

Form Filings Speed-to-Market Guide

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Introduction

Purpose: This Speed-to-Market (STM) Guide provides additional, optional, guidance outside the criteria listed in the **Washington State SERFF Health and Disability Form Filing General Instructions** (GFIs) for preparing a form filing.

Although using the STM tools and processes in this Guide does not guarantee that your form filing will be approved, it will help to expedite the review of your filing in four ways:

1. This Guide includes Speed-to-Market processes that allow you to **make fewer filings**.
2. The Guide includes Speed-to-Market tools that allow you to **avoid common objections** that extend the reviewing process.
3. When you use Speed-to-Market tools and processes, your **Analyst can review your filings much more quickly**. In some cases, the Analyst can skip review of certain forms entirely.
4. Use of Speed-to-Market tools and processes helps prioritize the review of your filing. For example, if two Individual health plan filings are received on the same day, the filing that includes an Analyst Checklist will be placed in the queue ahead of the filing that does not. A filing with a Statement of Variability in the preferred format detailed below will receive priority over a filing with a Statement of Variability in another format.

How Speed-to-Market tools expedite review of your filing:

- **Checklists** are valuable tools for both the carrier and the reviewing Analyst. Including a completed checklist will save time by ensuring that filed documents meet all applicable state and federal laws and regulations. OIC publishes the actual checklists used by our Analysts to review your filings. If you complete the checklist to ensure that your filing contains everything the Analysts will be looking for and meets the standards the Analysts will be applying, you can spot and correct issues before your forms are even submitted through SERFF. You are also pointing the Analyst directly to the location of information, which saves time the Analyst would otherwise spend searching for it. Plus, a filing that includes a completed checklist is prioritized over another similar filing that does not.
- **Certifications** allow you to attest that a form is compliant. This allows your Analyst to review your form at a much higher level – in some cases, skipping review entirely. Rather than spending time reviewing your form, OIC relies upon your certification. Form filings that are eligible for this option are detailed below.
- **Following OIC's guidelines for non-Administrative Variability** allows you to eliminate steps from the extremely time-consuming process of reviewing forms with variability. The more difficult variability is to interpret, the more time it takes. When your Statement of Variability is in the preferred format detailed below, you immediately eliminate two steps: (1)

your Analyst having to figure out your format, and (2) your Analyst having to shuffle between two sets of papers. Having to flip between a form and a separate Statement of Variability significantly increases both the review time and the chances of errors (for example, if variables are listed in a table).

The variability guidelines recommended by OIC have been developed based on many years of reviewing forms with variability. They are the result of experience with countless methods of expressing options. When you express your variables using the criteria recommended by OIC, your Analyst knows exactly what you mean. When you use the preferred format detailed below, your Analyst can see clearly how each variable is intended to work.

That saves time because your Analyst cannot guess the meaning of information in your forms. Something that seems obvious to you may not be obvious to others or may be interpreted more than one way. In that case, the Analyst must spend time trying to figure out what you meant and then ends up writing an objection to which you then must respond (including, probably, amending your form and your Statement of Variability).

How to Use This Document

The *Washington State SERFF Health and Disability Form Filing General Instructions (GFIs)* contain several instructions for which optional Speed-to-Market tools or processes are available. Notes within those instructions direct you to sections of this Speed-to-Market Guide where you will find information about Speed-to-Market tools or processes available to expedite preparation and review of your filings.

Section I – Associating Previously Approved Forms

Applies to the following GFI sections: I.B.2, I.B.5.a, I.C.3.a, I.D.3.d.i, I.E.3.a, I.F.3.a, I.G.1.c.i.1, I.G.2.a.v.1, I.G.2.b.v.1, I.H.4.a, II.B.1.a.v, II.B.2.d, and III.B.3

A. Except for ACA non-grandfathered Individual and Small Group filings, Higher Education Student Health Plan filings, large group Standard Master filings, and Short Forms filings, you do not need to attach forms for review if they have been **previously approved in Washington state under the same Type of Insurance (TOI)** as your filing. If your filing includes previously approved forms, or the form you are filing (i.e., application, rider, endorsement, etc.) will be used in conjunction with previously approved forms, you can simply “associate” the forms instead. To associate a form:

1. Create a separate line item for the previously approved form on the Form Schedule tab. Use the same form number and form name as the previously approved form on the Form Schedule tab, but **DO NOT** attach a PDF of the previously approved form:

- i. On the Form Schedule tab, populate the Action field with “Other” and the Action

