



PROPOSED RULE MAKING

CR-102 (October 2017)
(Implements RCW 34.05.320)
Do **NOT** use for expedited rule making

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STATE OF WASHINGTON
FILED

DATE: August 21, 2018

TIME: 3:54 PM

WSR 18-17-166

Agency: Office of the Insurance Commissioner

- Original Notice**
- Supplemental Notice to WSR** _____
- Continuance of WSR** _____

- Preproposal Statement of Inquiry was filed as WSR** 18-06-052 ; or
- Expedited Rule Making--Proposed notice was filed as WSR** _____ ; or
- Proposal is exempt under RCW 34.05.310(4) or 34.05.330(1); or**
- Proposal is exempt under RCW** _____.

Title of rule and other identifying information: (describe subject) Short-term limited duration medical plans

Insurance Commissioner Matter No. R2018-01

Hearing location(s):

Date:	Time:	Location: (be specific)	Comment:
September 26, 2018	1:00 pm	2:00 pm	

Date of intended adoption: October 5, 2018 (Note: This is **NOT** the **effective** date)

Submit written comments to:

Name: Jane Beyer
 Address: PO Box 40260, Olympia, WA 98504-0260
 Email: rulescoordinator@oic.wa.gov
 Fax: 360-586-3109
 Other:
 By (date) September 24, 2018

Assistance for persons with disabilities:

Contact Lorie Villaflores
 Phone: 360-725-7087
 Fax:
 TTY: 360-586-0241
 Email: LorieV@oic.wa.gov
 Other:
 By (date) September 24, 2018

Purpose of the proposal and its anticipated effects, including any changes in existing rules:

This proposed rule on short-term limited duration medical plans clarifies the Insurance Commissioner's process and standards relative to the filing and sale of short-term limited duration medical plans in Washington state. It will restore in large part federal rules previously in place from 2016 to date that limited the duration of short-term limited duration health insurance to three months. It establishes minimum standards for coverage offered through short-term limited duration medical plans, establishes requirements related to consumer disclosure, provides for prior approval of short-term limited duration medical plan forms and rates, and defines the circumstances under which those medical plans can be cancelled or rescinded.

Reasons supporting proposal:

The proposal is in response to final rules adopted by the federal Departments of Treasury, Labor and Health and Human Services related to short-term limited duration insurance. Short-term limited duration insurance is exempt from many of the health insurance reforms included in the Affordable Care Act. The final federal rule was adopted on August 3, 2018. The effective date of the rule is October 2, 2018. The federal rule expands the term of short-term limited duration health insurance to up to one year, expands the duration of such insurance policies to up to 36 months, and allows consumers to purchase a new policy after expiration of a previous policy. The rule allows states to adopt shorter periods for the term and duration of short-term limited duration insurance, and to impose additional requirements related to the insurance policies and consumer notices.

Short-term limited duration medical plans are designed to fill gaps in coverage for individuals who need access to “stop gap” coverage pending a transition to comprehensive coverage through, for example, employer-sponsored coverage, an upcoming individual market open enrollment period or Medicare coverage. Under the ACA, individuals have the opportunity to enroll in individual health insurance outside of the annual open enrollment period if they experience qualifying events, such as having a child, losing student health insurance or losing their employer-sponsored health insurance.

Short-term limited duration medical plans are exempt from many requirements of the Affordable Care Act. Carriers offering these plans can deny coverage based on health status. The plans can exclude coverage of pre-existing medical and behavioral health conditions, do not have to offer ACA essential health benefits and can set limits on annual and lifetime coverage.

Short-term limited duration coverage should not be considered a substitute for comprehensive benefits available through the ACA individual health insurance market or group health coverage.

Statutory authority for adoption: 48.43.005(26), 48.02.060, 48.44.050, 48.46.200

Statute being implemented: RCW 48.43.005(26)

Is rule necessary because of a:

Federal Law?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Federal Court Decision?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
State Court Decision?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No

If yes, CITATION: [26 CFR 54.9801-2](#), [29 CFR 2590.701-2](#) and [45 CFR 144.103](#)

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

Name of proponent: (person or organization) Mike Kreidler, Insurance Commissioner

Private
 Public
 Governmental

Name of agency personnel responsible for:

	Name	Office Location	Phone
Drafting:	Jane Beyer	PO Box 40260, Olympia WA, 98504-0260	360-725-7043
Implementation:	Molly Nollette	PO Box 40255, Olympia WA, 98504-0255	360-725-7117
Enforcement:	Doug Hartz	PO Box 40255, Olympia WA, 98504-0255	360-725-7214

Is a school district fiscal impact statement required under RCW 28A.305.135?

