

Chapter 284-170 WAC

HEALTH BENEFIT PLAN MANAGEMENT

WAC

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WAC 284-170-001 Transitional reinsurance program. (1) Issuers of health benefit plans in Washington state, and third party administrators of health benefit coverage offered in Washington, must participate as contributing entities in the transitional reinsurance program established pursuant to RCW 48.43.720.

(2) The U.S. Department of Health and Human Services (HHS) will operate the transitional health plan reinsurance program for the state of Washington. The program ceases operation on June 30, 2017, for payment of claims incurred through December 31, 2016.

(3) Contributing entities are not required to remit reinsurance contributions for the following types of coverage:

- (a) Coverage only for accident, or disability income insurance, or any combination thereof;
- (b) Coverage issued as a supplement to liability insurance;
- (c) Liability insurance, including general liability insurance and automobile liability insurance;
- (d) Workers' compensation or similar insurance;
- (e) Automobile medical payment insurance;
- (f) Credit-only insurance;
- (g) Coverage for on-site medical clinics;
- (h) Limited scope dental or vision benefits;
- (i) Benefits for long-term care, nursing home care, home health care, community-based care or any combination thereof;

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(j) Benefits provided under a health flexible spending arrangement as defined in Internal Revenue Code, Section 106 (c)(2) ("Health FSA") if other group health plan coverage, not limited to excepted benefits, is made available for the year to the class of participants by reason of their employment, and the Health FSA is structured so that the maximum benefit payable to any participant in the class for a year cannot exceed two times the participant's salary reduction election under the arrangement for the year (or, if greater, cannot exceed five hundred dollars plus the amount of the participant's salary reduction election). For this purpose, any amount that an employee can elect to receive as taxable income but elects to apply to the Health FSA is considered a salary reduction election (regardless of whether the amount is characterized as salary or as a credit under the Health FSA);

(k) Coverage for a specified disease or illness, if offered as independent, noncoordinated benefits;

(l) Hospital indemnity or other fixed indemnity insurance if offered as independent, noncoordinated benefits;

(m) Medicare supplemental health insurance, and similar supplemental coverage provided to coverage under a group health plan, provided such coverage is offered as a separate insurance policy;

(n) Other similar insurance coverage under which benefits for medical care are secondary or incidental to other insurance benefits, or that qualify as HIPAA-excepted benefits;

(o) Medicare advantage, medicaid, or any federal coverage program except multistate Office of Personnel Management plans;

(p) Washington state health insurance pool and the Pre-existing Condition Insurance Plan - Washington.

(4) As part of its rate filing, a carrier must identify the reinsurance payments received for each nongrandfathered individual health benefit plan for the prior plan or policy year.

(5) This rule expires September 1, 2017.

[Statutory Authority: RCW 48.02.060, 48.43.720. WSR 13-05-024 (Matter No. R 2012-09), § 284-170-001, filed 2/11/13, effective 3/14/13.]

WAC 284-170-002 Risk adjustment program. (1) An issuer of a nongrandfathered individual or small group health plan in Washington state must participate in the permanent risk adjustment program, established pursuant to RCW 48.43.720.

(2) U.S. Department of Health and Human Services (HHS) will administer the risk adjustment program for 2014-2015. Issuers must comply with HHS requirements for the risk adjustment program.

(3) Beginning September 1, 2015, or on the date established by the HHS, the commissioner will annually publish a notice of benefit and payment parameters, and include a statement of intent regarding whether the state or HHS will

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administer the risk adjustment program for the ensuring benefit year.

The commissioner will determine the form of the notice, which will be consistent with the form required by HHS.

(4) The commissioner will establish an advisory group to provide advice regarding whether the state should operate the risk adjustment program for a future period of benefit year or years.

(a) The advisory group consists of representatives from issuers who participate in the risk adjustment program, the health benefit exchange, and if under contract or otherwise established by the legislature, the designated administrative entity for the state risk adjustment program. If an issuer wishes to participate in the advisory group, it must notify the commissioner in writing of its designated participant not later than May 1st of each year.

(b) The advisory group will meet at the commissioner's discretion.

(5) If HHS does not provide the commissioner with the data submitted by issuers, for a benefit year during which HHS administers the program, within thirty days of its submission to HHS, an issuer must submit to an actuarial firm designated by the commissioner the same data that it submits to HHS for the risk adjustment program. Corrected data must also be submitted. All issuers participating in the risk adjustment program in Washington state, not just those participating in the advisory group, must conform to this requirement.

(a) The data may only be used to perform modeling to assist the advisory group and commissioner in the annual decision-making process described in this section. Modeling done using the data must deidentify both issuers and any enrollees. Each advisory group participant is entitled to review all modeling reports, and upon request, learn which deidentified issuer represents their data set. The actuarial firm may not otherwise disclose the identity of data set sources.

(b) The actuarial firm and each issuer must execute all necessary privacy and security agreements to ensure the confidentiality and privacy of personal health information, establish remedies for unauthorized release or distribution of the data that are consistent with state and federal law, provide for the retention of the data for not less than ten years, and for the destruction of the data after a ten year period of time.

The commissioner will prepare a template agreement for use by the actuarial firm and submitting issuers. The agreement must be identical for each issuer, unless the commissioner specifically agrees to an exception or change requested by an issuer or the actuarial firm for good cause. The commissioner will resolve disputes between the actuarial firm and an issuer.

(c) Where necessary to ensure that data is credible and useful to the modeling, the actuarial firm may issue specific data definition related to requested data submission, and may require submission of additional data to the data submitted to HHS.

(6) Each issuer must accurately report risk adjustment payments received or made under the risk adjustment program as part of a nongrandfathered individual or small group's rate filing.