Section III – Administrative and non-Administrative Variability

Applies to the following GFI sections: I.B.3, II.C, III.B.3, VII.B, and IX.B.3

A. Guidelines to assist in determining whether variability is “Administrative Variability”:

1. May be bracketed as a variable:
 - a. Policyholder/group name
 - b. Member name
 - c. Effective date(s) of plan
 - d. Signature blocks
 - e. Phone numbers
 - f. Addresses
 - g. Website addresses (URLs)
 - h. Table of Content page numbers
 - i. Group-specific policy numbers
2. May NOT be bracketed as a variable:
 - a. Benefits or benefit language
 - b. Exclusions or limitations language
 - c. Cost sharing
 - d. Networks
 - e. Benefit specific waiting periods
 - f. Performance Standards or Guarantees
 - g. Implementation Credits
3. Limited variability allowed:
 - a. Coordination of Benefits:
 1. Forms may bracket the plan’s Coordination of Benefits provision. Bracketing within the provision itself is not acceptable.
 - b. Dependent, employee-only and family coverage:
 1. Forms may include bracketed language stating the plan is employee-only (dependents are not covered) or employee with dependents are covered. One or the other bracketed provision is included.
 2. Forms may include bracketed options for the definition of dependent (who qualifies as a dependent). These options may be, but are not required to be, included within the larger bracketed section stating that dependents are covered.
 - c. Eligibility:
 1. ACA only:
 - i. When a plan is both on and off the Exchange, language specific to on-Exchange plans and off-Exchange plans may be bracketed.
 2. Classes or types of employees:
 - i. Eligible employee classes or types may be bracketed. Each bracketed class or type is either included or not included. For example: [full-time][part-time]

- [management][executive], [[Seasonal, temporary, on-call] employees are not eligible for coverage].
- ii. Definitions of eligible employee classes may be bracketed. Each bracketed definition would be included or excluded.
- d. Employer waiting period:
1. Forms may include bracketed language describing the employer waiting period. For example: Employees become eligible for coverage [on the date of hire.] [on the first day of the following month after hire.], [The probationary period is waived for an employee who was an on-call employee for a minimum of [1-6, in increments of 1] months immediately prior to becoming an eligible employee].
- e. Hours an employee must work to be eligible:
1. Language, and the numbers within the language, may be bracketed. For example: [Employees must work a minimum of 32 hours per week.], [Employees must work a [minimum, average] of [12 – 160, in .25 increments] hours per [week, month] over a 12-month period to be eligible for coverage].
- f. Percentage of eligible enrollees required to participate:
1. Forms may include two or more bracketed descriptions. Each description is either included or not included. For example: [If the Policyholder pays 100% of the premium, then 100% of the eligible employees must be enrolled.], [If the employee pays any portion of the premium, then at least [10-100, in increments of 1] % of the eligible employees must be enrolled].
- g. Grace period:
1. Forms may include bracketed language describing the grace period. For example: [A 30-day grace period is granted for payment of the premium.], [A [10-90, in increments of 1]-day grace period is granted for payment of the premium].
- h. Leave of absence/sabbatical criteria:
1. Forms may include two or more bracketed descriptions from which the group chooses (for example, different timelines based on employee status). Each description is either included or not included. Days, months, years may also be bracketed.
- i. Premiums:
1. Forms may include bracketed language describing when premiums are due. For example: [The premium is due the first day of each month.], [The premium is due on the Premium Due Date, which is the [15th, 25th] of each month.], [If additional premium is required, the additional premium must be paid no later than [60-90, in increments of 1] days after the eligible child's date of birth].
 2. Forms may include bracketed language describing the premium contribution types (contributory, non-contributory, voluntary). Each bracketed provision is either included or not included.
 3. Modes (monthly, quarterly, annual) and premiums may be bracketed.
- j. Reinstatement criteria:
1. Forms may include two or more bracketed descriptions from which the group chooses (for example, how long a member has to submit a reinstatement application).

