

CERTIFICATION OF ENROLLMENT

ENGROSSED SUBSTITUTE SENATE BILL 5261

Chapter 303, Laws of 2008

60th Legislature
2008 Regular Session

INSURANCE COMMISSIONER--AUTHORITY--RATE REVIEW

EFFECTIVE DATE: 06/12/08

Passed by the Senate March 8, 2008
YEAS 29 NAYS 17

BRAD OWEN

President of the Senate

Passed by the House February 29, 2008
YEAS 68 NAYS 26

FRANK CHOPP

Speaker of the House of Representatives

Approved April 1, 2008, 3:24 p.m.

CHRISTINE GREGOIRE

Governor of the State of Washington

CERTIFICATE

I, Thomas Hoemann, Secretary of the Senate of the State of Washington, do hereby certify that the attached is **ENGROSSED SUBSTITUTE SENATE BILL 5261** as passed by the Senate and the House of Representatives on the dates hereon set forth.

THOMAS HOEMANN

Secretary

FILED

April 2, 2008

**Secretary of State
State of Washington**

ENGROSSED SUBSTITUTE SENATE BILL 5261

AS AMENDED BY THE HOUSE

Passed Legislature - 2008 Regular Session

State of Washington 60th Legislature 2008 Regular Session

By Senate Health & Long-Term Care (originally sponsored by Senators Keiser, Franklin, Kohl-Welles, Fairley, and Kline; by request of Insurance Commissioner)

READ FIRST TIME 01/25/08.

1 AN ACT Relating to granting the insurance commissioner the
2 authority to review individual health benefit plan rates; amending RCW
3 48.18.110, 48.44.020, 48.46.060, 48.20.025, 48.44.017, and 48.46.062;
4 and creating new sections.

5 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

6 **Sec. 1.** RCW 48.18.110 and 2000 c 79 s 2 are each amended to read
7 as follows:

8 (1) The commissioner shall disapprove any such form of policy,
9 application, rider, or endorsement, or withdraw any previous approval
10 thereof, only:

11 (a) If it is in any respect in violation of or does not comply with
12 this code or any applicable order or regulation of the commissioner
13 issued pursuant to the code; or

14 (b) If it does not comply with any controlling filing theretofore
15 made and approved; or

16 (c) If it contains or incorporates by reference any inconsistent,
17 ambiguous or misleading clauses, or exceptions and conditions which
18 unreasonably or deceptively affect the risk purported to be assumed in
19 the general coverage of the contract; or

1 (d) If it has any title, heading, or other indication of its
2 provisions which is misleading; or

3 (e) If purchase of insurance thereunder is being solicited by
4 deceptive advertising.

5 (2) In addition to the grounds for disapproval of any such form as
6 provided in subsection (1) of this section, the commissioner may
7 disapprove any form of disability insurance policy(~~(, except an~~
8 ~~individual health benefit plan,~~) if the benefits provided therein are
9 unreasonable in relation to the premium charged. Rates, or any
10 modification of rates effective on or after July 1, 2008, for
11 individual health benefit plans may not be used until sixty days after
12 they are filed with the commissioner. If the commissioner does not
13 disapprove a rate filing within sixty days after the insurer has filed
14 the documents required in RCW 48.20.025(2) and any rules adopted
15 pursuant thereto, the filing shall be deemed approved.

16 **Sec. 2.** RCW 48.44.020 and 2000 c 79 s 28 are each amended to read
17 as follows:

18 (1) Any health care service contractor may enter into contracts
19 with or for the benefit of persons or groups of persons which require
20 prepayment for health care services by or for such persons in
21 consideration of such health care service contractor providing one or
22 more health care services to such persons and such activity shall not
23 be subject to the laws relating to insurance if the health care
24 services are rendered by the health care service contractor or by a
25 participating provider.

26 (2) The commissioner may on examination, subject to the right of
27 the health care service contractor to demand and receive a hearing
28 under chapters 48.04 and 34.05 RCW, disapprove any individual or group
29 contract form for any of the following grounds:

30 (a) If it contains or incorporates by reference any inconsistent,
31 ambiguous or misleading clauses, or exceptions and conditions which
32 unreasonably or deceptively affect the risk purported to be assumed in
33 the general coverage of the contract; or

34 (b) If it has any title, heading, or other indication of its
35 provisions which is misleading; or

36 (c) If purchase of health care services thereunder is being
37 solicited by deceptive advertising; or

1 (d) If it contains unreasonable restrictions on the treatment of
2 patients; or

3 (e) If it violates any provision of this chapter; or

4 (f) If it fails to conform to minimum provisions or standards
5 required by regulation made by the commissioner pursuant to chapter
6 34.05 RCW; or

7 (g) If any contract for health care services with any state agency,
8 division, subdivision, board, or commission or with any political
9 subdivision, municipal corporation, or quasi-municipal corporation
10 fails to comply with state law.

