S-4749.1

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.

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

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

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

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

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

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

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

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

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

(2) In addition to the grounds for disapproval of any such form as provided in subsection (1) of this section, the commissioner may disapprove any form of disability insurance policy((~~, except an individual health benefit plan,~~)) if the benefits provided therein are unreasonable in relation to the premium charged. Rates, or any modification of rates, for individual health benefit plans may not be used until sixty days after they are filed with the commissioner.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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