- k. Termination of Coverage:
 - 1. Forms may include bracketed language describing when coverage terminates. For example: [Coverage terminates at the beginning of the month.] or [Coverage terminates at the end of the month].
- l. Type of Insurance options (Application/Enrollment forms only):
 - 1. Forms may include bracketed language identifying criteria pertaining to a specific type of insurance. For example:
 - i. [Dental Insurance
Select level of coverage:
 - Employee Only
 - Employee + Spouse/Domestic Partner
 - Employee + Child(ren)
 - Employee + Spouse/Domestic Partner + Child(ren)]
 - ii. [Vision Insurance
Select level of coverage:
 - Employee Only
 - Employee + Spouse/Domestic Partner
 - Employee + Child(ren)
 - Employee + Spouse/Domestic Partner + Child(ren)]
 - iii. Multiple-coverage applications and/or enrollment forms:
 - [Life [& AD&D]]
 - [Short Term Disability]
 - [Long Term Disability]
 - [Dental]
 - [Accident]
 - [Critical Illness]

B. How to show variability in your form filing:

- 1. Remember that variability must be readily understandable. What seems obvious to you may not be obvious to everyone, and your Analyst cannot guess or assume they know what a variable means. Fully explain each variable separately and completely in a Statement of Variability attached on the Supporting Documentation tab.
- 2. Each non-Administrative variable must be separately and completely explained in the Statement of Variability attached to the Supporting Documentation tab. A clean copy of the form attached to the Form Schedule tab should also show all variability, including the range of cost sharing amounts available (see subsection i. below) but should not include the comments describing the variability that appears in the Statement of Variability.
 - i. If the group chooses benefit amounts within a range, state the specific available amounts within that range. For example: [5% - 25%, in increments of 5%], [10 – 20 visits, in increments of 1], [\$0 - \$50, in \$5 increments], [\$0, \$20, \$40, or \$80], or [30 – 90 days, in increments of 1]. Avoid variables within variables whenever possible.

3. Use the following preferred format for Statements of Variability:
 - i. Begin with a clean copy of the form, in WORD format. On the WORD toolbar, click the "Review" tab. Use the "New Comment" feature to provide a comment for each variable, indicating the exact variable provisions that may be included. See "Diagram: Preferred format for Statement of Variability" below. Once the document is completed in WORD, convert to a PDF before loading it to the SERFF Supporting Documentation tab (see example below). **Note: Your entire comment must be viewable. If each comment is not fully viewable, try adding page breaks in the document to correct the problem.**

Diagram: Preferred format for Statement of Variability

The screenshot shows a Microsoft Word document with the 'Review' tab selected on the ribbon. The document content includes several sections with variables in curly braces. Red boxes highlight these variables, and red lines connect them to callout boxes containing comments. The comments explain the options for each variable, such as including or excluding certain categories or deductibles.

Review Tab: The ribbon shows 'Review' as the active tab, with sub-tabs for 'Comments' and 'Tracking'. The 'New Comment' button is highlighted with a red arrow.

Document Content:

- Per Member:** $\$(1,000 - 6,850 \text{ in increments of } \$50)$
- Per Family:** $\$(\text{groups choose, two or three times the per Member maximum not to exceed } \$13,700)$
- [Categories 1 and 2]**
- Per Member:** $\$(1,000 - 6,850 \text{ in increments of } \$50)$
- Per Family:** $\$(\text{groups choose, two or three times the per Member maximum amount not to exceed } \$13,700)$
- Category 3**
- Per Member:** $\$(1,000 - 15,000, \text{ in increments of } \$50)$
- Per Family:** $\$(\text{groups choose, two or three times the per Member maximum amount})$
- COPAYMENTS AND COINSURANCE**
- Copayments and Coinsurance are listed in the tables for Covered Services for each applicable benefit.
- CALENDAR YEAR DEDUCTIBLES**
- [Not Applicable]**
- Per Member:** $\$(50 - 6,850 \text{ in increments of } \$50)$
- Per Family:** $\$(\text{groups choose, two or three times the per Member deductible amount not to exceed } \$13,700)$
- [Categories 1 and 2]**
- [Not Applicable]**
- Per Member:** $\$(50 - 6,850 \text{ in increments of } \$50)$
- Per Family:** $\$(\text{groups choose, two or three times the per Member deductible amount not to exceed } \$13,700)$
- Category 3**
- [Not Applicable]**
- Per Member:** $\$(100 - 15,000, \text{ in increments of } \$50)$
- Per Family:** $\$(\text{groups choose, two or three times the per Member deductible amount})$

Comments:

