General Filing Instructions For Disability Health Forms

1. **Question: What Are General Filing Instructions And What Do They Apply To?**

   Answer: The purpose of this document is to clarify how licensed health carriers are to file contract forms, rate schedules, and modifications to policies and rates with this office. For purposes of these general filing instructions a licensed health carrier is:

   - **A Life and Disability carrier licensed per RCW 48.05.030** that offer products subject to:
     - Chapter 48.20 RCW;
     - Chapter 48.21 RCW;
     - Chapter 48.42 RCW;
     - Chapter 48.70 RCW.
   - These types of products are prior approval as defined by RCW 48.18.100

2. **Question: Why Must A Carrier Conduct Business In Its Licensed Name?**

   Answer: RCW 48.05.190 and RCW 48.30.050 require the carrier conduct business in its own legal name.

   Due to the above statutes and this office's responsibility to ensure health products are being administered correctly, all carriers must conduct business in their licensed name. For example, the following forms must clearly indicate the correct name of the licensed carrier:

   - All enrollment forms or change forms
   - All group master application forms
   - All policies
   - All certificates of coverage
   - All summaries of benefits
   - All collateral documentation, handouts, marketing materials
   - All member identification cards, explanation of benefits, etc.
   - All provider agreements

3. **Question: How Should A Filing Be Submitted?**

   Answer: With the exception for certain network reports, all filings should be submitted in camera ready format. Please note our office images all filings. Therefore, we ask that carriers not submit duplicate filings when making a submission.

   It is not acceptable to file form or rate filings in the following manner:

   - **In Draft Format.** All filings should be in final format.
   - **In Binders.** All filings should be filed with a single rubber band or clip. Please do not use multiple staples or paper clips when submitting a filing.
   - **In Multiple Pieces.** Filings should be submitted as a complete submission. Our office does not have the resources to collate replacement pages or benefit changes for filings already submitted for review.
   - **Marked As Confidential.** With the exception of "not for public" rate filings, all documents on date received are subject to public disclosure; therefore, they cannot be filed as confidential.

4. **QUESTION: What Are "Single Case Filings"?**

   ANSWER: A single case filing is unique to a specific group or association. Please note that RCW 48.18.100 *requires every contract, certificate of coverage, application, rate, and endorsement/rider to be filed prior to use.*

5. **<u>QUESTION: What Generally Must Be Included In A Single Case Filing?</u>**

<u>Answer:</u> Filings must include the following --

A transmittal (NAIC January 1, 2006) for the *policy* and a ***separate*** transmittal for the *Proprietary and for-public Rate. (Please note, Association type filings are considered to be large groups and must comply with large group requirements. Additionally, the association, the member governed group or trust must be the policy holder.)*

a. For association, trust, and member governed group contracts, the cover letter must include the following:

   i. Purpose of the association or trust (By-laws)

   ii. Attach or list eligibility rules for membership in the association or trust including membership fees if any.

   iii. Attach or list eligibility rules for purchasing coverage through the association or trust.

      1) The “For-Public” rate.

      2) A completed “Groups Other Than Small Groups Filing Summary” as described at WAC 284-43-950.

b. Single Case filings must also include enrollment forms, certificate of coverage, and the master policy.

c. A copy of the cover letter for the proprietary rate filing.

d. Actuarial memorandum

6. **<u>QUESTION: What Is A Rider, An Amendment, An Endorsement?</u>**

<u>ANSWER:</u> A Rider is typically an additional offering or exclusion that is included in a policy at the time of issue. For example, a pharmacy rider might be attached to a health plan policy. An Amendment typically changes a certificate of coverage already in force. For example, an amendment might be added explaining that the benefit for chemical dependency might increase mid-year through a health plan. An Endorsement, similar to an amendment, adds or removes contract language to an in-force health product.

7. **<u>QUESTION: When Must I File A Provider Agreement?:</u>**

<u>ANSWER:</u> Any health carrier that wishes to market or sell a health product in Washington State that provides a higher benefit if a member uses the carriers preferred network of providers must file and receive approval of its provider agreements. This requirement is a health carrier compliance matter, not a benefit plan requirement.

