



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) upon filing (If less than 31 days after filing, a specific finding under RCW 34.05.380(3) is required and should be stated below) The requirements of SSB 5023 apply to plans issued or renewed on or after January 1, 2016, so the OIC needs to complete the rulemaking process immediately.

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

Yes **No** **If Yes, explain:**

Purpose: This rule deletes two sections from WAC 284-43 Subchapter I (WAC 284-43-920 and -950) and moves them to a new subchapter in WAC 284-43 called Subchapter J, while modifying the language to incorporate the requirements of SSB 5023.

Reasons supporting: During the 2015 legislative session, the state legislature passed SSB 5023, which became effective on 7/24/15. The intent of the new law is to create regulatory uniformity for the filing requirements for large group health benefit plans, including large group disability plans, as well as stand-alone dental plans and stand-alone vision plans.

Insurance Commissioner Matter No. R 2015-04

Citation of existing rules affected by this order:

Repealed: WAC 284-43-920, 284-43-950

Amended:

Suspended:

Statutory authority for adoption: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066.

Other authority: SSB 5023 (Chapter 19, Laws of 2015—effective 7/24/15)

PERMANENT RULE (Including Expedited Rule Making)

Adopted under notice filed as **WSR 15-21-078** on October 20, 2015.

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: January 8, 2016

NAME (TYPE OR PRINT)

Mike Kreidler

SIGNATURE

TITLE

Insurance Commissioner

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: January 08, 2016

TIME: 2:16 PM

WSR 16-03-018

(COMPLETE REVERSE SIDE)

**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>4</u>	Amended	Repealed <u>2</u>

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	Amended	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>4</u>	Amended	Repealed <u>2</u>

SUBCHAPTER J
HEALTH PLANS, STAND-ALONE DENTAL PLANS AND STAND-ALONE VISION PLANS—
FILING REQUIREMENTS

NEW SECTION

WAC 284-43-6500 Applicability and scope. This subchapter is adopted under the general authority of RCW 48.02.060. This subchapter applies to health benefit plans as defined in RCW 48.43.005 and contracts for limited health care services as defined in RCW 48.44.035. This subchapter also applies to plans issued or renewed on or after January 1, 2016, offered by carriers under the requirements of chapter 19, Laws of 2015.

NEW SECTION

WAC 284-43-6520 Definitions. For the purpose of this subchapter:

(1) "Contract" means an agreement to provide health care services or pay health care costs for or on behalf of a "subscriber" or group of "subscribers" and such eligible dependents as may be included therein.

(2) "Contract form" means the prototype of a "contract" and any associated riders and endorsements filed with the commissioner by a carrier.

(3) "Covered person" or "enrollee" has the same meaning as that contained in RCW 48.43.005.

(4) "Dependent" has the same meaning as that contained in RCW 48.43.005.

(5) "Health carrier" or "carrier" means an insurer that issues disability insurance regulated under chapter 48.20 or 48.21 RCW, a health care service contractor as defined in RCW 48.44.010, or a health maintenance organization as defined in RCW 48.46.020, and includes "issuers" as that term is used in the federal Patient Protection and Affordable Care Act (Public Law 111-148).

(6) "Large group contracts" or "large group plans" include group health benefit plans and stand-alone dental plans or stand-alone vision plans that are not small group plans and are not individual plans.

(7) "Limited health care service contractor" means a health care service contractor that offers one and only one limited health care service.

(8) "Negotiated contract" form means a health benefit plan or stand-alone dental plan or stand-alone vision plan where benefits and other terms and conditions, including the applicable rate schedules, are negotiated and agreed to by the carrier or limited health care

service contractor and the policy or contract holder. The only plans that carriers can negotiate are large group plans. The negotiated policy form and associated rate schedule must otherwise comply with state and federal laws governing the content and schedule of rates for the negotiated plans.

(9) "Premium" means all sums charged, received, or deposited as consideration for a contract or the continuance of a contract. Any assessment, or any "membership," "policy," "survey," "inspection," "service," or similar fee or charge made by the carrier in consideration for a contract is part of the premium. Premium does not include amounts paid as enrollee point-of-service cost-sharing.

(10) "Rate" or "rates" means all classification manuals, rate manuals, rating schedules, class rates, and rating rules.