(7) An issuer that does not submit data to either HHS or the actuarial firm pursuant to this rule, or otherwise fails to

comply with the risk adjustment program requirements, is subject to enforcement under Title 48 RCW.

[Statutory Authority: RCW 48.02.060, 48.43.720. WSR 13-05-025 (Matter No. R 2012-12), § 284-170-002, filed 2/11/13, effective 3/14/13.]

WAC 284-170-250 Geographic rating area factor development. (1) For nongrandfathered individual or small group health plans offered, issued or renewed on or after January 1, 2014, if an issuer elects to adjust its premium rates based on geographic area, the issuer must use the geographic rating areas designated in WAC 284-170-252.

(2) The premium ratio for the highest cost geographic rating area, when compared to the lowest cost geographic rating area, must not be more than 1.15.

(a) King County is the index geographic rating area for purposes of calculating the premium ratio. The geographic rating area factor for the index area must be set at 1.00.

(b) A health-status related factor may not be used to establish a rating factor for a geographic rating area. Health factor means any of the following:

- (i) Health status of enrollees or the population in an area;
- (ii) Medical condition of enrollees or the population in an area, including both physical and mental illnesses;
- (iii) Claims experience;
- (iv) Health services utilization in the area;
- (v) Medical history of enrollees or the population in an area;
- (vi) Genetic information of enrollees or the population in an area;
- (vii) Disability status of enrollees or the population in an area;
- (viii) Other evidence of insurability applicable to the area.

(3) Assignment of a factor to a geographic rating area must be actuarially sound and based on provider reimbursement differences. An issuer must fully document the basis for the assigned rating factors in the actuarial memo submitted with a rate filing.

(4) The geographic rating area factors must be applied uniformly to individuals or small groups applying for or receiving coverage from the issuer.

(5) For out-of-state enrollees covered under a health benefit plan issued to a Washington resident, an issuer must apply the geographic rating area factor based on the primary subscriber's Washington residence. For out-of-state enrollees who are covered under a health benefit plan issued through an employer whose primary place of business is Washington, an issuer must apply the geographic rating area factor based on the employer's primary place of business.

(6) This section does not apply to stand alone dental plans offered on the Washington health benefit exchange.

[Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, and 45 C.F.R. 147.102. WSR 13-11-003 (Matter No. R 2013-01), § 284-170-250, filed 5/1/13, effective 6/1/13.]

WAC 284-170-252 Geographic rating area designation. (1) The following geographic rating areas are designated for Washington state for nongrandfathered individual and small group plans:

Area 1: Index geographic rating area: King County.

Area 2: Clallam, Cowlitz, Grays Harbor, Island, Jefferson, Mason, Lewis, Kitsap, Pacific, Pierce, San Juan, Skagit, Snohomish, Thurston, Wahkiakum, and Whatcom counties.

Area 3: Clark, Klickitat, and Skamania counties.

Area 4: Ferry, Lincoln, Pend Oreille, Spokane, and Stevens counties.

Area 5: Adams, Asotin, Benton, Chelan, Columbia, Douglas, Franklin, Garfield, Grant, Kittitas, Okanogan, Walla Walla, Whitman, and Yakima counties.

(2) The commissioner will review the geographic rating area designation in this section not more frequently than every three years, beginning January 31, 2016. The commissioner will publish changes in the geographic rating area designation within sixty days of the review date.

[Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, and 45 C.F.R. 147.102. WSR 13-11-003 (Matter No. R 2013-01), § 284-170-252, filed 5/1/13, effective 6/1/13.]

WAC 284-170-400 Preexisting condition limitations.

For health plans offered, issued or renewed on or after January 1, 2014, issuers must not condition or otherwise limit enrollment based on preexisting health conditions.

[Statutory Authority: RCW 48.02.060, 48.18.120(2), 48.20.450, 48.43.0211, 48.43.720(3), 48.44.050, 48.46.200, 45 C.F.R. §§ 147.104, 147.106, 155.420, and 155.725. WSR 14-01-042 (Matter No. R 2013-02), § 284-170-400, filed 12/11/13, effective 1/1/14.]

WAC 284-170-410 Special enrollment requirements for small group plans. (1) A "special enrollment period" means a period of time outside the initial or annual group renewal period during which an individual applicant may enroll if the individual has experienced a qualifying event. An issuer must make periods for special enrollment in its small group plans available to an otherwise eligible applicant if the applicant has experienced one of the qualifying events identified in this section.

(2) A qualifying event for special enrollment in small group plans offered on or off the health benefit exchange is one of the following:

(a) The loss of minimum essential benefits, including loss of employer sponsored insurance coverage, or of the coverage of a person under whose policy they were enrolled, unless the loss is based on the individual's voluntary termination of employer sponsored coverage, the misrepresentation of a material fact affecting coverage or for fraud related to the terminated health coverage;

(b) The loss of eligibility for medicaid or a public program providing health benefits;

(c) The loss of coverage as the result of dissolution of marriage or termination of a domestic partnership;

(d) A permanent change in residence, work, or living situation, whether or not within the choice of the individual, where the health plan under which they were covered does not provide coverage in that person's new service area;

(e) The birth, placement for adoption or adoption of the applicant for whom coverage is sought;

(f) A situation in which a plan no longer offers benefits to the class of similarly situated individuals that includes the applicant;

(g) Loss of individual or group coverage purchased on the health benefit exchange due to an error on the part of the

exchange, the issuer or the U.S. Department of Health and Human Services;

(h) Marriage or entering into a domestic partnership, including eligibility as a dependent of an individual marrying or entering into a domestic partnership.