11 (3) In addition to the grounds listed in subsection (2) of this
12 section, the commissioner may disapprove any (~~group~~) contract if the
13 benefits provided therein are unreasonable in relation to the amount
14 charged for the contract. Rates, or any modification of rates
15 effective on or after July 1, 2008, for individual health benefit plans
16 may not be used until sixty days after they are filed with the
17 commissioner. If the commissioner does not disapprove a rate filing
18 within sixty days after the health care service contractor has filed
19 the documents required in RCW 48.44.017(2) and any rules adopted
20 pursuant thereto, the filing shall be deemed approved.

21 (4)(a) Every contract between a health care service contractor and
22 a participating provider of health care services shall be in writing
23 and shall state that in the event the health care service contractor
24 fails to pay for health care services as provided in the contract, the
25 enrolled participant shall not be liable to the provider for sums owed
26 by the health care service contractor. Every such contract shall
27 provide that this requirement shall survive termination of the
28 contract.

29 (b) No participating provider, agent, trustee, or assignee may
30 maintain any action against an enrolled participant to collect sums
31 owed by the health care service contractor.

32 **Sec. 3.** RCW 48.46.060 and 2000 c 79 s 31 are each amended to read
33 as follows:

34 (1) Any health maintenance organization may enter into agreements
35 with or for the benefit of persons or groups of persons, which require
36 prepayment for health care services by or for such persons in
37 consideration of the health maintenance organization providing health

1 care services to such persons. Such activity is not subject to the
2 laws relating to insurance if the health care services are rendered
3 directly by the health maintenance organization or by any provider
4 which has a contract or other arrangement with the health maintenance
5 organization to render health services to enrolled participants.

6 (2) All forms of health maintenance agreements issued by the
7 organization to enrolled participants or other marketing documents
8 purporting to describe the organization's comprehensive health care
9 services shall comply with such minimum standards as the commissioner
10 deems reasonable and necessary in order to carry out the purposes and
11 provisions of this chapter, and which fully inform enrolled
12 participants of the health care services to which they are entitled,
13 including any limitations or exclusions thereof, and such other rights,
14 responsibilities and duties required of the contracting health
15 maintenance organization.

16 (3) Subject to the right of the health maintenance organization to
17 demand and receive a hearing under chapters 48.04 and 34.05 RCW, the
18 commissioner may disapprove an individual or group agreement form for
19 any of the following grounds:

20 (a) If it contains or incorporates by reference any inconsistent,
21 ambiguous, or misleading clauses, or exceptions or conditions which
22 unreasonably or deceptively affect the risk purported to be assumed in
23 the general coverage of the agreement;

24 (b) If it has any title, heading, or other indication which is
25 misleading;

26 (c) If purchase of health care services thereunder is being
27 solicited by deceptive advertising;

28 (d) If it contains unreasonable restrictions on the treatment of
29 patients;

30 (e) If it is in any respect in violation of this chapter or if it
31 fails to conform to minimum provisions or standards required by the
32 commissioner by rule under chapter 34.05 RCW; or

33 (f) If any agreement for health care services with any state
34 agency, division, subdivision, board, or commission or with any
35 political subdivision, municipal corporation, or quasi-municipal
36 corporation fails to comply with state law.

37 (4) In addition to the grounds listed in subsection (2) of this
38 section, the commissioner may disapprove any ((group)) agreement if the

1 benefits provided therein are unreasonable in relation to the amount
2 charged for the agreement. Rates, or any modification of rates
3 effective on or after July 1, 2008, for individual health benefit plans
4 may not be used until sixty days after they are filed with the
5 commissioner. If the commissioner does not disapprove a rate filing
6 within sixty days after the health maintenance organization has filed
7 the documents required in RCW 48.46.062(2) and any rules adopted
8 pursuant thereto, the filing shall be deemed approved.