Yes No

If yes, insert statement here:

The public may obtain a copy of the school district fiscal impact statement by contacting:

Name:
Address:
Phone:
Fax:
TTY:

Email:

Other:

Is a cost-benefit analysis required under RCW 34.05.328?

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

Name: Zachary Mason

Address: PO Box 40258

Phone: (360)725-7170

Fax: (360 586-3109)

TTY: 360-586-0241

Email: zachm@oic.wa.gov

Other:

No: Please explain:

Regulatory Fairness Act Cost Considerations for a Small Business Economic Impact Statement:

This rule proposal, or portions of the proposal, **may be exempt** from requirements of the Regulatory Fairness Act (see chapter 19.85 RCW). Please check the box for any applicable exemption(s):

This rule proposal, or portions of the proposal, is exempt under RCW 19.85.061 because this rule making is being adopted solely to conform and/or comply with federal statute or regulations. Please cite the specific federal statute or regulation this rule is being adopted to conform or comply with, and describe the consequences to the state if the rule is not adopted.

Citation and description:

This rule proposal, or portions of the proposal, is exempt because the agency has completed the pilot rule process defined by RCW 34.05.313 before filing the notice of this proposed rule.

This rule proposal, or portions of the proposal, is exempt under the provisions of RCW 15.65.570(2) because it was adopted by a referendum.

This rule proposal, or portions of the proposal, is exempt under RCW 19.85.025(3). Check all that apply:

RCW 34.05.310 (4)(b)
(Internal government operations)

RCW 34.05.310 (4)(e)
(Dictated by statute)

RCW 34.05.310 (4)(c)
(Incorporation by reference)

RCW 34.05.310 (4)(f)
(Set or adjust fees)

RCW 34.05.310 (4)(d)
(Correct or clarify language)

RCW 34.05.310 (4)(g)
((i) Relating to agency hearings; or (ii) process requirements for applying to an agency for a license or permit)

This rule proposal, or portions of the proposal, is exempt under RCW 19.85.025(4).

- Explanation of exemptions, if necessary: The health insurance issuers that are affected by this rule are not small businesses as defined by RCW 19.85.020(2).

COMPLETE THIS SECTION ONLY IF NO EXEMPTION APPLIES

If the proposed rule is **not exempt**, does it impose more-than-minor costs (as defined by RCW 19.85.020(2)) on businesses?

No Briefly summarize the agency's analysis showing how costs were calculated. _____

Yes Calculations show the rule proposal likely imposes more-than-minor cost to businesses, and a small business economic impact statement is required. Insert statement here:

The public may obtain a copy of the small business economic impact statement or the detailed cost calculations by contacting:

- Name:
- Address:
- Phone:
- Fax:
- TTY:
- Email:
- Other:

Date: August 21, 2018

Name: Mike Kreidler

Title: Insurance Commissioner

Signature:



SUBCHAPTER L
SHORT-TERM LIMITED DURATION MEDICAL PLANS

NEW SECTION

WAC 284-43-8000 Definition of short-term limited duration medical plan. (1) "Short-term limited duration medical plan" means a policy, contract or agreement offered or issued by a health carrier with an effective date on or after January 1, 2019, that:

(a) Provides comprehensive major medical coverage, that includes, at a minimum, the following benefits:

(i) Hospital, surgical and medical expense coverage, to an aggregate maximum of not less than one million dollars and copayment or co-insurance by the covered person not to exceed fifty percent of covered charges;

(ii) The coverage for hospital services must include:

(A) Inpatient services and other miscellaneous services associated with admission to a hospital for diagnosis and treatment of a covered condition. "Miscellaneous services" includes medically necessary services delivered in a hospital setting, including professional services, anesthesia, facility fees, supplies, imaging, laboratory, pharmacy services and prescription drugs, treatments, therapy, or other services delivered on an inpatient basis;