8. **<u>QUESTION: How Do I file A Provider Agreement?</u>**

<u>ANSWER:</u> All Participating Provider, Facility and Subcontractor (template) Agreements require prior approval and must be filed at least 15 working days prior to intended date of use (Please note the OIC would prefer at least 30 days). Agreements may not be executed until they have first been filed, and until the carrier has either received a letter advising that the form has been approved for use or the agreement has been deemed approved in accordance with RCW 48.18.100 and WAC 284-43-330.

A material change to an approved agreement requires:

a. Submission of the new template with any modifications. Please include a second copy that includes underlines, highlights or strikeout language with the modified template.
b. Submission of the addendum to be sent to contracted providers, if any.

Please note if a provider network is subcontracted then the agreement between the carrier and network as well as the agreement between the network and provider must be filed with this office. Additionally, per RCW 48.43.550, WAC 284-43-120 and WAC 284-43-300, the health carrier is held accountable for the actions of its subcontractors.

9. QUESTION: What Is A Small Group?

ANSWER: RCW 48.43.005(24) defines a small group as having at least two but no more than fifty eligible employees. Health plans offered to small employer groups must be filed with this office prior to use and be community rated.

10. QUESTION: How Do You Count Employees To Determine If A Group Qualifies As A Small Group?

ANSWER: Per RCW 48.43.005(10), an eligible employee is one who works on a full-time basis with a normal work week of 30 or more hours. Per RCW 48.21.045(5), the carrier shall not require a minimum participation level greater than 100% of eligible employees working for groups with 3 or less employees; and 75% of eligible of eligible employees working for groups with more than 3 employees.

The participation level is based on the number of employees actually covered under the plan divided by the number of eligible employees. Please note that a small employer shall not include employees or dependents that have similar existing coverage when calculating the applicable percentage of participation is met. When calculating participation levels, employees with other coverage are not considered eligible employees.

11. QUESTION: When Must I File Network Reports?

ANSWER: Any health carrier that wishes to market or sell a health product in Washington State that provides a higher benefit if a member uses the carriers preferred network of providers must file network reports prescribed in WAC 284-43-210 and WAC 284-43-220. This requirement is a health carrier compliance matter, not a benefit plan requirement.

12. QUESTION: What Are Network Reports?

Answer: There are four different reports that **must** be filed by health carriers.

They are as follows:

a. **Provider Network Form A** as required by WAC 284-43-220. This monthly report is submitted electronically and contains data on contracted providers.
b. **Enrollee Network Form B** as required by WAC 284-43-220. This report is filed electronically on an annual basis and contains enrollment information by county per line of business.
c. **Access Plans** as required by WAC 284-43-210 & WAC 284-43-220. Please note that an Access Plan is required to be filed prior to offering a new health plan or when there is a material change to an existing health plan. Access Plans must be submitted in hard copy format.

d. **Geographic Network Report** as required by WAC 284-43-220. This annual report is a geographic representation of enrollees and providers. This report may be filed electronically or via hard copy.

Please see our WEB page at:
http://www.insurance.wa.gov/insurers/rates_forms/main_health_care.shtml for instructions.

13. **QUESTION: What Are Conversion Plans?**

ANSWER: Conversion plans are required to be offered to members who have lost coverage under their group health plan. These plans are part of the "state alternative mechanism" required by the federal government ensuring access to health care. Because conversion plans are not "true" individual plans they are not subject to the replacement of contract language provided in RCW 48.43.038 or the group requirements of RCW 48.43.035. Please note, however, that as part of the state alternative mechanism, once a conversion plan is issued it must continually be renewed.

14. **QUESTION: What Are "Analyst Checklists?"**

ANSWER: Analyst Checklists identify required elements that must be contained in a document filed with this office. Our staff completes these forms to ensure consistent reviews. Please note that the checklist is a tool listing the various legal requirements that must be contained in a filing, however, the analyst checklist is not meant to represent every law that might impact the filing. Copies of these checklists may be obtained at the following website:

http://www.insurance.wa.gov/insurers/rates_forms/main_health_care.shtml

15. **QUESTION: How Do We Obtain A Status Of A Filing?**

ANSWER: Carriers' can check the status of their filings by contacting the Rates and Forms Help Desk at (360) 725-7111 or via e-mail at mailto:RFHelpDesk@oic.wa.gov.

16. **QUESTION: How Do We Obtain Confirmation of Final Action?**

ANSWER: If you want notice that your submission has been processed you must submit a duplicate NAIC transmittal form and cover letter. We will stamp and code these after we process your filing and return them to you if you have provided a self-addressed stamped or metered envelope. Please do not provide duplicate copies of filings. They will not be returned.

