

---

**SUBSTITUTE SENATE BILL 5261**

---

**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 a new section.

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, for individual health benefit plans may not be  
11 used until sixty days after they are filed with the commissioner.

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

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

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

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

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

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

34 (d) If it contains unreasonable restrictions on the treatment of  
35 patients; or

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

1 (f) If it fails to conform to minimum provisions or standards  
2 required by regulation made by the commissioner pursuant to chapter  
3 34.05 RCW; or

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

8 (3) In addition to the grounds listed in subsection (2) of this  
9 section, the commissioner may disapprove any group contract if the  
10 benefits provided therein are unreasonable in relation to the amount  
11 charged for the contract. Rates, or any modification of rates, for  
12 individual health benefit plans may not be used until sixty days after  
13 they are filed with the commissioner.

14 (4)(a) Every contract between a health care service contractor and  
15 a participating provider of health care services shall be in writing  
16 and shall state that in the event the health care service contractor  
17 fails to pay for health care services as provided in the contract, the  
18 enrolled participant shall not be liable to the provider for sums owed  
19 by the health care service contractor. Every such contract shall  
20 provide that this requirement shall survive termination of the  
21 contract.

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

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

27 (1) Any health maintenance organization may enter into agreements  
28 with or for the benefit of persons or groups of persons, which require  
29 prepayment for health care services by or for such persons in  
30 consideration of the health maintenance organization providing health  
31 care services to such persons. Such activity is not subject to the  
32 laws relating to insurance if the health care services are rendered  
33 directly by the health maintenance organization or by any provider  
34 which has a contract or other arrangement with the health maintenance  
35 organization to render health services to enrolled participants.

36 (2) All forms of health maintenance agreements issued by the  
37 organization to enrolled participants or other marketing documents

1 purporting to describe the organization's comprehensive health care  
2 services shall comply with such minimum standards as the commissioner  
3 deems reasonable and necessary in order to carry out the purposes and  
4 provisions of this chapter, and which fully inform enrolled  
5 participants of the health care services to which they are entitled,  
6 including any limitations or exclusions thereof, and such other rights,  
7 responsibilities and duties required of the contracting health  
8 maintenance organization.

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

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

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

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

21 (d) If it contains unreasonable restrictions on the treatment of  
22 patients;

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

26 (f) If any agreement for health care services with any state  
27 agency, division, subdivision, board, or commission or with any  
28 political subdivision, municipal corporation, or quasi-municipal  
29 corporation fails to comply with state law.

30 (4) In addition to the grounds listed in subsection (2) of this  
31 section, the commissioner may disapprove any (~~group~~) agreement if the  
32 benefits provided therein are unreasonable in relation to the amount  
33 charged for the agreement. Rates, or any modification of rates, for  
34 individual health benefit plans may not be used until sixty days after  
35 they are filed with the commissioner.

36 (5) No health maintenance organization authorized under this  
37 chapter shall cancel or fail to renew the enrollment on any basis of an  
38 enrolled participant or refuse to transfer an enrolled participant from

1 a group to an individual basis for reasons relating solely to age, sex,  
2 race, or health status. Nothing contained herein shall prevent  
3 cancellation of an agreement with enrolled participants (a) who violate  
4 any published policies of the organization which have been approved by  
5 the commissioner, or (b) who are entitled to become eligible for  
6 medicare benefits and fail to enroll for a medicare supplement plan  
7 offered by the health maintenance organization and approved by the  
8 commissioner, or (c) for failure of such enrolled participant to pay  
9 the approved charge, including cost-sharing, required under such  
10 contract, or (d) for a material breach of the health maintenance  
11 agreement.

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

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

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

18 (a) "Claims" means the cost to the insurer of health care services,  
19 as defined in RCW 48.43.005, provided to a policyholder or paid to or  
20 on behalf of the policyholder in accordance with the terms of a health  
21 benefit plan, as defined in RCW 48.43.005. This includes capitation  
22 payments or other similar payments made to providers for the purpose of  
23 paying for health care services for a policyholder.

24 (b) "Claims reserves" means: (i) The liability for claims which  
25 have been reported but not paid; (ii) the liability for claims which  
26 have not been reported but which may reasonably be expected; (iii)  
27 active life reserves; and (iv) additional claims reserves whether for  
28 a specific liability purpose or not.

29 (c) "Earned premiums" means premiums, as defined in RCW 48.43.005,  
30 plus any rate credits or recoupments less any refunds, for the  
31 applicable period, whether received before, during, or after the  
32 applicable period.

33 (d) "Incurred claims expense" means claims paid during the  
34 applicable period plus any increase, or less any decrease, in the  
35 claims reserves.

36 (e) "Loss ratio" means incurred claims expense as a percentage of  
37 earned premiums.

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

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

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

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

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

15 (c) The percentage of premium attributable in aggregate for  
16 nonclaims expenses used to determine the adjusted community rates  
17 charged; and

18 (d) A certification by a member of the American academy of  
19 actuaries, or other person approved by the commissioner, that the  
20 adjusted community rate charged can be reasonably expected to result in  
21 a loss ratio that meets or exceeds the loss ratio standard established  
22 in subsection ~~((7))~~ (5) of this section.

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

25 ~~(5))~~ (3) By the last day of May each year any insurer issuing or  
26 renewing individual health benefit plans in this state during the  
27 preceding calendar year shall file for review by the commissioner  
28 supporting documentation of its actual loss ratio for its individual  
29 health benefit plans offered or renewed in the state in aggregate for  
30 the preceding calendar year. The filing shall include aggregate earned  
31 premiums, aggregate incurred claims, and a certification by a member of  
32 the American academy of actuaries, or other person approved by the  
33 commissioner, that the actual loss ratio has been calculated in  
34 accordance with accepted actuarial principles.