- Comment []:** Include if group elects the combined category out-of-pocket maximum option (there is one amount for Categories 1, 2 and 3 combined).
- Comment []:** Group may choose out-of-pocket maximum amount within this range.
- Comment []:** Include if group elects the split category out-of-pocket maximum option (there is one amount for Category 1 and 2 and a separate amount for Category 3).
- Comment []:** Group may choose out-of-pocket maximum amount within this range.
- Comment []:** Group may choose out-of-pocket maximum amount within this range.
- Comment []:** Include if group does not choose a calendar year deductible.
- Comment []:** Include if group elects the combined deductible option (there is one amount for Categories 1, 2 and 3 combined).
- Comment []:** Group may choose deductible amount within this range.
- Comment []:** Include if group elects the split category deductible option (there is one amount for Category 1 and 2 and a separate amount for Category 3).
- Comment []:** Include if group does not choose a Category 1 and 2 calendar year deductible.
- Comment []:** Group may choose deductible amount within this range.
- Comment []:** Include if group does not choose a Category 3 calendar year deductible.
- Comment []:** Group may choose deductible amount within this range.

Section IV – Expediting Review of Custom Applications and Enrollment Forms (Including Web-Based)

Applies to the following GFI sections: I.F, I.G.2.a.vi, I.G.2.b.vi, and II.B.1.a.v.2

A. Certifying Custom Enrollment / Application Forms

1. Attach to the Supporting Documentation tab one completed and signed “Custom Enrollment/Application Certification” for each custom form loaded to the Form Schedule tab in SERFF.
 - i. The certification form is available under the Filing Rules tab, General Instructions section, in SERFF or on our website at <https://insurance.wa.gov/insurers-regulated-entities/rate-and-form-filing/form-filing-speed-market-tools-health-and-disability>.

B. Linking Custom Enrollment / Application Forms to the Plans to Which They Apply

If you are submitting a Custom Application/Enrollment form by itself, see Section I in this Speed-to-Market Guide for how to “associate” previously approved forms.

Section V – Expediting Review of Grandfathered Association Health Plans

Applies to the following GFI section: I.B.2 and I.G.1

See Section VIII of this Guide regarding Expediting Review of Grandfathered Health Plans (Other Than Association Plans).

A. Certifying Grandfathered Status

Attach a certification, signed by a person with authority to make a certification on behalf of the company, to the Supporting Documentation tab verifying that the Grandfathered plan(s) meets all the criteria under WAC 284-43-0250.

B. Certifying Compliance with Nondiscrimination Laws

1. Attach a certification, signed by a person with authority to make a certification on behalf of the company, to the Supporting Documentation tab stating that the rules for the eligibility (including continued eligibility) of any individual to enroll under the terms of the Large Group plan are not based on any of the following health status-related factors (prescribed in HIPAA at 29 CFR §2590.702) in relation to the individual or a dependent of the individual:
 - i. Health status;

- ii. Medical condition (including both physical and mental illnesses);
- iii. Claims experience;
- iv. Receipt of health care;
- v. Medical history;
- vi. Genetic information;
- vii. Evidence of insurability (including conditions arising out of acts of domestic violence); or
- viii. Disability.

C. Facilitating Review with Other Filings

1. If your Grandfathered Association health plan is based on a filed Standard Master health plan with no deviations, please indicate this in the General Information tab's Filing Description field or in your cover letter. Once this is confirmed, the Analyst does not need to do further review of the forms.
2. If your Grandfathered Association health plan is based on a filed Standard Master health plan, but there are differences in the forms, you may expedite review of this filing by attaching to the Supporting Documentation tab ~~strikeout/underline~~ (redline) documents showing the changes from each previously approved form. In the General Information tab's Filing Description field or in a cover letter, indicate that you have attached a ~~strikeout/underline~~ (redline) and provide the Form Number and Tracking ID for the filed Standard Master. This allows your Analyst to review only the parts of the form(s) that are different from the Standard Master forms and prevents multiple objections to the same language in different filings. The redline must match the clean copy of the form attached to the Form Schedule tab exactly. Please note that at the Analyst discretion, you may be asked to attach a certification, signed by a person with authority to make a certification on behalf of the company, to the Supporting Documentation tab verifying that only those modifications indicated on the redline were made.

D. Attaching a Completed Analyst Checklist

1. Attach to the Supporting Documentation tab a completed Analyst Checklist. For requirements that do not apply to the plan because it is a Grandfathered plan, note "Does not apply – Grandfathered Plan" in the "Section/Page #" column.
2. Use the appropriate Checklist for the applicable market (Large Group or Small Group) and carrier license (i.e. Disability, HCSC, or HMO).
3. Checklists are available under the Filing Rules tab, General Instructions section, in SERFF or on our website at <https://insurance.wa.gov/insurers-regulated-entities/rate-and-form-filing/form-filing-speed-market-tools-health-and-disability>.