(B) Outpatient services, including medically necessary services ordered by the member's attending health care practitioner and rendered on an ambulatory basis for diagnosis and treatment of a covered condition, including office and clinic visits, diagnostic imaging, laboratory services, radiation therapy, physical/speech/occupational therapy, and hemodialysis; and

(C) An extension of the medical plan term while hospitalized. If a member is hospitalized as an inpatient on the expiration date of the medical plan, the member's coverage under the medical plan will continue for purposes of that covered medical condition without payment of additional premium. The coverage will continue until the date the member is discharged from the hospital or until the date on which the applicable benefit maximums are reached, whichever occurs first.

(iii) The coverage for surgical services for diagnosis and treatment of a covered condition must include inpatient and outpatient surgical services at a hospital, ambulatory surgical facility, surgical suite or provider's office. "Surgical services" includes medically necessary services delivered in a hospital, ambulatory surgical facility, surgical suite or provider's office related to provision of a surgical service, including professional services, anesthesiology, facility fees, supplies, laboratory, pharmacy services and prescription drugs related to, or required as a result of, the surgical procedure; and

(iv) The coverage for medical services for diagnosis and treatment of a covered condition must include office visits.

(b) Limits the look-back period for any preexisting medical condition, illness or injury to no more than twenty-four months prior to

the date of application for the medical plan, if coverage of preexisting conditions is excluded. For purposes of this section, "preexisting medical condition" means a condition for which medical advice, diagnosis, care or treatment was received or recommended; and

(c) Has an expiration date specified in the contract (taking into account any extensions that may be elected by the member with or without the carrier's consent) that is not more than three months after the original effective date of the policy, contract or agreement.

(2) Any carrier offering a short-term limited duration medical plan must offer at least one such plan with a deductible stated on a per person basis of two thousand dollars or less.

(3) A short-term limited duration medical plan cannot be issued if it would result in a person being covered by a short-term limited duration medical plan for more than three months in any twelve-month period.

(4) A carrier must not issue a short-term limited duration medical plan during an annual open enrollment period, as defined in WAC 284-43-1080, for coverage beginning in the upcoming year.

(5) Short-term limited duration medical plan has the same meaning as short-term limited duration insurance, as used in 26 C.F.R. 54.9801-2, 29 C.F.R. 2590.701-2 and 45 C.F.R. 144.103, except that:

(a) The duration of a short-term limited duration medical plan cannot exceed three months;

(b) A short-term limited duration medical plan cannot be renewed or extended, except as provided in subsection (1)(a)(ii)(C) of this section; and

(c) A short-term limited duration medical plan cannot be issued if it would result in a person being covered by a short-term limited duration medical plan for more than three months in any twelve-month period.

NEW SECTION

WAC 284-43-8010 Standard disclosure form for short-term limited duration medical plans. (1) All carriers offering or issuing a short-term limited duration medical plan with an effective date on or after January 1, 2019, must issue a standard disclosure form for each short-term limited duration medical plan in the same format and with the same content as the disclosure form included in this section. The standard disclosure form must be displayed prominently in the medical plan contract and in any application materials provided in connection with enrollment in such coverage, and must be provided as a distinct, separate document to the person upon initial receipt of the medical plan application.

(2) Every carrier must have a mechanism in place to verify delivery of the standard disclosure form to the applicant and obtain the applicant's acknowledgment of receipt of the form. The carrier must retain each acknowledged disclosure form for five years. The forms must be available for review by the commissioner upon request.

(3) The type size and font of the standard disclosure form must be easily read and be no smaller than fourteen point.

(4) The standard disclosure form must not be used until it has been filed with and approved by the commissioner.

(5) The standard disclosure form must include, at a minimum, the following information and must be presented in the following format:

(Carrier's name and address)

IMPORTANT INFORMATION
ABOUT THE LIMITS OF THE
COVERAGE
YOU ARE BEING OFFERED

Save this document! It may be important to you in the future.

CAUTION:

This plan may not cover pre-existing conditions, including any medical or mental health condition you've been treated for in the past.

It provides limited benefits and does *not* include benefits required by the Affordable Care Act.

It's temporary and may not cover your costs for most hospital or other medical services, or some essential health benefits.