9 (5) No health maintenance organization authorized under this
10 chapter shall cancel or fail to renew the enrollment on any basis of an
11 enrolled participant or refuse to transfer an enrolled participant from
12 a group to an individual basis for reasons relating solely to age, sex,
13 race, or health status. Nothing contained herein shall prevent
14 cancellation of an agreement with enrolled participants (a) who violate
15 any published policies of the organization which have been approved by
16 the commissioner, or (b) who are entitled to become eligible for
17 medicare benefits and fail to enroll for a medicare supplement plan
18 offered by the health maintenance organization and approved by the
19 commissioner, or (c) for failure of such enrolled participant to pay
20 the approved charge, including cost-sharing, required under such
21 contract, or (d) for a material breach of the health maintenance
22 agreement.

23 (6) No agreement form or amendment to an approved agreement form
24 shall be used unless it is first filed with the commissioner.

25 **Sec. 4.** RCW 48.20.025 and 2003 c 248 s 8 are each amended to read
26 as follows:

27 (1) The definitions in this subsection apply throughout this
28 section unless the context clearly requires otherwise.

29 (a) "Claims" means the cost to the insurer of health care services,
30 as defined in RCW 48.43.005, provided to a policyholder or paid to or
31 on behalf of the policyholder in accordance with the terms of a health
32 benefit plan, as defined in RCW 48.43.005. This includes capitation
33 payments or other similar payments made to providers for the purpose of
34 paying for health care services for a policyholder.

35 (b) "Claims reserves" means: (i) The liability for claims which
36 have been reported but not paid; (ii) the liability for claims which

1 have not been reported but which may reasonably be expected; (iii)
2 active life reserves; and (iv) additional claims reserves whether for
3 a specific liability purpose or not.

4 (c) "Declination rate" for an insurer means the percentage of the
5 total number of applicants for individual health benefit plans received
6 by that insurer in the aggregate in the applicable year which are not
7 accepted for enrollment by that insurer based on the results of the
8 standard health questionnaire administered pursuant to RCW
9 48.43.018(2)(a).

10 (d) "Earned premiums" means premiums, as defined in RCW 48.43.005,
11 plus any rate credits or recoupments less any refunds, for the
12 applicable period, whether received before, during, or after the
13 applicable period.

14 ~~((d))~~ (e) "Incurred claims expense" means claims paid during the
15 applicable period plus any increase, or less any decrease, in the
16 claims reserves.

17 ~~((e))~~ (f) "Loss ratio" means incurred claims expense as a
18 percentage of earned premiums.

19 ~~((f))~~ (g) "Reserves" means: (i) Active life reserves; and (ii)
20 additional reserves whether for a specific liability purpose or not.

21 ~~(2) ((An insurer shall file, for informational purposes only, a~~
22 ~~notice of its schedule of rates for its individual health benefit plans~~
23 ~~with the commissioner prior to use.~~

24 ~~(3))~~ An insurer ~~((shall))~~ must file ~~((with the notice required~~
25 ~~under subsection (2) of this section))~~ supporting documentation of its
26 method of determining the rates charged~~((.~~~~—The commissioner may~~
27 ~~request only))~~ for its individual health benefit plans. At a minimum,
28 the insurer must provide the following supporting documentation:

29 (a) A description of the insurer's rate-making methodology;

30 (b) An actuarially determined estimate of incurred claims which
31 includes the experience data, assumptions, and justifications of the
32 insurer's projection;

33 (c) The percentage of premium attributable in aggregate for
34 nonclaims expenses used to determine the adjusted community rates
35 charged; and

36 (d) A certification by a member of the American academy of
37 actuaries, or other person approved by the commissioner, that the
38 adjusted community rate charged can be reasonably expected to result in

1 a loss ratio that meets or exceeds the loss ratio standard
2 (~~established in subsection (7) of this section~~) of seventy-four
3 percent, minus the premium tax rate applicable to the insurer's
4 individual health benefit plans under RCW 48.14.020.

5 ~~((4) The commissioner may not disapprove or otherwise impede the~~
6 ~~implementation of the filed rates.~~

7 ~~(5))~~ (3) By the last day of May each year any insurer issuing or
8 renewing individual health benefit plans in this state during the
9 preceding calendar year shall file for review by the commissioner
10 supporting documentation of its actual loss ratio and its actual
11 declination rate for its individual health benefit plans offered or
12 renewed in the state in aggregate for the preceding calendar year. The
13 filing shall include aggregate earned premiums, aggregate incurred
14 claims, and a certification by a member of the American academy of
15 actuaries, or other person approved by the commissioner, that the
16 actual loss ratio has been calculated in accordance with accepted
17 actuarial principles.

