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ENGROSSED SENATE BILL 5261

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State of Washington

60th Legislature

2007 Regular Session

By Senators Keiser, Franklin, Kohl-Welles, Fairley and Kline; by request of Insurance Commissioner

Read first time 01/15/2007. Referred to Committee on Health & Long-Term Care.

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

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 file with the notice required under subsection  
7 (2) of this section supporting documentation of its method of  
8 determining the rates charged. The commissioner may request only the  
9 following supporting documentation:

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

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

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

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

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

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

34 (a) At the expiration of a thirty-day period beginning with the  
35 date the filing is received by the commissioner, the filing shall be  
36 deemed approved unless prior thereto the commissioner contests the  
37 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) If the actual loss ratio for the preceding calendar year is  
8 less than the loss ratio established in subsection (7) of this section,  
9 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) 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)(a) of this section or the determination  
26 by an administrative law judge under subsection (5)(c) of this section.

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

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

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

34 (a) "Claims" means the cost to the health care service contractor  
35 of health care services, as defined in RCW 48.43.005, provided to a  
36 contract holder or paid to or on behalf of a contract holder in  
37 accordance with the terms of a health benefit plan, as defined in RCW

1 48.43.005. This includes capitation payments or other similar payments  
2 made to providers for the purpose of paying for health care services  
3 for an 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) "Earned premiums" means premiums, as defined in RCW 48.43.005,  
10 plus any rate credits or recoupments less any refunds, for the  
11 applicable period, whether received before, during, or after the  
12 applicable period.

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

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

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

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

23 (3) A health care service contractor shall file with the notice  
24 required under subsection (2) of this section supporting documentation  
25 of its method of determining the rates charged. The commissioner may  
26 request only the following supporting documentation:

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

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

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

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



1 a loss ratio that meets or exceeds the loss ratio standard established  
2 in subsection (7) of this section.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

35 (e) "Loss ratio" means incurred claims expense as a percentage of  
36 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) A health maintenance organization shall file, for informational  
4 purposes only, a notice of its schedule of rates for its individual  
5 agreements with the commissioner prior to use.

6 (3) A health maintenance organization shall file with the notice  
7 required under subsection (2) of this section supporting documentation  
8 of its method of determining the rates charged. The commissioner may  
9 request only the following supporting documentation:

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

12 (b) An actuarially determined estimate of incurred claims which  
13 includes the experience data, assumptions, and justifications of the  
14 health maintenance organization'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) of this section.

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

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

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

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

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

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

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

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

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

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