Read carefully what the plan does and doesn't cover before you sign up.

Before enrolling, check to see if you can buy a health plan through Washington State's Exchange, at www.wahealthplanfinder.org or 1-855-923-4633. If so, you may get help lowering your premium. Health plans sold through the Exchange provide more coverage and protections. If you missed the annual open enrollment period, see if you qualify for a special enrollment period here: www.insurance.wa.gov/when-can-i-buy-individual-health-plan

This medical plan is not a Medicare supplement plan.

This medical plan is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your medical plan carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your medical plan might also have lifetime and/or annual dollar limits on health benefits.

This disclosure form is not a complete description of this medical plan. To understand what is and isn't covered, please read your plan. The plan will include information about your rights and the company's responsibilities.

Short-Term Limited Duration Medical Plan Disclosure

Below is a summary of the key benefits provided by this short-term limited duration medical plan:

Type of coverage: Short-term limited duration medical plan

How long does coverage last? *(Provide the number of days or months of coverage)*

Does this policy cover pre-existing conditions? *("Yes" or "No, it limits/excludes coverage for medical or behavioral health conditions for which medical advice, diagnosis, care or treatment was received by or recommended to you, including taking prescription medication, in the 24 months prior to the date you apply for coverage under the plan. See policy for details.").*

Who is NOT eligible for coverage? *(List all excluded categories, e.g. over a certain age, Medicare/Medicaid eligible, pregnant women, those with certain preexisting conditions, etc.)*

Can the policy be renewed? No

What benefits are covered and what is the financial responsibility of the member? (For each benefit listed below, if not covered, list "Not covered". If covered, list applicable cost-sharing, including whether or not the deductible applies, the member's percentage of coinsurance, copayment, any quantitative treatment limitations and any cap on the amount the policy will pay for the service.

Examples include: "Covered after deductible, \$45 copay plus 20% coinsurance, limited to only \$1,000 of coverage"; "Covered without deductible, \$50 copay, limited to 30 visits total or per year"; "Covered after deductible, limited to treatment of involuntary complications of pregnancy")

- **Deductible:** \$_____ (If there is more than one deductible, list each deductible with a description of the services to which it applies.)
- **Plan coinsurance (amount member must pay per service) _____%** (Must be expressed in terms of the percentage to be paid by the member. If coinsurance applies up to a maximum amount, provide that information here. Example: "This policy has a 50% coinsurance up to \$10,000, after which benefits are paid at 100%.")
- **The maximum amount a member will pay out-of-pocket for cost-sharing for the term of the plan: \$_____** (If there is no out-of-pocket maximum, clearly state that there is no limit on the amount a member will have to pay for out-of-pocket cost-sharing. If there is an out of pocket maximum, clearly state which member payments are applied to this maximum, such as deductibles, copayments and coinsurance.)
- **The maximum dollar amount this plan will pay: \$_____** (Also include lifetime limit, if applicable. Example: "\$1 Million under this plan; lifetime limit of \$2 Million")
- **Emergency Room Services:**
- **Ambulance Services:**
- **Inpatient Hospital Services:**
- **Outpatient Hospital Services:**
- **Services at an Urgent Care Facility:**
- **Primary Care Visit to Treat an Injury or Illness:**
- **Specialist Visit:**
- **Physical therapy, speech therapy, occupational therapy:**
- **Mental Health Outpatient Services**
- **Mental Health Inpatient Services**
- **Substance Use Disorder Outpatient Services:**
- **Substance Use Disorder Inpatient Services;**
- **Imaging (CT/PET Scans, MRIs):**
- **Laboratory testing and services:**
- **Durable medical equipment:**
- **Preventive Care/Screening/Immunization:**
- **Prescription drugs:**
- **Skilled Nursing Facility:**
- **Services in an Ambulatory Surgical Center:**

Does the policy exclude, eliminate, restrict, reduce, limit, or delay coverage for any benefits NOT listed above? ("No" or if "Yes", include details)

Does the policy require that the member use a specific network of health care providers or pharmacies? ("No" or if "Yes", include details)

Can a member be charged additional costs for covered services, in addition to their coinsurance or copays? (If members can be balance billed for any covered service, answer "Yes" and explain when this would occur. You must answer "Yes" for plan designs that do not use a provider network, or that use in-network facilities where not all services may be provided by in-network providers. If other situations apply, include any further explanation about when balance billing is possible.)