Section VI – Expediting Review of non-Grandfathered Association Health Plans

Applies to the following GFI section: I.G.2

A. Certifying Compliance with Nondiscrimination Laws

1. Attach a certification, signed by a person with authority to make a certification on behalf of the company, to the Supporting Documentation tab stating that the rules for the eligibility (including continued eligibility) of any individual to enroll under the terms of the Large Group plan are not based on any of the following health status-related factors (prescribed in HIPAA at 29 CFR §2590.702) in relation to the individual or a dependent of the individual:
 - i. Health status;
 - ii. Medical condition (including both physical and mental illnesses);
 - iii. Claims experience;
 - iv. Receipt of health care;
 - v. Medical history;
 - vi. Genetic information;
 - vii. Evidence of insurability (including conditions arising out of acts of domestic violence); or
 - viii. Disability.

B. Facilitating Review with Other Filings

1. If your non-Grandfathered Association health plan is based on a filed Standard Master health plan with no deviations, please indicate that in the General Information tab's Filing Description field or in your cover letter. Once this is confirmed, the Analyst does not need to do further review of the forms.
2. If your non-Grandfathered Association health plan is based on a filed Standard Master health plan, but there are differences in the forms, you may expedite review of this filing by attaching to the Supporting Documentation tab ~~strikeout~~/underline (redline) documents showing the changes from each previously approved form. In the General Information tab's Filing Description field or in a cover letter, indicate that you have attached a ~~strikeout~~/underline (redlines), and provide the Form Number and Tracking ID for the filed Standard Master. This allows your Analyst to review only the parts of the form(s) that are different from the Standard Master forms and prevents multiple objections to the same language in different filings. The redline must match the clean copy of the form attached to the Form Schedule tab exactly. Please note that at the Analyst discretion, you may be asked to attach a certification, signed by a person with authority to make a certification on behalf of the company, to the Supporting

Documentation tab verifying that only those modifications indicated on the redline were made.

C. Attaching a Completed Analyst Checklist

1. Attach to the Supporting Documentation tab a completed Analyst Checklist.
2. Use the appropriate Checklist for the applicable market (Large Group or Small Group) and carrier license (i.e. Disability, HCSC, or HMO).
3. Checklists are available under the Filing Rules tab, General Instructions section, in SERFF or on our website at <https://insurance.wa.gov/insurers-regulated-entities/rate-and-form-filing/form-filing-speed-market-tools-health-and-disability>.

Section VII – Expediting Review of non-Grandfathered Large Group Health Plans (Other than Association Health Plans)

Applies to the following GFI sections: II.B.1, II.B.2, and II.B.3

A. Associating Previously Approved Forms

See Section I of this Speed-to-Market Guide for how to “associate” previously approved forms.

B. Facilitating Review of Variability

See Section III of this Speed-to-Market Guide for assistance determining whether variability is “Administrative Variability” and for OIC’s recommended format for your Statement of Variability. Remember that non-Administrative Variability is not allowed in Fully Negotiated filings.

C. Attaching a Completed Large Group Analyst Checklist

1. Attach to the Supporting Documentation tab a completed Large Group Analyst Checklist. Be sure to correctly populate the “Section/Page #” column.
2. Use the appropriate Checklist for carrier license (i.e. Disability, HCSC, or HMO).
3. Checklists are available under the Filing Rules tab, General Instructions section, in SERFF or on our website at <https://insurance.wa.gov/insurers-regulated-entities/rate-and-form-filing/form-filing-speed-market-tools-health-and-disability>.