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

1 (b) If the commissioner contests the calculation of the actual loss  
2 ratio, the commissioner shall state in writing the grounds for  
3 contesting the calculation to the insurer.

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

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

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

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

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

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

28 ~~((+7))~~ (5) The loss ratio applicable to this section shall be  
29 ~~((seventy—four))~~ seventy-seven percent minus the premium tax rate  
30 applicable to the insurer's individual health benefit plans under RCW  
31 48.14.020.

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

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

36 (a) "Claims" means the cost to the health care service contractor  
37 of health care services, as defined in RCW 48.43.005, provided to a

1 contract holder or paid to or on behalf of a contract holder in  
2 accordance with the terms of a health benefit plan, as defined in RCW  
3 48.43.005. This includes capitation payments or other similar payments  
4 made to providers for the purpose of paying for health care services  
5 for an enrollee.

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

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

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

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

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

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

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

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

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

36 (c) The percentage of premium attributable in aggregate for  
37 nonclaims expenses used to determine the adjusted community rates  
38 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 established  
5 in subsection ~~((+7))~~ (5) of this section.

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

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

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

29 ~~((+6))~~ (4) If the actual loss ratio for the preceding calendar  
30 year is less than the loss ratio standard established in subsection  
31 ~~((+7))~~ (5) of this section, a remittance is due and the following  
32 shall apply:

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

37 (b) The remittance to the Washington state health insurance pool is  
38 the percentage calculated in (a) of this subsection, multiplied by the

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

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

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

13 ~~((+7))~~ (5) The loss ratio applicable to this section shall be  
14 ~~((seventy—four))~~ seventy-seven percent minus the premium tax rate  
15 applicable to the health care service contractor's individual health  
16 benefit plans under RCW 48.14.0201.

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

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

21 (a) "Claims" means the cost to the health maintenance organization  
22 of health care services, as defined in RCW 48.43.005, provided to an  
23 enrollee or paid to or on behalf of the enrollee in accordance with the  
24 terms of a health benefit plan, as defined in RCW 48.43.005. This  
25 includes capitation payments or other similar payments made to  
26 providers for the purpose of paying for health care services for an  
27 enrollee.

28 (b) "Claims reserves" means: (i) The liability for claims which  
29 have been reported but not paid; (ii) the liability for claims which  
30 have not been reported but which may reasonably be expected; (iii)  
31 active life reserves; and (iv) additional claims reserves whether for  
32 a specific liability purpose or not.

33 (c) "Earned premiums" means premiums, as defined in RCW 48.43.005,  
34 plus any rate credits or recoupments less any refunds, for the  
35 applicable period, whether received before, during, or after the  
36 applicable period.

1 (d) "Incurred claims expense" means claims paid during the  
2 applicable period plus any increase, or less any decrease, in the  
3 claims reserves.

4 (e) "Loss ratio" means incurred claims expense as a percentage of  
5 earned premiums.

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

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

11 ~~(3))~~ A health maintenance organization ~~((shall))~~ must file ~~((with  
12 the notice required under subsection (2) of this section))~~ supporting  
13 documentation of its method of determining the rates charged~~((The  
14 commissioner may request only))~~ for its individual agreements. At a  
15 minimum, the health maintenance organization must provide the following  
16 supporting documentation:

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

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

22 (c) The percentage of premium attributable in aggregate for  
23 nonclaims expenses used to determine the adjusted community rates  
24 charged; and

25 (d) A certification by a member of the American academy of  
26 actuaries, or other person approved by the commissioner, that the  
27 adjusted community rate charged can be reasonably expected to result in  
28 a loss ratio that meets or exceeds the loss ratio standard established  
29 in subsection ~~((7))~~ (5) of this section.

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

32 ~~(5))~~ (3) By the last day of May each year any health maintenance  
33 organization issuing or renewing individual health benefit plans in  
34 this state during the preceding calendar year shall file for review by  
35 the commissioner supporting documentation of its actual loss ratio for  
36 its individual health benefit plans offered or renewed in the state in  
37 aggregate for the preceding calendar year. The filing shall include  
38 aggregate earned premiums, aggregate incurred claims, and a

1 certification by a member of the American academy of actuaries, or  
2 other person approved by the commissioner, that the actual loss ratio  
3 has been calculated in accordance with accepted actuarial principles.

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

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

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

15 ~~((+6+))~~ (4) If the actual loss ratio for the preceding calendar  
16 year is less than the loss ratio standard established in subsection  
17 ~~((+7+))~~ (5) of this section, a remittance is due and the following  
18 shall apply:

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

24 (b) The remittance to the Washington state health insurance pool is  
25 the percentage calculated in (a) of this subsection, multiplied by the  
26 premium earned from each enrollee in the previous calendar year.  
27 Interest shall be added to the remittance due at a five percent annual  
28 rate calculated from the end of the calendar year for which the  
29 remittance is due to the date the remittance is made.

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

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

1           ((~~7~~)) (5) The loss ratio applicable to this section shall be  
2   (~~seventy-four~~) seventy-seven percent minus the premium tax rate  
3   applicable to the health maintenance organization's individual health  
4   benefit plans under RCW 48.14.0201.

5           NEW SECTION. **Sec. 7.** The insurance commissioner's ability to  
6   review and disapprove rates for individual products, as established in  
7   sections 1 through 6 of this act, expires January 1, 2012.

--- END ---