18 (a) At the expiration of a thirty-day period beginning with the
19 date the filing is received by the commissioner, the filing shall be
20 deemed approved unless prior thereto the commissioner contests the
21 calculation of the actual loss ratio.

22 (b) If the commissioner contests the calculation of the actual loss
23 ratio, the commissioner shall state in writing the grounds for
24 contesting the calculation to the insurer.

25 (c) Any dispute regarding the calculation of the actual loss ratio
26 shall, upon written demand of either the commissioner or the insurer,
27 be submitted to hearing under chapters 48.04 and 34.05 RCW.

28 ~~((6))~~ (4) If the actual loss ratio for the preceding calendar
29 year is less than the loss ratio established in subsection ~~((7))~~ (5)
30 of this section, a remittance is due and the following shall apply:

31 (a) The insurer shall calculate a percentage of premium to be
32 remitted to the Washington state health insurance pool by subtracting
33 the actual loss ratio for the preceding year from the loss ratio
34 established in subsection ~~((7))~~ (5) of this section.

35 (b) The remittance to the Washington state health insurance pool is
36 the percentage calculated in (a) of this subsection, multiplied by the
37 premium earned from each enrollee in the previous calendar year.

1 Interest shall be added to the remittance due at a five percent annual
2 rate calculated from the end of the calendar year for which the
3 remittance is due to the date the remittance is made.

4 (c) All remittances shall be aggregated and such amounts shall be
5 remitted to the Washington state high risk pool to be used as directed
6 by the pool board of directors.

7 (d) Any remittance required to be issued under this section shall
8 be issued within thirty days after the actual loss ratio is deemed
9 approved under subsection ~~((+5+))~~ (3)(a) of this section or the
10 determination by an administrative law judge under subsection ~~((+5+))~~
11 (3)(c) of this section.

12 ~~((+7+))~~ (5) The loss ratio applicable to this section shall be
13 ~~((seventy-four percent))~~ the percentage set forth in the following
14 schedule that correlates to the insurer's actual declination rate in
15 the preceding year, minus the premium tax rate applicable to the
16 insurer's individual health benefit plans under RCW 48.14.020.

<u>Actual Declination Rate</u>	<u>Loss Ratio</u>
<u>Under Six Percent (6%)</u>	<u>Seventy-Four Percent (74%)</u>
<u>Six Percent (6%) or more (but less than Seven Percent)</u>	<u>Seventy-Five Percent (75%)</u>
<u>Seven Percent (7%) or more (but less than Eight Percent)</u>	<u>Seventy-Six Percent (76%)</u>
<u>Eight Percent (8%) or more</u>	<u>Seventy-Seven Percent (77%)</u>

22 **Sec. 5.** RCW 48.44.017 and 2001 c 196 s 11 are each amended to read
23 as follows:

24 (1) The definitions in this subsection apply throughout this
25 section unless the context clearly requires otherwise.

26 (a) "Claims" means the cost to the health care service contractor
27 of health care services, as defined in RCW 48.43.005, provided to a
28 contract holder or paid to or on behalf of a contract holder in
29 accordance with the terms of a health benefit plan, as defined in RCW
30 48.43.005. This includes capitation payments or other similar payments
31 made to providers for the purpose of paying for health care services
32 for an enrollee.

33 (b) "Claims reserves" means: (i) The liability for claims which
34 have been reported but not paid; (ii) the liability for claims which
35 have not been reported but which may reasonably be expected; (iii)

1 active life reserves; and (iv) additional claims reserves whether for
2 a specific liability purpose or not.

3 (c) "Declination rate" for a health care service contractor means
4 the percentage of the total number of applicants for individual health
5 benefit plans received by that health care service contractor in the
6 aggregate in the applicable year which are not accepted for enrollment
7 by that health care service contractor based on the results of the
8 standard health questionnaire administered pursuant to RCW
9 48.43.018(2)(a).

10 (d) "Earned premiums" means premiums, as defined in RCW 48.43.005,
11 plus any rate credits or recoupments less any refunds, for the
12 applicable period, whether received before, during, or after the
13 applicable period.