(3) Nothing in this rule is intended to alter or affect the requirements of RCW 48.43.517.

(4) An issuer may require reasonable proof or documentation that an individual seeking special enrollment has experienced a qualifying event.

(5) An issuer must offer a special enrollee each benefit package available to members of the group who enrolled when first eligible. A special enrollee cannot be required to pay more for coverage than other members of the group who enrolled in the same coverage when first eligible. Any difference in benefits or cost-sharing requirements constitutes a different benefit package.

(6) An issuer must include detailed information about special enrollment options and rights in its health plan documents provided pursuant to WAC 284-43-820, and in any policy or certificate of coverage provided to an employer, plan sponsor, or enrollee. The notice must be substantially similar to the model notice provided by the U.S. Department of Labor or the U.S. Department of Health and Human Services.

(7) For children who experience a qualifying event, if the selected plan is not the plan on which the parent is then enrolled, or if the parent does not have coverage, the issuer must permit the parent to enroll when the child seeks enrollment for dependent coverage. An enrolling child must have access to any benefit package offered to employees, even if that requires the issuer to permit the parent to switch benefit packages.

[Statutory Authority: RCW 48.02.060, 48.18.120(2), 48.20.450, 48.43.0211, 48.43.720(3), 48.44.050, 48.46.200, 45 C.F.R. §§ 147.104, 147.106, 155.420, and 155.725. WSR 14-01-042 (Matter No. R 2013-02), § 284-170-410, filed 12/11/13, effective 1/1/14.]

WAC 284-170-412 Special enrollment periods for small group qualified health plans. (1) Issuers of small group qualified health plans must comply with the additional special enrollment period requirements set forth in 45 C.F.R. 155.420 (b)(2) and 45 C.F.R. 155.725.

(2) In addition to meeting the requirements set forth in WAC 284-170-410, issuers must include in qualified health plan contract forms and required disclosure documents an explanation of special enrollment rights if one of the following triggering events occurs:

(a) In addition to the requirements for adopted, placed for adoption, and newborn children, the same special enrollment right accrues for foster children and children placed in foster care;

(b) The individual demonstrates to the health benefit exchange that the qualified health plan in which they are enrolled violated a material provision of the coverage contract in relation to the individual;

(c) An individual's enrollment in or nonenrollment in a qualified health plan is unintentional, inadvertent or erroneous, and is the result of the error, misinterpretation or inaction of an officer, employee or agent of the health benefit exchange of the U.S. Department of Health and Human Ser-

vices, as determined by the health benefit exchange upon evaluation;

(d) In addition to the special enrollment event in WAC 284-170-410 (2)(d), a change in the individual's residence as the result of a permanent move results in new eligibility for previously unavailable qualified health plans;

(e) For qualified individuals who are an Indian, as defined by Section 4 of the Indian Health Care Improvement Act, enrollment in a qualified health plan or change from one qualified health plan to another must be permitted one time per month, without requiring an additional special enrollment triggering event.

(3) If the health benefit exchange establishes earlier effective dates for special enrollment periods, pursuant to 45 C.F.R. 155.420, an issuer must include in its plan documents and required disclosures an explanation of the effective date for special enrollment periods.

[Statutory Authority: RCW 48.02.060, 48.18.120(2), 48.20.450, 48.43.0211, 48.43.720(3), 48.44.050, 48.46.200, 45 C.F.R. §§ 147.104, 147.106, 155.420, and 155.725. WSR 14-01-042 (Matter No. R 2013-02), § 284-170-412, filed 12/11/13, effective 1/1/14.]

WAC 284-170-415 Duration and effective dates of small group special enrollment periods. (1) This section applies to nongrandfathered small group plans offered on or off the health benefit exchange.

(2) Special enrollment periods must not be shorter than sixty days from the date of the qualifying event.

(3) The effective date of coverage for those enrolling in a small group plan through a special enrollment period is the first date of the next month after the application for coverage is received, unless one of the following exceptions applies:

(a) For special enrollment of newborn, adopted or placed for adoption children, the date of birth, date of adoption or date of placement for adoption becomes the first effective date of coverage;

(b) For applicants enrolling after the fifteenth of the month, the issuer must begin coverage not later than the first date of the second month after the application is received, unless the applicant is enrolling due to marriage or the commencement of a domestic partnership. An issuer may establish an earlier effective date at their discretion. An issuer may establish an earlier effective date at their discretion;

(c) For applicants enrolling because of marriage or the commencement of a domestic partnership, when notice of the marriage or domestic partnership is received within sixty days of the marriage or commencement of the domestic partnership, either as spouse, domestic partner or as a dependent child, coverage must begin no later than the first date of the month immediately following the date of marriage or domestic partnership.

(4) An issuer must not refuse to enroll an applicant who applies within sixty days of the qualifying event, if the applicant would be eligible had the application been received during open enrollment.

[Statutory Authority: RCW 48.02.060, 48.18.120(2), 48.20.450, 48.43.0211, 48.43.720(3), 48.44.050, 48.46.200, 45 C.F.R. §§ 147.104, 147.106, 155.420, and 155.725. WSR 14-01-042 (Matter No. R 2013-02), § 284-170-415, filed 12/11/13, effective 1/1/14.]

WAC 284-170-420 Individual market open enrollment requirements. (1) For purposes of this section, "open enrollment" means a specific period of time each year during which enrollment in a health benefit plan is permitted. This section applies to plans offered in the individual market.

(2) An issuer must limit the dates for enrollment in plans offered on the individual market off the health benefit exchange to the same time period for open enrollment established by the health benefit exchange.

(3) An issuer must prominently display information on its web site about open enrollment periods and special enrollment periods applicable to its plans offered either on or off the health benefit exchange.