If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage. This coverage is **not** considered comprehensive and would not qualify you for a special enrollment period.

Open enrollment for individual health plans begins November 1 each year for coverage that begins January 1 of the upcoming year.

You will need to complete and confirm all medical information you provide when applying for this plan. Your producer (also referred to as insurance agent) is not allowed to fill out any of this information for you.

Consumer acknowledgment:

I confirm that I have reviewed the content of this disclosure form and that I understand the limitations of this short-term limited-duration medical plan.

Consumer signature/name: _____

Date: _____

This notice has important information about this short-term limited duration medical plan. If you, or someone you're helping, has questions about this document or complaints about this medical plan and how it was sold to you, call the Washington State Office of the Insurance Commissioner at 1-800-562-6900. If you need help speaking to us in your preferred language, we will find an interpreter for you at no cost.

NEW SECTION

WAC 284-43-8020 Commissioner's approval required. (1) A short-term limited duration medical plan form, application form, or disclosure form must not be issued, delivered, or used unless it has been filed with and approved in writing by the commissioner.

(2) Rates, or modification of rates, for short-term limited duration medical plans must not be used until filed with and approved in writing by the commissioner.

(3) The commissioner may disapprove any forms or rates if the benefit provided therein is unreasonable in relation to the premium charged. The commissioner's order disapproving any form or rate shall state the grounds therefor.

(4) A form or rate must not knowingly be issued, delivered, or used if the commissioner's approval does not then exist.

(5) The commissioner may withdraw any approval at any time for cause. The commissioner's withdrawal of a previous approval shall state the grounds therefor.

NEW SECTION

WAC 284-43-8030 Short-term limited duration medical plan cancellation and rescission. (1) As used in this section:

(a) "Rescission" or "rescind" means the undoing or retroactive cancellation of a short-term limited duration medical plan. Rescission returns the carrier and member to the same positions as if the medical plan had never existed.

(b) "Cancellation" or "cancel" means termination of a short-term limited duration medical plan before the end of the coverage period under the plan.

(2) A short-term limited duration medical plan cannot be rescinded by the carrier during the coverage period except for a member's committing fraudulent acts as to the carrier or a member's intentional nondisclosure regarding his or her coverage under a short-term limited duration medical plan during the twelve-month period prior to the date of application. If the plan is rescinded, the carrier must refund to the member all payments made by or on behalf of the member prior to the rescission date or the expiration date of the short-term limited duration medical plan.

(3) A short-term limited duration medical plan cannot be canceled by the carrier during the coverage period except for the following:

(a) Nonpayment of premium;

(b) Violation of published policies of the carrier approved by the insurance commissioner;

(c) A member's committing fraudulent acts as to the carrier;

(d) A member's material breach of the medical plan; or

(e) Change or implementation of federal or state laws that no longer permit the continued offering of the coverage.

(4) No oral or written misrepresentation or warranty made in the process of applying for a short-term limited duration medical plan, by the person applying for coverage or on his or her behalf, will be deemed material or allows the carrier to cancel or rescind the medical plan, unless the misrepresentation or warranty is made with actual intent to deceive.

(5) In any application for a short-term limited duration medical plan made in writing by a person or on his or her behalf, all statements in the application by the person applying for coverage or on his or her behalf are, in the absence of fraud, deemed representations and not warranties. The falsity of any statement shall not bar the right to recovery under the contract unless the false statement was made with actual intent to deceive.

(6) Nothing in this section shall be construed to provide the member with any benefits they would not otherwise be entitled to under their short-term limited duration medical plan.

(7) When cancellation is for nonpayment of premium, the carrier must notify the member in writing ten days prior to the cancellation date that his or her short-term limited duration medical plan will be

canceled, unless payment is made prior to the cancellation date. When cancellation or rescission is for any other reason allowed under this section, the carrier must notify the member in writing twenty days prior to the cancellation or rescission date or the expiration date of the short-term limited duration medical plan, whichever occurs first. The notice must specifically state the reason(s) for the cancellation or rescission. The written communications required by this subsection must be phrased in simple language that is readily understood.