WAC 284-66-243 Filing and approval of policies and certificates and premium rates. (1) An issuer may not deliver or issue for delivery a policy or certificate to a resident of this state unless the policy form or certificate form has been filed with and approved by the commissioner according to the filing requirements and procedures prescribed by the commissioner.

(2) An issuer may not use or change premium rates for a medicare supplement policy or certificate unless the rates, rating schedule, and supporting documentation have been filed with and approved by the commissioner according to the filing requirements and procedures prescribed by the commissioner.

(3)(a) Except as provided in (b) of this subsection, an issuer may not file for approval more than one form of a policy or certificate of each type for each standard medicare supplement benefit plan.

(b) An issuer may offer, with the approval of the commissioner, up to four additional policy forms or certificate forms of the same type for the same standard medicare supplement benefit plan, one for each of the following cases:

(i) The inclusion of new or innovative benefits;

(ii) The addition of either direct response or insurance producer marketing methods;

(iii) The addition of either guaranteed issue or underwritten coverage;

(iv) The offering of coverage to individuals eligible for medicare by reason of disability. The form number for products offered to enrollees who are eligible by reason of disability must be distinct from the form number used for a corresponding standardized plan offered to an enrollee eligible for medicare by reason of age.

(c) For the purposes of this section, a "type" means an individual policy, a group policy, an individual medicare SELECT policy, or a group medicare SELECT policy.

(4)(a) Except as provided in (a)(i) of this subsection, an issuer must continue to make available for purchase any policy form or certificate form issued after the effective date of this regulation that has been approved by the commissioner. A policy form or certificate form is not considered to be available for purchase unless the issuer has actively offered it for sale in the previous twelve months.

(i) An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the commissioner in writing its decision at least thirty days before discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the commissioner, the issuer may no longer offer for sale the policy form or certificate form in this state.

(ii) An issuer that discontinues the availability of a policy form or certificate form under (a)(i) of this subsection, may not file for approval a new policy form or certificate form of the same type for the same standard medicare supplement benefit plan as the discontinued form for a period of five years after the issuer provides notice to the commissioner of the discontinuance. The period of discontinuance may be reduced if the commissioner determines that a shorter period is appropriate.

(b) The sale or other transfer of medicare supplement business to another issuer is considered a discontinuance for the purposes of this subsection.

(c) A change in the rating structure or methodology is considered a discontinuance under (a) of this subsection, unless the issuer complies with the following requirements:

(i) The issuer provides an actuarial memorandum, in a form and manner prescribed by the commissioner, describing the manner in that the revised rating methodology and resultant rates differ from the existing rating methodology and resultant rates.

(ii) The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The commissioner may approve a change to the differential that is in the public interest.

(5)(a) Except as provided in (b) of this subsection, the experience of all policy forms or certificate forms of the same type in a standard medicare supplement benefit plan must be combined for purposes of the refund or credit calculation prescribed in WAC 284-66-203.

(b) Forms assumed under an assumption reinsurance agreement may not be combined with the experience of other forms for purposes of the refund or credit calculation.

(6) An issuer may set rates only on a community rated basis or on an issue-age level premium basis for policies issued prior to January 1, 1996, and may set rates only on a community rated basis for policies issued after December 31, 1995.

(a) For policies issued prior to January 1, 1996, community rated premiums must be equal for all individual policyholders or certificateholders under a standardized medicare supplement benefit form. Such premiums may not vary by age or sex. For policies issued after December 31, 1995, community rated premiums must be set according to RCW 48.66.045(3).

(b) Issue-age level premiums must be calculated for the lifetime of the insured. This will result in a level premium if the effects of inflation are ignored.

(7) All filings of policy or certificate forms must be accompanied by the proposed application form, outline of coverage form, proposed rate schedule, and an actuarial memorandum completed, signed and dated by a qualified actuary as defined in WAC 284-05-060. In addition to the actuarial memorandum, the following supporting documentation must be submitted to demonstrate to the satisfaction of the commissioner that rates are not excessive, inadequate, or unfairly discriminatory and otherwise comply with the requirements of this chapter:

(a) Anticipated loss ratios stated on a calendar year basis by duration for the period for which the policy is rated. Filings of future rate adjustments must contain the actual calendar year loss ratios experienced since inception, both before and after the refund required, if any and the actual loss ratios in comparison to the expected loss ratios stated in the initial rate filing on a calendar year basis by duration if applicable;

(b) Anticipated total termination rates on a calendar year basis by duration for the period for which the policy is rated. The termination rates should be stated as a percentage and the source of the mortality assumption must be specified. Filings of future rate adjustments must include the actual total termination rates stated on a calendar year basis since inception;

(c) Expense assumptions including fixed and percentage expenses for acquisition and maintenance costs;

(d) Schedule of total compensation payable to insurance producers and other producers as a percentage of premium, if any;

(e) A complete specimen copy of the compensation agreements or contracts between the issuer and its insurance producers, as well as the contracts between any insurance producers or others whose compen-

sation is based in whole or in part on the sale of medicare supplement insurance policies. The agreements must demonstrate compliance with WAC 284-66-350 (where appropriate);

(f) Other data necessary in the reasonable opinion of the commissioner to substantiate the filing.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.010(5). WSR 11-01-159 (Matter No. R 2010-09), § 284-66-243, filed 12/22/10, effective 1/22/11. Statutory Authority: RCW 48.66.030 (3)(a), 48.66.041, and 48.66.165. WSR 09-24-052 (Matter No. R 2009-08), § 284-66-243, filed 11/24/09, effective 1/19/10. Statutory Authority: RCW 48.02.060 and 48.66.165. WSR 05-17-019 (Matter No. R 2004-08), § 284-66-243, filed 8/4/05, effective 9/4/05. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130 and 48.46.200. WSR 92-06-021 (Order R 92-1), § 284-66-243, filed 2/25/92, effective 3/27/92.]