D. Facilitating Review with Other Filings

1. **When your filing incorporates a form that is substantially similar to a previously approved form:** You may expedite review of this form by attaching to the Supporting Documentation tab a strikeout/underline (redline) document showing the changes from that previously approved form. In the General Information tab's Filing Description field, or in a cover letter, indicate that you have attached a strikeout/underline (redline), and provide the Form Number and Tracking ID for the filing in which the substantially similar form was approved. This allows your Analyst to review only the parts of the form(s) that are different from the previously approved form and prevents multiple objections to the same language in different filings. The redline must match the clean copy of the form attached to the Form Schedule tab exactly. Please note that at the Analyst discretion, you may be asked to attach a certification, signed by a person with authority to make a certification on behalf of the company, to the Supporting Documentation tab verifying that only those modifications indicated on the redline were made.
2. **When your filing is very similar to another filing:**
 - i. Very similar filings can also be reviewed as a group. This allows for quicker review and disposition on your filings and prevents multiple objections to the same language in different filings. Your Analyst may contact you to discuss whether a particular set of Large Group filings should be reviewed as a group. You are encouraged to contact your Analyst if you wish to suggest group review of a set of your Large Group filings.
 - a. You may indicate in your filing that you believe the filing should be reviewed together with some of your other filings. You can do this by creating a list of Tracking IDs for filings that can be reviewed as a group and attaching it on the Supporting Documentation tab. Please indicate in the General Information tab's Filing Description field or in your cover letter that the filing is part of a group that may be reviewed together.
 - ii. Filings that may be reviewed together include a group of **Fully Negotiated** filings or **Standard Master** filings which all use the same "base" forms so that they include much of the same language. Based on experience and working with carriers, the Health Forms Compliance Analysts try to group Standard Master filings with all Fully Negotiated filings that use the same "base" form. The Standard Master is reviewed as the "primary" filing, and the "secondary" filings that use the same "base" are reviewed by comparison with the "primary" filing.

Section VIII – Expediting Review of Grandfathered Health Plans (Other than Association Health Plans)

Applies to the following GFI section: II

A. Certifying Grandfathered Status

Attach a certification, signed by a person with authority to make a certification on behalf of the company, to the Supporting Documentation tab verifying that the Grandfathered plan(s) meets all the criteria under WAC 284-43-0250.

Section IX – Expediting Review of 2027 Individual and Small Group Non-Grandfathered Health Plan, Individual Standardized Health Plan, Individual Public Option Health Plan, and Pediatric Stand-Alone Dental Plan Filings by All Carriers

Applies to the following GFI section: IV

A. Attaching a completed Analyst Checklist

1. Attach to the Supporting Documentation tab a completed Analyst Checklist for your recommended primary product*.
 - i. Identify the product/plan upon which the checklist is based by including that information on the checklist itself.
 - ii. Checklists are available under the Filing Rules tab, General Instructions section, in SERFF or on our website at <https://insurance.wa.gov/insurers-regulated-entities/rate-and-form-filing/form-filing-speed-market-tools-health-and-disability>. Use the appropriate Checklist for the applicable market (Individual or Small Group), line of business (i.e. medical, stand-alone dental with pediatrics, etc.) and carrier license (i.e. Disability, HCSC, or HMO).
 - a. Standardized Health plans and Public Option Health plans must use the Individual Analyst Checklist for the appropriate carrier license.

*Primary Product is defined as the product with the most complex benefit design in the particular market. The OIC will consider using the carrier's recommended "primary product" for our primary form filing review.

B. Including only Administrative Variability

See Section III of this Speed-to-Market Guide for assistance determining whether variability is “Administrative Variability.” Non-Administrative variability is not allowed.

C. Facilitating Review with Other Filings

1. Include a Snapshot document in the Binder associated with your filing. See the *Washington State SERFF Health and Disability Binder Filing General Instructions* for instructions on the Snapshot Document.

Section X – Short-Term Limited Duration Medical Plans

Applies to the following GFI section: IX

For individual and group filings, attach to the Supporting Documentation tab a completed Short Term Plans Analyst Checklist. The Checklist is available under the Filing Rules tab, General Instructions section, in SERFF or on our website at <https://insurance.wa.gov/insurers-regulated-entities/rate-and-form-filing/form-filing-speed-market-tools-health-and-disability>.

Section XI – Student Health Plans

Applies to the following GFI section: VI

1. **Student Health Plans filing submissions:** Attach to the Supporting Documentation tab a completed *2026-2027 School Year Higher Education Student Health Plan Checklist*.
 - i. The *2026-2027 School Year Higher Education Student Health Plan Checklist* is available under the Filing Rules tab, General Instructions section, in SERFF or on our website at <https://insurance.wa.gov/insurers-regulated-entities/rate-and-form-filing/form-filing-speed-market-tools-health-and-disability>.
2. **To expedite review of Student Health Plans Formulary Filings:** Attach a certification, signed by a person with authority to make a certification on behalf of the company, to the Supporting Documentation tab, confirming that modifications (if any) to the formulary, as originally approved in the initial Student Health Plan(s) filing submission, continue to comply with the requirements of WAC 284-43-5644(6).

For questions related to SERFF filing procedures, contact:

Rates, Forms & Provider Networks Help Desk

(360) 725-7111

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