14 ~~((d))~~ (e) "Incurred claims expense" means claims paid during the
15 applicable period plus any increase, or less any decrease, in the
16 claims reserves.

17 ~~((e))~~ (f) "Loss ratio" means incurred claims expense as a
18 percentage of earned premiums.

19 ~~((f))~~ (g) "Reserves" means: (i) Active life reserves; and (ii)
20 additional reserves whether for a specific liability purpose or not.

21 ~~(2) ((A health care service contractor shall file, for~~
22 ~~informational purposes only, a notice of its schedule of rates for its~~
23 ~~individual contracts with the commissioner prior to use.~~

24 ~~(3))~~ A health care service contractor ~~((shall))~~ must file ~~((with~~
25 ~~the notice required under subsection (2) of this section))~~ supporting
26 documentation of its method of determining the rates charged~~((.~~
27 ~~—The commissioner may request only))~~ for its individual contracts. At a
28 minimum, the health care service contractor must provide the following
29 supporting documentation:

30 (a) A description of the health care service contractor's rate-
31 making methodology;

32 (b) An actuarially determined estimate of incurred claims which
33 includes the experience data, assumptions, and justifications of the
34 health care service contractor's projection;

35 (c) The percentage of premium attributable in aggregate for
36 nonclaims expenses used to determine the adjusted community rates
37 charged; and

1 (d) A certification by a member of the American academy of
2 actuaries, or other person approved by the commissioner, that the
3 adjusted community rate charged can be reasonably expected to result in
4 a loss ratio that meets or exceeds the loss ratio standard
5 (~~established in subsection (7) of this section~~) of seventy-four
6 percent, minus the premium tax rate applicable to the carrier's
7 individual health benefit plans under RCW 48.14.0201.

8 (~~(4) The commissioner may not disapprove or otherwise impede the~~
9 ~~implementation of the filed rates.~~

10 ~~(5))~~ (3) By the last day of May each year any health care service
11 contractor issuing or renewing individual health benefit plans in this
12 state during the preceding calendar year shall file for review by the
13 commissioner supporting documentation of its actual loss ratio and its
14 actual declination rate for its individual health benefit plans offered
15 or renewed in this state in aggregate for the preceding calendar year.
16 The filing shall include aggregate earned premiums, aggregate incurred
17 claims, and a certification by a member of the American academy of
18 actuaries, or other person approved by the commissioner, that the
19 actual loss ratio has been calculated in accordance with accepted
20 actuarial principles.

21 (a) At the expiration of a thirty-day period beginning with the
22 date the filing is received by the commissioner, the filing shall be
23 deemed approved unless prior thereto the commissioner contests the
24 calculation of the actual loss ratio.

25 (b) If the commissioner contests the calculation of the actual loss
26 ratio, the commissioner shall state in writing the grounds for
27 contesting the calculation to the health care service contractor.

28 (c) Any dispute regarding the calculation of the actual loss ratio
29 shall upon written demand of either the commissioner or the health care
30 service contractor be submitted to hearing under chapters 48.04 and
31 34.05 RCW.

32 (~~(6))~~ (4) If the actual loss ratio for the preceding calendar
33 year is less than the loss ratio standard established in subsection
34 (~~(7))~~ (5) of this section, a remittance is due and the following
35 shall apply:

36 (a) The health care service contractor shall calculate a percentage
37 of premium to be remitted to the Washington state health insurance pool

1 by subtracting the actual loss ratio for the preceding year from the
2 loss ratio established in subsection ~~((+7))~~ (5) of this section.

3 (b) The remittance to the Washington state health insurance pool is
4 the percentage calculated in (a) of this subsection, multiplied by the
5 premium earned from each enrollee in the previous calendar year.
6 Interest shall be added to the remittance due at a five percent annual
7 rate calculated from the end of the calendar year for which the
8 remittance is due to the date the remittance is made.

9 (c) All remittances shall be aggregated and such amounts shall be
10 remitted to the Washington state high risk pool to be used as directed
11 by the pool board of directors.

12 (d) Any remittance required to be issued under this section shall
13 be issued within thirty days after the actual loss ratio is deemed
14 approved under subsection ~~((+5))~~ (3)(a) of this section or the
15 determination by an administrative law judge under subsection ~~((+5))~~
16 (3)(c) of this section.