(a) The web site information about enrollment periods must provide a consumer with the ability to access or request and receive an application packet for enrollment at any time.

(b) The displayed information must include details written in plain language explaining what constitutes a qualifying event for special enrollment.

(4) Written notice of open enrollment must be provided to enrolled persons at some point between September 1st and September 30th of each year.

[Statutory Authority: RCW 48.02.060, 48.18.120(2), 48.44.050, 48.46.200 and 45 C.F.R. Parts 144, 146 and 147. WSR 14-08-036 (Matter No. R 2014-01), § 284-170-420, filed 3/26/14, effective 4/26/14. Statutory Authority: RCW 48.02.060, 48.18.120(2), 48.20.450, 48.43.0211, 48.43.720(3), 48.44.050, 48.46.200, 45 C.F.R. §§ 147.104, 147.106, 155.420, and 155.725. WSR 14-01-042 (Matter No. R 2013-02), § 284-170-420, filed 12/11/13, effective 1/1/14.]

WAC 284-170-425 Individual market special enrollment requirements. (1) For a nongrandfathered individual health plan offered on or off the health benefit exchange, an issuer must make a special enrollment period of not less than sixty days available to any person who experiences a qualifying event, permitting enrollment in an individual health benefit plan outside the open enrollment period. This requirement applies to plans offered on the health benefit exchange that cover pediatric oral benefits offered as essential health benefits necessary to satisfy minimum essential coverage requirements.

(2) A qualifying event means the occurrence of one of the following:

(a) The loss of minimum essential coverage, including employer sponsored insurance coverage due to action by either the employer or the issuer or due to the individual's loss of eligibility for the employer sponsored coverage, or the loss of the individual or group coverage of a person under whose policy they were enrolled, unless the loss is based on the individual's misrepresentation of a material fact affecting coverage or for fraud related to the discontinued health coverage;

(b) The loss of eligibility for medicaid or a public program providing health benefits;

(c) The loss of coverage as the result of dissolution of marriage or termination of a domestic partnership;

(d) A permanent change in residence, work, or living situation, whether or not within the choice of the individual, where the health plan under which they were covered does not provide coverage in that person's new service area;

(e) The birth, placement for or adoption of the person for whom coverage is sought. For newborns, coverage must be effective from the moment of birth; for those adopted or

placed for adoption, coverage must be effective from the date of adoption or placement for adoption, whichever occurs first;

(f) A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual;

(g) Coverage is discontinued in a qualified health plan by the health benefit exchange pursuant to 45 C.F.R. 155.430 and the three month grace period for continuation of coverage has expired;

(h) Exhaustion of COBRA coverage due to failure of the employer to remit premium;

(i) Loss of COBRA coverage where the individual has exceeded the lifetime limit in the plan and no other COBRA coverage is available;

(j) If the person discontinues coverage under a health plan offered pursuant to chapter 48.41 RCW;

(k) Loss of coverage as a dependent on a group plan due to age;

(l) Marriage or entering into a domestic partnership, including eligibility as a dependent of an individual marrying or entering into a domestic partnership.

(3) If the special enrollee had prior coverage, an issuer must offer a special enrollee each of the benefit packages available to individuals who enrolled during the open enrollment period within the same metal tier or level at which the person was previously enrolled. Any difference in benefits or cost-sharing requirements for different individuals constitutes a different benefit package.

(a) A special enrollee cannot be required to pay more for coverage than a similarly situated individual who enrolls during open enrollment.

(b) An issuer may limit a special enrollee who was enrolled in a catastrophic plan as defined in RCW 48.43.005(8) to the plans available during open enrollment at either the bronze or silver level.

(c) An issuer may restrict a special enrollee whose eligibility is based on their status as a dependent to the same metal tier for the plan on which the primary subscriber is enrolled.

(4) An issuer may require reasonable proof or documentation that an individual seeking special enrollment has experienced a qualifying event.

[Statutory Authority: RCW 48.02.060, 48.18.120(2), 48.20.450, 48.43.0211, 48.43.720(3), 48.44.050, 48.46.200, 45 C.F.R. §§ 147.104, 147.106, 155.420, and 155.725. WSR 14-01-042 (Matter No. R 2013-02), § 284-170-425, filed 12/11/13, effective 1/1/14.]

WAC 284-170-430 Individual market special enrollment period requirements for qualified health plans. (1)

An issuer offering individual qualified health plans on the health benefit exchange must make special enrollment opportunities, subject to the same terms and conditions specified in WAC 284-170-425, available to applicants who experience a qualifying event.

(2) In addition to the special enrollment qualifying events set forth in WAC 284-170-425, the following special enrollment opportunities must be made available for individual plans offered on the health benefit exchange:

(a) For qualified individuals who are an Indian, as defined by Section 4 of the Indian Health Care Improvement Act, enrollment in a qualified health plan or change from one

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qualified health plan to another must be permitted one time per month, without requiring an additional special enrollment triggering event;

(b) The applicant demonstrates to the health benefit exchange that the qualified health plan in which they are enrolled violated a material provision of the coverage contract in relation to the individual;

(c) If applicant lost prior coverage due to errors by the health benefit exchange staff or the U.S. Department of Health and Human Services;

(d) The applicant, or his or her dependent, not previously a citizen, national or lawfully present individual, gains such status. For purposes of this subsection, "dependent" means a dependent as defined in RCW 48.43.005;

(e) The individual becomes newly eligible or newly ineligible for advance payment of premium tax credits, has a change in eligibility for cost-sharing reductions, or the individual's dependent becomes newly eligible. For purposes of (e) and (f) of this subsection, "dependent" means dependent as defined in 26 C.F.R. 54.9801-2;

(f) The individual or their dependent who is currently enrolled in employer sponsored coverage is determined newly eligible for advance payment of premium tax credit pursuant to the criteria established in 45 C.F.R. 155.420 (d)(6)(iii);

(g) In addition to the special enrollment event in WAC 284-170-425 (2)(d), a change in the individual's residence as the result of a permanent move results in new eligibility for previously unavailable qualified health plans.