If at a later date you need copies of a filing you may contact Public Records at 360-725-7000. Copies of these documents are available from our website or you may request hard copies that are subject to copying costs.

17. **QUESTION: What Is The Definition Of Guaranteed Issue?**

ANSWER: Guaranteed issue, specifically for group health plans, is regulated by RCW 48.43.035. Health carriers shall accept for enrollment any state resident within the group to whom the plan is offered and within the carrier's service area and provide or assure the provision of all covered services regardless of age, sex, family structure, ethnicity, race, health condition, geographic location, employee status, socioeconomic status, other condition or situation, or the provisions of RCW 49.60.174(2).

18. **<u>QUESTION: What Is "Guarantee Of Continuity Of Coverage" For *Individual* Health Plans?</u>**

<u>ANSWER:</u> Individual health plans are governed by RCW 48.43.038. Individual health plans are guaranteed continuity of coverage meaning the carrier cannot terminate coverage, except for:

- There is a non-payment of premium
- Violation of published policies approved by the insurance commissioner
- Member becomes eligible for Medicare
- Covered person fails to pay any deductible or copayment amounts owed to the carrier and not the provider of health care services
- Change or implementation of federal or state laws
- Covered person commits a fraudulent act against the carrier
- Covered persons who materially breach the health plan

19. **<u>QUESTION: What Is "Guaranteed Renewable" For *Group* Health Plans?</u>**

<u>ANSWER:</u> Group health plans are governed by RCW 48.43.035. The carrier may consider the group's anniversary date as the renewal date for compliance purposes. Group health plans are guaranteed renewable meaning the carrier cannot terminate coverage, except for:

- There is a non-payment of premium
- Violation of published policies approved by the insurance commissioner
- Member becomes eligible for Medicare
- Covered person fails to pay any deductible or copayment amounts owed to the carrier and not the provider of health care services
- Change or implementation of federal or state laws
- Covered person commits a fraudulent act against the carrier
- Covered persons who materially breach the health plan

20. **<u>QUESTION: What Triggers The Replacement Process?</u>**

<u>ANSWER:</u> Any change to a policy or certificate of coverage may trigger replacement. This includes carriers that are considering modifying a product by either, adding, deleting, modifying or replacing language; therefore, carriers should first verify with the OIC if the carrier will be subject to the replacement requirements.

If a carrier changes benefits or language, it is replacing its products and must provide the following:

- Must provide notice 90 days in advance of renewal date to the affected individual/groups offering the individual/group to enroll in any other health plan. For group plans this means the 90-day notice must be sent 90 days prior to the group's renewal date.
- Participants of individual plans may transfer to any open individual plan without completion of the standard health questionnaire. See RCW 48.43.038(3)(c).
- Participants of group plans (up to 200 employees) including small group plans must be allowed opportunity to enroll in any available open plan. See RCW 48.43.035(4)(c).

21. **<u>QUESTION: When Are Changes To A Contract Not Subject To The Replacement Process?</u>**

<u>ANSWER:</u> Changes to group policies are not subject to the replacement process when:

- The carrier has zero enrollment on a product

- The carrier notifies the OIC with 180 days advanced notice that the carrier is withdrawing from the state in which case notice must be provided to covered members currently on health plan. This notice must be calculated 180 days prior to the renewal date.
- There is a change or implementation of federal or state laws

22. **QUESTION: What Are "State Mandates"?**

    ANSWER: Mandated health benefits are developed under the provisions of Chapter 48.47 RCW. Per RCW 48.47.010(7), a mandated benefit means coverage or offering required by law to be provided by a health carrier to: (a) cover a specific health care service or services; (b) cover treatment of a specific condition or conditions; or (c) contract, pay, or reimburse specific categories of health care providers for specific services.

    Mandated benefit offerings and coverage are dependent on the type of product marketed. For example, carriers marketing catastrophic individual plans are not required to offer maternity coverage; however, the carrier must market at least one individual plan that does cover maternity.

    For additional reference, please see the analyst checklist developed for the specific line of business.