17 ~~((+7))~~ (5) The loss ratio applicable to this section shall be
18 ~~((seventy-four percent))~~ the percentage set forth in the following
19 schedule that correlates to the health care service contractor's actual
20 declination rate in the preceding year, minus the premium tax rate
21 applicable to the health care service contractor's individual health
22 benefit plans under RCW 48.14.0201.

<u>Actual Declination Rate</u>	<u>Loss Ratio</u>
<u>Under Six Percent (6%)</u>	<u>Seventy-Four Percent (74%)</u>
<u>Six Percent (6%) or more (but less than Seven Percent)</u>	<u>Seventy-Five Percent (75%)</u>
<u>Seven Percent (7%) or more (but less than Eight Percent)</u>	<u>Seventy-Six Percent (76%)</u>
<u>Eight Percent (8%) or more</u>	<u>Seventy-Seven Percent (77%)</u>

28 **Sec. 6.** RCW 48.46.062 and 2001 c 196 s 12 are each amended to read
29 as follows:

30 (1) The definitions in this subsection apply throughout this
31 section unless the context clearly requires otherwise.

32 (a) "Claims" means the cost to the health maintenance organization
33 of health care services, as defined in RCW 48.43.005, provided to an
34 enrollee or paid to or on behalf of the enrollee in accordance with the
35 terms of a health benefit plan, as defined in RCW 48.43.005. This

1 includes capitation payments or other similar payments made to
2 providers for the purpose of paying for health care services for an
3 enrollee.

4 (b) "Claims reserves" means: (i) The liability for claims which
5 have been reported but not paid; (ii) the liability for claims which
6 have not been reported but which may reasonably be expected; (iii)
7 active life reserves; and (iv) additional claims reserves whether for
8 a specific liability purpose or not.

9 (c) "Declination rate" for a health maintenance organization means
10 the percentage of the total number of applicants for individual health
11 benefit plans received by that health maintenance organization in the
12 aggregate in the applicable year which are not accepted for enrollment
13 by that health maintenance organization based on the results of the
14 standard health questionnaire administered pursuant to RCW
15 48.43.018(2)(a).

16 (d) "Earned premiums" means premiums, as defined in RCW 48.43.005,
17 plus any rate credits or recoupments less any refunds, for the
18 applicable period, whether received before, during, or after the
19 applicable period.

20 ((+d)) (e) "Incurred claims expense" means claims paid during the
21 applicable period plus any increase, or less any decrease, in the
22 claims reserves.

23 ((+e)) (f) "Loss ratio" means incurred claims expense as a
24 percentage of earned premiums.

25 ((+f)) (g) "Reserves" means: (i) Active life reserves; and (ii)
26 additional reserves whether for a specific liability purpose or not.

27 (2) ~~((A health maintenance organization shall file, for~~
28 ~~informational purposes only, a notice of its schedule of rates for its~~
29 ~~individual agreements with the commissioner prior to use.~~

30 (+3)) A health maintenance organization ~~((shall))~~ must file ~~((with~~
31 ~~the notice required under subsection (2) of this section))~~ supporting
32 documentation of its method of determining the rates charged~~((.~~
33 ~~The commissioner may request only))~~ for its individual agreements. At a
34 minimum, the health maintenance organization must provide the following
35 supporting documentation:

36 (a) A description of the health maintenance organization's rate-
37 making methodology;

1 (b) An actuarially determined estimate of incurred claims which
2 includes the experience data, assumptions, and justifications of the
3 health maintenance organization's projection;

4 (c) The percentage of premium attributable in aggregate for
5 nonclaims expenses used to determine the adjusted community rates
6 charged; and

7 (d) A certification by a member of the American academy of
8 actuaries, or other person approved by the commissioner, that the
9 adjusted community rate charged can be reasonably expected to result in
10 a loss ratio that meets or exceeds the loss ratio standard
11 ~~((established in subsection (7) of this section))~~ of seventy-four
12 percent, minus the premium tax rate applicable to the carrier's
13 individual health benefit plans under RCW 48.14.0201.