(3) An individual who experiences a qualifying event and whose prior coverage was on a catastrophic health plan as defined in RCW 48.43.005 (8)(c)(i) may be limited by the exchange to enrollment in a bronze or silver level plan.

(4) This section must not be interpreted or applied to preclude or limit the health benefit exchange's rights to automatically enroll qualified individuals based on good cause, exceptional circumstances as defined by the health benefit exchange or as required by the U.S. Department of Health and Human Services.

(5) Issuers must comply with the special enrollment event requirements established for qualified health plans offered on the health benefit exchange in 45 C.F.R. 155.420. If the health benefit exchange establishes earlier effective dates for special enrollment periods, pursuant to 45 C.F.R. 155.420, an issuer must include in its plan documents and required disclosures an explanation of the effective date for special enrollment periods.

[Statutory Authority: RCW 48.02.060, 48.18.120(2), 48.20.450, 48.43.0211, 48.43.720(3), 48.44.050, 48.46.200, 45 C.F.R. §§ 147.104, 147.106, 155.420, and 155.725. WSR 14-01-042 (Matter No. R 2013-02), § 284-170-430, filed 12/11/13, effective 1/1/14.]

WAC 284-170-435 Duration, notice requirements and effective dates of coverage for individual market special enrollment periods. (1) Special enrollment periods must not be shorter than sixty days from the date of the qualifying event.

(2) The effective date of coverage for those enrolling in an individual health plan through a special enrollment period is the first date of the next month after the premium is

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received by the issuer, unless one of the following exceptions applies:

(a) For those enrolling after the twentieth of the month, the issuer must begin coverage not later than the first date of the second month after the application is received. Issuers may establish an earlier effective date at their discretion;

(b) For special enrollment of newborn, adopted or placed for adoption children, the date of birth, date of adoption or date of placement for adoption, as applicable, becomes the first effective date of coverage. The same requirement applies to foster children or children placed for foster care on qualified health plans;

(c) For special enrollment based on marriage or the beginning of a domestic partnership, and for special enrollment based on loss of minimum essential coverage, coverage must begin on the first day of the next month.

(3) For individual plans offered either on or off the health benefit exchange, an issuer must include detailed information about special enrollment options and rights in its health plan documents provided pursuant to WAC 284-43-820, and in the policy, contract or certificate of coverage provided to an employer, plan sponsor or enrollee. The notice must be substantially similar to the model notice provided by the U.S. Department of Health and Human Services.

[Statutory Authority: RCW 48.02.060, 48.18.120(2), 48.20.450, 48.43.0211, 48.43.720(3), 48.44.050, 48.46.200, 45 C.F.R. §§ 147.104, 147.106, 155.420, and 155.725. WSR 14-01-042 (Matter No. R 2013-02), § 284-170-435, filed 12/11/13, effective 1/1/14.]

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.

[Statutory Authority: RCW 48.02.060 and 48.43.715. WSR 14-09-080 (Matter No. R 2013-19), § 284-170-800, filed 4/18/14, effective 5/19/14.]

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).

[Statutory Authority: RCW 48.02.060 and 48.43.715. WSR 14-09-080 (Matter No. R 2013-19), § 284-170-805, filed 4/18/14, effective 5/19/14.]

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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.

[Statutory Authority: RCW 48.02.060 and 48.43.715. WSR 14-09-080 (Matter No. R 2013-19), § 284-170-810, filed 4/18/14, effective 5/19/14.]

WAC 284-170-870 Deadline for filing individual health plans, small group health plans, and stand-alone dental plans. This section applies to all individual health plans, small group health plans, and stand-alone dental plans that provide pediatric dental benefits as one of the essential health benefits. Each year, issuers must file with the commissioner a complete rate and form filing for the next calendar year on or before the deadline set by the commissioner. The commissioner must announce and post the filing deadline no later than March 31st of each year. Issuers will be permitted to amend filings only at the direction of the commissioner. Filings not timely submitted will be rejected without review.

(4/18/14)

[Statutory Authority: RCW 48.02.060, 48.18.100, 48.43.340, 48.43.715, 48.44.050, and 48.46.200. WSR 14-07-047 (Matter No. R 2013-27), § 284-170-870, filed 3/13/14, effective 4/13/14.]

WAC 284-170-950 Grandfathered health plan status. (1) An issuer must retain in its files all necessary documentation to support its determination that a purchaser's plan is grandfathered. The information must be sufficient to demonstrate that the issuer's determination of grandfathered status is credible. For purposes of this section, "grandfathered plan" means a health plan that meets the requirements of this section and as defined in RCW 48.43.005.

(2) An issuer's documentation supporting grandfathered plan designation must be made available to the commissioner or the U.S. Department of Health and Human Services for review and examination upon request. Beginning with the effective date of this section, for fully insured health plans designated as grandfathered, an issuer must retain the records for a period of not less than ten years. For each plan, the records supporting the issuer's determination must also be made available to participants and beneficiaries upon request.

