on anterior teeth only, with prior authorization;
- (o) Space maintainers for missing primary molars A, B, I, J, K, L, S, and T;
- (p) One resin based partial denture, if provided at least three years after the seat date;
- (q) One complete denture upper and lower, and one replacement denture per lifetime after at least five years from the seat date;
- (r) Rebasing and relining of complete or partial dentures once in a three-year period, if performed at least six months from the seat date.

NEW SECTION

WAC 284-170-800 Purpose and scope—Pediatric dental benefits for health benefit plans sold outside of the health benefit exchange. For plan years beginning on or after January 1, 2015, each nongrandfathered health benefit plan offered, issued or renewed to small employers or individuals, outside the Washington health benefit exchange, must include pediatric dental benefits as an essential health benefit (EHB). This design requirement must be met by one of the methods set forth in WAC 284-170-810. Pediatric dental benefits must meet cost sharing requirements including deductible and out-of-pocket maximums as required by the ACA. All pediatric dental benefits are subject to premium tax.

NEW SECTION

WAC 284-170-805 Definitions. "PPACA" or "ACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), collectively known as the Affordable Care Act, and any rules, regulations, or guidance issued, thereunder.

"Stand-alone dental plan" means coverage for a set of benefits limited to oral care including, but not necessarily limited to, the pediatric oral services listed in WAC 284-43-879(3).

NEW SECTION

WAC 284-170-810 Pediatric dental benefits design—Methods of satisfying requirements. (1) An issuer of a health benefit plan may satisfy the requirement of WAC 284-170-800 in any one of the following ways.

(a) A health benefit plan includes pediatric dental benefits as an embedded benefit; or

(b) A separate health benefit plan is offered without pediatric dental benefits, if and only if, the issuer receives reasonable assurance that the applicant has obtained or will obtain pediatric dental benefits through a stand-alone dental plan certified as a qualified dental plan. This reasonable assurance must be received by the issuer within sixty days.

(i) "Reasonable assurance" means receipt of proof of coverage from the stand-alone dental plan and a signed attestation of coverage from the applicant. In cases where the enrollment process is for a health plan and a dental plan that are being jointly purchased (bundled), verification by the dental carrier of enrollment in the dental plan and transmission of the enrollment confirmation to the health carrier will be considered reasonable assurance.

(ii) The health benefit plan issuer has the responsibility to obtain any required documents establishing reasonable assurance at the initial application and every renewal.

(iii) The stand-alone dental plan issuer has the responsibility for providing the proof of coverage upon request of the health benefit plan issuer or applicant. If a health benefit plan issuer requests proof of coverage for an applicant, the stand-alone dental issuer must provide proof of coverage or inform the health benefit plan issuer that no coverage exists. The stand-alone dental issuer must respond within thirty days of a request for proof of coverage.

(iv) The health benefit plan issuer may issue coverage prior to receiving reasonable assurance. If the health benefit plan issuer receives the reasonable assurance within sixty days of the effective date of the health benefit plan, the enrollee's stand-alone dental coverage will be considered to satisfy the requirement of WAC 284-43-879. If the health benefit plan issuer does not receive reasonable assurance within the sixty days provided in (iii) of this subsection, the health benefit plan issuer must discontinue the health benefit plan for that applicant unless and until the health benefit plan issuer receives reasonable assurance that the applicant has obtained pediatric dental benefits as required under the ACA.

(2) Nothing in this section precludes issuing ACA compliant pediatric dental benefits as part of a family dental plan sold as group or individual coverage.