23. **QUESTION: How Can We Learn About "State Mandates"?**

    ANSWER: The required state mandated benefits for a particular line of business can be identified by reviewing the "Analyst Checklist" developed for that line of business. These checklists may be located on our web page at:

    http://www.insurance.wa.gov/insurers/rates_forms/main_health_care.shtml

    Additionally, the legislative page for the State of Washington contains the specific RCW or WAC for the mandated benefit. The web site also provides notices of forthcoming notices, meetings, and changes to rules. The state legislative page is:

    http://www1.leg.wa.gov/LawsAndAgencyRules/

24. **QUESTION: How Are Groups Rated?**

    ANSWER: Small group health plans are community rated and the medical experience of all small groups must be pooled for rating purposes. See RCW 48.21.045. Carriers can file multiple rating methodologies for different kinds of large group pools, or a single case rate filing for a particular group (*See Chapter 284-60 WAC*). Please note that conversion policy rates should be generally included with small group ratings.

25. **QUESTION: When Are Rates Required to be Filed?**

    ANSWER: Per RCW 48.18.100(7), RCW 48.18.140, and RCW 48.19.010(2), rates are required to be filed before a new contract is offered for sale to the public. Additionally, any manual of classification, manual of rules and or rates, and any modification thereof must be filed before using.

26. **QUESTION: How Do I File A Proprietary Rate Filing?**

    ANSWER: Per RCW 48.02.120(3), in order to preserve trade secrets and prevent unfair competition, carriers may request certain documents related to rate development be withheld from public inspection. Carriers must include a filing transmittal and identify those materials that are desired to be non-public by separately marking or stamping "proprietary" or "not-for-public" **on each page of the documents.**

27. **<u>QUESTION: What Is Acceptable In A "Statement Of Variability?"</u>**

<u>ANSWER:</u> Health and Disability filings are prior approval and must reflect what is expected to be marketed in the State of Washington. Submitting variability tables indicating benefits will be paid from "0%-100%", copays are from "$0.00 - $100.00", etc., are not acceptable. Please note that our office will accept a limited amount of variability provided that the related benefits can be clearly identified and rates support the benefit options. Example of acceptable variability is: [$0, $10,$15, $20, $25] Copay, or [70%,80%,90%,100%] Coinsurance Plan.

28. **<u>QUESTION: Why Must A Filing Represent What Will Actually Be Marketed?</u>**

<u>ANSWER:</u> RCW 48.18.100 requires products be filed and approved prior to being marketed. Due to evolving legislation at the state and federal level concerning health products, our office must assure that carriers operating in Washington State offer compliant policies.

29. **<u>QUESTION: How Come The OIC Does Not Accept Component Filings?</u>**

<u>ANSWER:</u> RCW 48.18.140 defines the contents of insurance policies. RCW 48.18.190 states that the policy must contain the entire contract. As the filing must be filed for approval and RCW 48.18.190 states the policy must contain the entire contract, this office cannot accept components or different sections filed separate from the policy.

30. **<u>QUESTION: How Come Certain Lines Of Business Cannot Be Combined In A Filing?</u>**

<u>ANSWER:</u> RCW 48.20.460 defines for the individual market the minimum standards for benefits and coverage that may be combined. State law only allows; basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage and/or accident only coverage to be sold in combination. Specified disease or specified accident coverage, medical supplement coverage, and limited benefit coverage may only be sold as "stand-alone" coverage.

The Group Market has two specific tests that it must meet in order to sell in combined format. First, the policy must either meet all federal requirements, unless it meets the "excepted benefit" rules in 2791 HIPAA. Depending upon the answer to the federal question, the group product must then also meet state mandated requirements. Product combinations may subject the filing to meeting multiple state mandates.

31. **<u>QUESTION: Is It Acceptable To File "Blank Pages" As Place Holders For Future Benefit Modification?</u>**

<u>ANSWER:</u> No. Health and disability contracts are "prior approved" per RCW 48.18.100. That stated, any future benefit modification would have to be filed along with the core policy.

32. **<u>QUESTION: What Is A Blanket Disability Product?</u>**

<u>ANSWER:</u> A blanket disability product can be any of the following six definitions contained in RCW 48.21.040. A blanket disability policy can be:

(a) A policy issued to any common carrier of passengers, which carrier shall be deemed the policyholder, covering a group defined as all persons who may become such passengers, and whereby such passengers shall be insured against loss or damage resulting from death or bodily injury either while, or as a result of, being such passengers.