14 ~~((4) The commissioner may not disapprove or otherwise impede the~~
15 ~~implementation of the filed rates.~~

16 ~~(5))~~ (3) By the last day of May each year any health maintenance
17 organization issuing or renewing individual health benefit plans in
18 this state during the preceding calendar year shall file for review by
19 the commissioner supporting documentation of its actual loss ratio and
20 its actual declination rate for its individual health benefit plans
21 offered or renewed in the state in aggregate for the preceding calendar
22 year. The filing shall include aggregate earned premiums, aggregate
23 incurred claims, and a certification by a member of the American
24 academy of actuaries, or other person approved by the commissioner,
25 that the actual loss ratio has been calculated in accordance with
26 accepted actuarial principles.

27 (a) At the expiration of a thirty-day period beginning with the
28 date the filing is received by the commissioner, the filing shall be
29 deemed approved unless prior thereto the commissioner contests the
30 calculation of the actual loss ratio.

31 (b) If the commissioner contests the calculation of the actual loss
32 ratio, the commissioner shall state in writing the grounds for
33 contesting the calculation to the health maintenance organization.

34 (c) Any dispute regarding the calculation of the actual loss ratio
35 shall, upon written demand of either the commissioner or the health
36 maintenance organization, be submitted to hearing under chapters 48.04
37 and 34.05 RCW.

1 ~~((+6+))~~ (4) If the actual loss ratio for the preceding calendar
2 year is less than the loss ratio standard established in subsection
3 ~~((+7+))~~ (5) of this section, a remittance is due and the following
4 shall apply:

5 (a) The health maintenance organization shall calculate a
6 percentage of premium to be remitted to the Washington state health
7 insurance pool by subtracting the actual loss ratio for the preceding
8 year from the loss ratio established in subsection ~~((+7+))~~ (5) of this
9 section.

10 (b) The remittance to the Washington state health insurance pool is
11 the percentage calculated in (a) of this subsection, multiplied by the
12 premium earned from each enrollee in the previous calendar year.
13 Interest shall be added to the remittance due at a five percent annual
14 rate calculated from the end of the calendar year for which the
15 remittance is due to the date the remittance is made.

16 (c) All remittances shall be aggregated and such amounts shall be
17 remitted to the Washington state high risk pool to be used as directed
18 by the pool board of directors.

19 (d) Any remittance required to be issued under this section shall
20 be issued within thirty days after the actual loss ratio is deemed
21 approved under subsection ~~((+5+))~~ (3)(a) of this section or the
22 determination by an administrative law judge under subsection ~~((+5+))~~
23 (3)(c) of this section.

24 ~~((+7+))~~ (5) The loss ratio applicable to this section shall be
25 ~~((seventy-four percent))~~ the percentage set forth in the following
26 schedule that correlates to the health maintenance organization's
27 actual declination rate in the preceding year, minus the premium tax
28 rate applicable to the health maintenance organization's individual
29 health benefit plans under RCW 48.14.0201.

<u>Actual Declination Rate</u>	<u>Loss Ratio</u>
<u>Under Six Percent (6%)</u>	<u>Seventy-Four Percent (74%)</u>
<u>Six Percent (6%) or more (but less than Seven Percent)</u>	<u>Seventy-Five Percent (75%)</u>
<u>Seven Percent (7%) or more (but less than Eight Percent)</u>	<u>Seventy-Six Percent (76%)</u>
<u>Eight Percent (8%) or more</u>	<u>Seventy-Seven Percent (77%)</u>

35 NEW SECTION. **Sec. 7.** The insurance commissioner's authority to

1 review and disapprove rates for individual products, as established in
2 sections 1 through 6 of this act, expires January 1, 2012.

3 NEW SECTION. **Sec. 8.** (1) The office of the insurance commissioner
4 shall explore the feasibility of entering into a multistate health
5 insurance plan compact for the purpose of providing affordable health
6 insurance coverage for persons purchasing individual health coverage.
7 The office of the insurance commissioner shall propose model state
8 legislation that each participating state would enact prior to entering
9 into the multistate health insurance plan compact. If federal
10 legislation is necessary to permit the operation of the multistate
11 health insurance plan, the office of the insurance commissioner shall
12 identify needed changes in federal statutes and rules.

13 (2) The office of the insurance commissioner shall report the
14 findings and recommendations of the feasibility study to the
15 appropriate committees of the senate and house of representatives by
16 December 1, 2008.

Passed by the Senate March 8, 2008.

Passed by the House February 29, 2008.

Approved by the Governor April 1, 2008.

Filed in Office of Secretary of State April 2, 2008.