(3) An issuer's documentation must establish for each grandfathered plan that since March 23, 2010:

(a) The plan was not amended to eliminate all or substantially all the benefits to diagnose or treat a particular condition. A list of all plan benefit amendments that eliminate benefits and the date of the amendment is the minimum level of acceptable documentation that must be available to support this criteria;

(b) The percentage of fixed amount cost-sharing percentage requirements, if applicable, for the plan were not increased when measured from March 23, 2010. A list of each cost-sharing percentage that has been in place for a grandfathered group's plan, beginning with the cost-sharing percentage on March 23, 2010, is the minimum level of acceptable documentation that must be available to support this criteria;

(c) The fixed cost-sharing requirements other than copayments did not increase by a total percentage measured from March 23, 2010, to the date of change that is more than the sum of medical inflation plus fifteen percent. A list of the fixed cost-sharing requirements other than copayments that apply to a grandfathered group's plan beginning on March 23, 2010, and a record of any increase, the date and the amount of the increase, is the minimum level of documentation that must be available to support this criteria;

(d) Copayments did not increase by an amount that exceeds the greater of:

(i) A total percentage measured from March 23, 2010, to the date of change that is more than the sum of medical inflation plus fifteen percent; or

(ii) Five dollars, adjusted annually for medical inflation measured from March 23, 2010. A record of all copayments beginning on March 23, 2010, applicable to a grandfathered group plan, and any changes in the copayment since that date is the minimum level of documentation that must be available to support this criterion.

(e) The employer's contribution rate toward any tier of coverage for any class of similarly situated individuals did not decrease by more than five percent below the contribution rate in place on March 23, 2010, expressed as a percent-

age of the total cost of coverage. The total cost of coverage must be determined using the methodology for determining applicable COBRA premiums. If the employer's contribution rate is based on a formula such as hours worked, a decrease of more than five percent in the employer's contributions under the formula will cause the plan to lose grandfathered status. The issuer must retain a record of the employer's contribution rate for each tier of coverage, and any changes in that contribution rate, beginning March 23, 2010, as the minimum level of documentation that must be available to support this criteria;

(f) On or after March 23, 2010, the plan was not amended to impose an overall annual limit on the dollar value of benefits that was not in the applicable plan documents on March 23, 2010;

(g) On or after March 23, 2010, the plan was not amended to adopt an overall annual limit at a dollar value that is lower than the dollar value of the lifetime limit for all benefits that was in effect on March 23, 2010; and

(h) The plan was not amended to decrease the dollar value of the annual limit, regardless of whether the plan or health insurance coverage also imposes an overall lifetime limit on the dollar value of all benefits.

(4) In addition to documentation establishing that none of the prohibited changes described in subsection (3) of this section have occurred, an issuer must also make available to the commissioner upon request the following information for each grandfathered plan:

(a) Enrollment records of new employees and members added to the plan after March 23, 2010;

(b) Underwriting rules and guidelines applied to enrollees on or after March 23, 2010; and

(c) Proof of notification to the individual or group of its plan's grandfathered status designation for each year for which the status is claimed.

(5) A change made to a plan before March 23, 2010, but that became effective after March 23, 2010, is permitted without negating a plan's grandfathered status if the change was adopted pursuant to a legally binding contract, state insurance department filing or written plan amendment. If the plan change resulted from a merger, acquisition or similar business action where one of the principal purposes is covering new individuals from the merged or acquired group under a grandfathered health plan, the plan may not be designated as grandfathered.

(6) An issuer may delegate the administrative functions related to documenting or determining grandfathered status designation to a third party. Such delegation does not relieve the issuer of its obligation to ensure that the designation is correctly made, that replacement plans are issued in a timely and compliant manner as required by state or federal law, and that all requisite documentation is kept by the issuer.

(7) If the commissioner determines that an issuer incorrectly designated a group plan as grandfathered, the plan is nongrandfathered, and must be discontinued and replaced with a plan that complies with all relevant market requirements within thirty days. This section does not preclude additional enforcement action.

(8) An issuer must designate on its filings whether a plan is grandfathered or nongrandfathered as required by the

Washington state system for electronic rate and form filing (SERFF) filing instructions.

[Statutory Authority: RCW 48.02.060, 48.43.700, 48.43.715, 48.44.050, 48.46.200, and 45 C.F.R. 150.101(2). WSR 14-01-039 (Matter No. R 2013-13), § 284-170-950, filed 12/11/13, effective 1/11/14.]

WAC 284-170-952 Market conduct requirements related to grandfathered status. (1) An issuer may allow a group covered by grandfathered health insurance coverage to add new employees to its health benefit plan, and move employees between benefit options at open enrollment without affecting grandfathered status, as long as the group's plan does not change in any way that triggers the loss of grandfathered status as set forth in 45 C.F.R. 147.140 and WAC 284-170-950.

(2) An issuer must provide a statement in the plan materials provided to participants or beneficiaries describing the benefits provided under the plan, explaining that the group health plan believes it is a grandfathered health plan within the meaning of Section 1251 of the Affordable Care Act, and include contact information for questions and complaints that conforms to the model notice language found in 45 C.F.R. 147.140.

(3) An issuer must not restrict group eligibility to purchase a nongrandfathered plan offered through an association or member-governed group because the group is not affiliated with or does not participate in the association or member-governed group, unless the association or member-governed group meets the requirements of WAC 284-170-958(1).

(4) WAC 284-170-950 through 284-170-958 does not prohibit an issuer from discontinuing a grandfathered plan design and replacing it with a nongrandfathered plan.

(5) An issuer must not limit eligibility based on health status for either grandfathered or nongrandfathered health plans.

[Statutory Authority: RCW 48.02.060, 48.43.700, 48.43.715, 48.44.050, 48.46.200, and 45 C.F.R. 150.101(2). WSR 14-01-039 (Matter No. R 2013-13), § 284-170-952, filed 12/11/13, effective 1/11/14.]