(b) A policy issued in the name of any volunteer fire department, first aid or ambulance squad or volunteer police organization, which shall be deemed the policyholder, and covering all the members of any such organization against loss from accidents resulting from hazards incidental to duties in connection with such organizations.

(c) A policy issued in the name of any established organization whether incorporated or not, having community recognition and operated for the welfare of the community and its members and not for profit, which shall be deemed the policyholder, and covering all volunteer workers who serve without pecuniary compensation and the members of the organization, against loss from accidents occurring while engaged in the actual performance of duties on behalf of such organization or in the activities thereof.

(d) A policy issued to an employer, who shall be deemed the policyholder, covering any group of employees defined by reference to exceptional hazards incident to such employment, insuring such employees against death or bodily injury resulting while, or from, being exposed to such exceptional hazards.

(e) A policy covering students or employees issued to a college, school, or other institution of learning or to the head or principal thereof, who or which shall be deemed the policyholder.

(f) A policy or contract issued to any other substantially similar group, which, in the commissioner's discretion, may be subject to the insurance of a blanket disability policy or contract.

33. QUESTION: How Are Out Of State Groups Regulated By The State Of Washington?

ANSWER: RCW 48.01.020 defines that all insurance transacted in Washington State by carriers is subject state law. RCW 48.18.100 requires prior approval by this office of all disability forms. Additionally, WAC 284-30-600 regulates unfair practices of out-of-state group life and disability insurance. Solicitation of insurance coverage by out-of-state groups is regulated by WAC 284-30-600. Please note that certificates of coverage and applications issued in Washington for out-of-state groups are prior approval and must be filed and approved by the OIC prior to use.

34. QUESTION: The Filing Is Approved In Our State Of Domicile. How Come It Is Not Approved In Washington?

ANSWER: Per RCW 48.01.020, Insurance transactions that take place in the State of Washington are subject to this state's laws and regulations. Therefore, fully insured products must be fully compliant.

35. QUESTION: What Is A"Health Benefit Plan"?

ANSWER: A health benefit plan as defined by state law under RCW 48.43.005(19) means any policy, contract, or agreement offered by a health carrier to provide, arrange, reimburse, or pay for health care services except the following:

- **a.** Long-term care insurance governed by chapter 48.84 RCW;
- **b.** Medicare supplemental health insurance governed by chapter 48.66 RCW;
- **c.** Limited health care services offered by limited health care service contractors in accordance with RCW 48.44.035;
- **d.** Disability income;
- **e.** Coverage incidental to a property/casualty liability insurance policy such as automobile personal injury protection coverage and homeowner guest medical;
- **f.** Workers' compensation coverage;
- **g.** Accident only coverage;

h. Specified disease and hospital confinement indemnity when marketed solely as a supplement to a health plan;
i. Employer-sponsored self-funded health plans;
j. Dental only and vision only coverage; and
k. Plans deemed by the insurance commissioner to have a short-term limited purpose or duration, or to be a student-only plan that is guaranteed renewable while the covered person is enrolled as a regular full-time undergraduate or graduate student at an accredited higher education institution, after a written request for such classification by the carrier and subsequent written approval by the insurance commissioner.

Federal law defines a health benefit plan under 2791 HIPAA. State law has a more limited definition of health benefit plan than federal law. When filing a health benefit plan, please ensure that it meets the state definition.

36. QUESTION: What Is The BIAW case?

ANSWER: Regence Blueshield v. State of Washington, Office of Insurance Commissioner, Case No. 04-2-01761-8 confirmed that discrimination among employer-members, including discrimination based on the number of employees of the member, is prohibited per RCW 48.43.035(1). In the Thurston County Superior Court case, it was found that of the eleven Building Industry Association of Washington (BIAW) health plans issued by Regence BlueShield, only one type of plan was offered to employer groups of fewer than five employees.

Washington State's guaranteed issue provisions of RCW 48.43.035 require that all member employer groups of an association be offered the same menu of plan designs. The court found that treating some member groups different than other member groups was indeed a discriminatory practice.

37. QUESTION: Why Might This Court Case Affect A Carrier's Business Practices?

ANSWER: Per RCW 48.43.035, Washington State law clearly states that group health plans are guaranteed issue. The law's definition of guaranteed issue was challenged in court and the carrier was required to change its business practices and offer all association members the same plan options.