(11) "Rate schedule" means the schedule of rates that includes the description of methodology used to obtain the premium rate for a specific individual or group, if given the necessary information such as the demographic data and plan design of the individual or group. For a single negotiated contract form, the rate schedule also includes the premium for the employer.

(12) "Small employer" means an employer that fits within the definition of small employer as that term is used in the federal Patient Protection and Affordable Care Act (Public Law 111-148).

(13) "Small group plans" means the class of "group contracts" issued to "small employers." For the purposes of this section, "small group contracts" and "small group plans" also apply to stand-alone dental plans or stand-alone vision plans.

(14) "Stand-alone dental plan" means coverage for a set of benefits limited to oral care including, but not necessarily limited to, pediatric oral care.

(15) "Stand-alone vision plan" means coverage for a set of benefits limited to vision care including, but not necessarily limited to, materials.

(16) "Subscriber" means a person on whose behalf a "contract" or "certificate" is issued.

NEW SECTION

WAC 284-43-6540 Summary for group contract filings other than small group contract filings.

Groups Other Than Small Groups Filing Summary

Carrier Name	_____
Address	_____

Contract Holder/Pool Category and Name (Check One Box)	<input type="checkbox"/> Single Employer Group:
	Employer Name: _____
	<input type="checkbox"/> Multiemployer other than Association/Trust Groups
	Group Pool Name: _____
	<input type="checkbox"/> Association/Trust Groups
	Association/Trust Group Name: _____

Contract Form Number _____
Rate Form Number (if different from Contract Form Number) _____
Product Name _____

If additional space is required to list the contract/rate form number and product name, attach a separate sheet.

Rate Renewal Period: From: _____ To: _____
Date Submitted: _____
Type of Filing (Check One Box) <input type="checkbox"/> New Group Contract <input type="checkbox"/> Revision of Existing Group Contract

Proposed Rate Schedules: Attach a separate sheet to list all proposed tier rates.

Rate Summary

Current Rate (Composite per employee or per member)	\$ _____ per member per month
Percentage Rate Change	_____ %
New Rate	\$ _____ per member per month
Average Number of Enrollees Each Month During the Experience Period (If the average number of enrollees is equal to or less than fifty, explain why this is not a small group, as defined in RCW 48.43.005.)	_____
Anticipated Loss Ratio	_____ %
Portion of carrier's total enrollment affected	_____ %
Portion of carrier's total premium revenue affected	_____ %

Summary of Contract Experience

	Experience Period	First Prior Period	Second Prior Period
	From To	From To	From To
Member Months			
Billed Premium			
Incurred Claims			
Expenses			
Gain/Loss			
Experience Refund/Credit or Recoupment			
Earned Premium (Billed Premium +/- Refund/Credit or Recoupment)			
Loss Ratio Percentage			

Attach comments or additional information.
Preparer's Information
Name: _____
Title: _____
Telephone Number: _____

NEW SECTION

WAC 284-43-6560 When a carrier is required to file. (1) All rates and forms of group health benefit plans other than small group plans and all stand-alone dental and stand-alone vision plans offered by a health carrier or limited health care service contractor as defined in RCW 48.44.035 and modification of a contract form or rate must be filed before the contract form is offered for sale to the public and before the rate schedule is used.

(2) Filings of negotiated contract forms for groups other than small groups, and applicable rate schedules, that are placed into effect at time of negotiation or that have a retroactive effective date are not required to be filed in accordance with subsection (1) of this section, but must be filed within thirty working days after the earlier of:

- (a) The date group contract negotiations are completed; or
- (b) The date renewal premiums are implemented.

(3) When a carrier submits a late filing, the carrier must include an explanation on the filing document describing why the carrier submitted the filing late.

(4) The negotiated policy form and associated rate schedule must otherwise comply with state and federal laws governing the content and schedule of rates for the negotiated plans.

(5) Stand-alone dental plans and stand-alone vision plans offered by a disability insurer to out-of-state groups specified by RCW 48.21.010(2) may be negotiated, but may not be offered in this state before the commissioner finds that the stand-alone dental plan or stand-alone vision plan otherwise meets the standards set forth in RCW 48.21.010 (2)(a) and (b).

REPEALER

The following sections of the Washington Administrative Code are repealed:

- WAC 284-43-920 When a carrier is required to file.
- WAC 284-43-950 Summary for group contract filings
 other than small group contract
 filings.