RCW 48.43.733 Rates and forms of group health benefit plans—Timing of filings—Exceptions—Rules. (1) All rates and forms of group health benefit plans other than small group plans, and all stand-alone dental and all stand-alone vision plans offered by a health carrier or limited health care service contractor as defined in RCW 48.44.035 and modification of a contract form or rate must be filed before the contract form is offered for sale to the public and before the rate schedule is used.

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

(a) The date group contract negotiations are completed; or

(b) The date renewal premiums are implemented.

(3) For purposes of this section, a negotiated contract form is a health benefit plan, stand-alone dental plan, or stand-alone vision plan where benefits, and other terms and conditions, including the applicable rate schedules are negotiated and agreed to by the carrier or limited health care service contractor and the policy or contract holder. The negotiated policy form and associated rate schedule must otherwise comply with state and federal laws governing the content and schedule of rates for the negotiated plans.

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

(5) The commissioner may, subject to a carrier's or limited health care service contractor's right to demand and receive a hearing under chapters 48.04 and 34.05 RCW, disapprove filings submitted under this section, as permitted under RCW 48.18.110, 48.44.020, and 48.46.060.

(6) The commissioner shall amend existing rules to standardize the rate and form filing process as well as regulatory review standards for the rates and forms of the plans submitted under this section. The commissioner may amend the rules previously adopted under RCW 48.43.733 and shall amend any additional rating requirements established by existing rule, that are not applied to health care service contractors and health maintenance organizations.

(7) The requirements of this section apply to all group health benefit plans other than small group plans, all stand-alone dental plans, and all stand-alone vision plans issued or renewed on or after March 31, 2016. [2016 c 156 § 2; 2015 c 19 § 3.]

Effective date—2016 c 156: "This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately [March 31, 2016]." [2016 c 156 § 3.]

Intent—2016 c 156: "It is the intent of the legislature to enhance competition among all health carriers and limited health care service contractors by having the office of the insurance commissioner

establish regulatory uniformity for the rate and form filing process and the rate and form filing content and regulatory review standards for group health benefit plans other than small group health benefit plans, as well as all stand-alone dental plans and all stand-alone vision plans." [2016 c 156 § 1.]

Intent—2015 c 19: See note following RCW 48.18.100.