WAC 284-170-954 Small group coverage market transition requirements. (1) For all nongrandfathered small group plans issued and in effect prior to January 1, 2014, in 2014 issuers must replace issued nongrandfathered small group health benefit plans with health benefit plans approved by the commissioner as follows:

(a) An issuer may elect to withdraw a product pursuant to RCW 48.43.035, and discontinue each health benefit plan in force under that product on the same date, requiring groups to select a replacement plan to be effective on the date of discontinuation; or

(b) An issuer may discontinue a small group's coverage at renewal and offer the full range of plans the issuer offers in the small group market as replacement options, to take effect on the small group's renewal date. For small groups covered by nongrandfathered health benefit plans purchased based on an association or member-governed group affiliation or membership, the requirements of WAC 284-170-955 and 284-170-958 apply;

(c) If an issuer does not have a replacement plan approved by the commissioner to offer in place of the discon-

tinued plan, the issuer must assist each enrollee in identifying a replacement option offered by another issuer.

(2) If an issuer selects the replacement option described in subsection (1)(b) of this section, the issuer must provide the small group plan sponsor with written notice of the discontinuation and replacement options not later than ninety days before the renewal date for the small group's coverage. The commissioner may, for good cause shown, permit a shorter notice period for providing the replacement option information to a group. The written notice must contain the following information:

(a) Specific descriptions of the replacement plans for which the small group and its enrollees are eligible, both on or off the health benefit exchange. At the issuer's discretion, rate information may but is not required to be, included in the notice describing the replacement plans, provided subsequent rating information is provided with renewal;

(b) Electronic link information to the summary of benefits and explanation of coverage for each replacement plan option;

(c) Contact information to access assistance from the issuer in selecting the replacement plan option or answering enrollee questions about the replacement plans made available to them by their employer.

(3) For either replacement option set forth in subsection (1) of this section, the issuer must provide a separate written notice to each enrollee notifying the enrollee that their small group plan coverage will be discontinued and replaced. The notice must be provided not later than ninety days prior to the discontinuation and replacement date.

(4) If an issuer has electronic mail contact information for the small group plan sponsor or the enrollees, the written notice may be provided electronically. The issuer must be able to document to the commissioner's satisfaction both the content and timing of transmission. The issuer must send written notice by U.S. mail to a sponsor or enrollee for whom the electronic mail message was rejected.

(5) An issuer may offer small groups the option to voluntarily discontinue and replace their coverage prior to their renewal date.

(a) An issuer must not selectively offer early renewal to small groups, but must make this option universally available.

(b) An issuer must not alter or change a small group's renewal date to lengthen the period of time before discontinuation and replacement occurs in 2014. For example, if a small group's renewal date is March 31st of each year, the issuer may not adjust the small group's benefit year in 2013 to effect a renewal date of November 30th.

(6) This section applies to each health benefit plan that provides coverage based on receipt of claims for services, even if the coverage falls under one of the categories excepted from the definition of "health plan" as set forth in RCW 48.43.005 (26)(i) and (l). This section does not apply to a health benefit plan that provides per diem or single payment coverage based on a triggering event or diagnosis regardless of the medical necessity of the type or range of services received by an enrollee.

[Statutory Authority: RCW 48.02.060, 48.43.700, 48.43.715, 48.44.050, 48.46.200, and 45 C.F.R. 150.101(2). WSR 14-01-039 (Matter No. R 2013-13), § 284-170-954, filed 12/11/13, effective 1/11/14.]

WAC 284-170-955 Association health plan compliance with statutory or regulatory changes. (1) An issuer offering plans through an association or member-governed group must implement all new federal or state health plan market requirements when they become effective. Replacement requirements for this section apply based on whether the purchaser is classified as an individual, small group, or large group purchaser. These requirements also apply to member employer groups of less than two or to individual member purchasers.

(2) An issuer providing plans of the type referenced in subsection (1) of this section must discontinue a noncompliant plan, and offer replacement plans effective on the renewal date of the master group contract for large groups, and on the group's anniversary renewal date for nongrandfathered small group and individual plans.

(3) If the association is a large group as defined in WAC 284-170-958(1), the same renewal date must apply to all participating employers and individuals, and the replacement coverage must take effect on the same date for each participant. The purchaser's anniversary date must not be used in lieu of this uniform renewal date for purposes of discontinuation and replacement of noncompliant coverage.

(4) If the association is not a large group as defined in WAC 284-170-958(1), and the master group contract and the member group do not have the same renewal date, an issuer must provide notice of the discontinuation and replacement of the plan to the affected association member group or plan sponsor, and each enrollee in the affected member group, not fewer than ninety days prior to the member's anniversary renewal date.

(5) If an issuer does not have a replacement plan approved by the commissioner to offer in place of a discontinued plan, the issuer must assist each enrollee in identifying a replacement option offered by another issuer.

(6) For purposes of this section, "purchaser" means the group or individual whose eligibility for the plan is based in whole or in part on membership in the association or member-governed group.

(7) For purposes of this section, the "anniversary renewal date" means the initial or first date on which a purchasing group's health benefit plan coverage became effective with the issuer, regardless of whether the issuer is subject to other agreements, contracts or trust documents that establish requirements related to the purchaser's coverage in addition to the health benefit plan.

(8) An issuer must not adjust the master contract renewal or anniversary date to delay or prevent application of any federal or state health plan market requirement.

[Statutory Authority: RCW 48.02.060, 48.43.700, 48.43.715, 48.44.050, 48.46.200, and 45 C.F.R. 150.101(2). WSR 14-01-039 (Matter No. R 2013-13), § 284-170-955, filed 12/11/13, effective 1/11/14.]

