



# RULE-MAKING ORDER

**CR-103P (May 2009)**  
**(Implements RCW 34.05.360)**

**Agency:** Office of the Insurance Commissioner

**Permanent Rule Only**

**Effective date of rule:**

**Permanent Rules**

X 31 days after filing.

Other (specify) \_\_\_\_\_ (If less than 31 days after filing, a specific finding under RCW 34.05.380(3) is required and should be stated below)

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

Yes  No If Yes, explain:

**Purpose:** The purpose of the rules is to protect consumers during the transition to health care benefit plans in the individual, small and large groups that comply with the Affordable Care Act and its implementing regulations. The rules provide ongoing market conduct guidance to issuers on required documentation related to plans designated as grandfathered, and determining which market standards apply when offering and issuing coverage to an association's membership.

Insurance Commissioner Matter No. R 2013-13

**Citation of existing rules affected by this order:**

Repealed:

Amended:

Suspended:

**Statutory authority for adoption:** RCW 48.02.060, 48.43.700, 48.43.715, 48.44.050, 48.46.200.

**Other authority :** 45 CFR 150.101(2)

**PERMANENT RULE (Including Expedited Rule Making)**

Adopted under notice filed as WSR 13-20-141 on October 2, 2013.

Describe any changes other than editing from proposed to adopted version:

1. Additional language was added to WAC 284-170-950(2) to clarify the application of the rule to fully insured grandfathered plans.
2. WAC 284-170-950(3)(b) was amended to conform to existing federal law 45 CFR 147.170 (g) (1).
3. WAC 284-170-952(1) was amended to include the reference to the prior grandfathered plan WAC, WAC 284-170-950.
4. WAC 284-170-954(2)(a) was amended to specifically confirm that rate information is not required to be in the 90-day notice. This is a clarification, for as a practical matter, for some product withdrawal and replacement scenarios, rates are not developed at the time the notice is issued.
5. WAC 284-170-958(1) was amended to eliminate redundant references to types of large groups.
6. WAC 284-170-958(2) was amended to include a sentence explaining that an issuer must retain the documentation on which it made a determination about what market groups filing through associations belong to, and provide it to the commissioner upon request. This is a clarification requested by commenters.
7. WAC 284-170-958(4) was deleted. Because the federal standard on which the section is based still applies, this change does not result in a substantially different rule from that published, pursuant to RCW 34.05.335.

If a preliminary cost-benefit analysis was prepared under RCW 34.05.328, a final cost-benefit analysis is available by contacting:

Name: Jim Keogh  
Address: PO Box 40258  
Olympia WA 98504

phone ( 360 ) 725-7056  
fax (360) 586- 3109  
e-mail rulescoordinator@oic.wa.gov

**Date adopted:**

December 11, 2013

**NAME (TYPE OR PRINT)**

Mike Kreidler

**SIGNATURE**

**TITLE**

Insurance Commissioner

**CODE REVISER USE ONLY**

OFFICE OF THE CODE REVISER  
STATE OF WASHINGTON  
FILED

**DATE: December 11, 2013**

**TIME: 10:41 AM**

**WSR 14-01-039**

**Note: If any category is left blank, it will be calculated as zero.  
No descriptive text.**

**Count by whole WAC sections only, from the WAC number through the history note.  
A section may be counted in more than one category.**

**The number of sections adopted in order to comply with:**

<b>Federal statute:</b>	New	<u>4</u>	Amended	_____	Repealed	_____
<b>Federal rules or standards:</b>	New	<u>4</u>	Amended	_____	Repealed	_____
<b>Recently enacted state statutes:</b>	New	_____	Amended	_____	Repealed	_____

**The number of sections adopted at the request of a nongovernmental entity:**

New	_____	Amended	_____	Repealed	_____
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**The number of sections adopted in the agency's own initiative:**

New	<u>6</u>	Amended	_____	Repealed	_____
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**The number of sections adopted in order to clarify, streamline, or reform agency procedures:**

New	_____	Amended	_____	Repealed	_____
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**The number of sections adopted using:**

<b>Negotiated rule making:</b>	New	_____	Amended	_____	Repealed	_____
<b>Pilot rule making:</b>	New	_____	Amended	_____	Repealed	_____
<b>Other alternative rule making:</b>	New	<u>6</u>	Amended	_____	Repealed	_____

NEW SECTION

**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 percentage 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.

NEW SECTION

**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.

NEW SECTION

**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 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, 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.

#### NEW SECTION

**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. Re-

placement 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.

#### NEW SECTION

**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 sup-

porting 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.

#### NEW SECTION

**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.