WAC 284-170-958 Transition of plans purchased by association members. (1) An issuer must not offer or issue a plan to individuals or small groups through an association or member-governed group as a large group plan unless the association or member-governed group to whom the plan is issued constitutes an employer under 29 U.S.C. § 1002(5) of the Employee Retirement Income Security Act of 1974 (29

U.S.C. Section 1001 et. seq.), as amended, and the number of eligible employees is more than fifty.

(2) An issuer must make a good faith effort to ensure that any association or member-governed group to whom it issues a large group plan meets the requirements of subsection (1) of this section prior to submitting its form and rate filings to the commissioner, and prior to issuing such coverage. An issuer must maintain the documentation supporting the determination and provide it to the commissioner upon request. An issuer may reasonably rely upon an opinion from the U.S. Department of Labor as reasonable proof that the requirements of 29 U.S.C. 1002(5) are met by the association or member-governed group.

(3) For plans offered to association or member-governed groups that do not meet the requirements of subsection (1) of this section, the following specific requirements apply:

(a) An issuer must treat grandfathered plans issued under those purchasing arrangements as a closed pool, and file a single case closed pool rate filing. For purposes of this section, a single case closed pool rate filing means a rate filing which includes the rates and the rate filing information only for the issuer's closed pool enrollees.

(b) For each single case closed pool rate filing, an issuer must file a certification from an officer of the issuer attesting that:

(i) The employer groups covered by the filing joined the association prior to or on March 23, 2010;

(ii) The issuer can establish with documentation in its files that none of the conditions triggering termination of grandfathered status set forth in WAC 284-170-950 or in 45 C.F.R. 2590.715-1251(g) have occurred for any plan members.

(4) For each grandfathered plan issued to an association or member governed group under subsection (3) of this section, the issuer must include the following items in its rate filing:

- (a) Plan number;
- (b) Identification number assigned to each employer group, including employer groups of less than two;
- (c) Initial contract or certificate date;
- (d) Number of employees for each employer group, pursuant to RCW 48.43.005(11);
- (e) Number of enrolled employees for each employer group for the prior calendar year;
- (f) Current and proposed rate schedule for each employer group; and
- (g) Description of the rating methodology and rate change for each employer group.

(5) WAC 284-43-950 applies for a single case rate closed pool under this section.

[Statutory Authority: RCW 48.02.060, 48.43.700, 48.43.715, 48.44.050, 48.46.200, and 45 C.F.R. 150.101(2). WSR 14-01-039 (Matter No. R 2013-13), § 284-170-958, filed 12/11/13, effective 1/11/14.]

WAC 284-170-959 Individual coverage market transition requirements. (1) For all nongrandfathered individual health benefit plans issued and in effect prior to January 1, 2014, during 2014 issuers must replace the plans with health benefit plans approved by the commissioner as follows:

(a) An issuer may elect to withdraw a product, pursuant to RCW 48.43.038, and discontinue each health benefit plan

in force under that product on the same date, requiring selection of a replacement plan to be effective on the date of discontinuation; or

(b) An issuer may discontinue an individual's coverage and offer the full range of plans the issuer offers in the individual market as replacement options. The replacement coverage must take effect on the individual's renewal date.

(c) If an issuer does not have a replacement plan approved by the commissioner to offer in place of the discontinued plan, the issuer must assist each enrollee in identifying a replacement option offered by another issuer.

(2) If an issuer selects the replacement option described in subsection (1)(b) of this section, not fewer than ninety days before the renewal date for the coverage, the issuer must provide the individual and each enrollee under the health benefit plan with written notice of the discontinuation and replacement options. The commissioner may, for good cause shown, permit a shorter notice period for providing the replacement option information to a group. The written notice must contain the following information:

(a) Specific descriptions of the replacement plans for which the enrollees are eligible, both on or off the health benefit exchange;

(b) Electronic link information to the summary of benefits and explanation of coverage for each replacement plan option;

(c) Contact information for assistance from the issuer in selecting the replacement plan option or answering enrollee questions about the replacement plans;

(d) If a renewal date is later than January 1, 2014, the issuer's ninety day discontinuation and replacement notice must notify the individual and any other enrollees on the plan of the shortened plan year for 2014 under the replacement coverage.

(3) For either replacement option set forth in subsection (1) of this section, the issuer must provide a separate written notice to each enrollee notifying the enrollee that their existing coverage will be discontinued and replaced. The notice must be provided not later than ninety days prior to the discontinuation and replacement date.

(4) If an issuer has electronic mail contact information for the enrollees, the notice may be provided electronically. The issuer must be able to document to the commissioner's satisfaction both the content and timing of transmission. The issuer must send written notice by U.S. mail to an enrollee for whom the electronic mail message was rejected.

(5) This section applies to each health benefit plan that provides coverage based on receipt of claims for services, even if the coverage falls under one of the categories excepted from the definition of "health plan" as set forth in RCW 48.43.005 (26)(i) and (l). This section does not apply to a health benefit plan that provides per diem or single payment coverage based on a triggering event or diagnosis regardless of the medical necessity of the type or range of services received by an enrollee.

(6) Between September 1st and September 30th of each year, an issuer must provide written notice to each enrollee under an individual health benefit plan of the availability of health benefit exchange coverage, and contact information for the health benefit exchange.

[Statutory Authority: RCW 48.02.060, 48.43.700, 48.43.715, 48.44.050, 48.46.200, and 45 C.F.R. 150.101(2). WSR 14-01-039 (Matter No. R 2013-13), § 284-170-959, filed 12/11/13, effective 1/11/14.]