

ESSB 5261 - H COMM AMD

By Committee on Health Care & Wellness

ADOPTED AND ENGROSSED 2/29/08

1 Strike everything after the enacting clause and insert the  
2 following:

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

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

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

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

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

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

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

21 (2) In addition to the grounds for disapproval of any such form as  
22 provided in subsection (1) of this section, the commissioner may  
23 disapprove any form of disability insurance policy(~~(, except an~~  
24 ~~individual health benefit plan,~~)) if the benefits provided therein are  
25 unreasonable in relation to the premium charged. Rates, or any  
26 modification of rates effective on or after July 1, 2008, for  
27 individual health benefit plans may not be used until sixty days after  
28 they are filed with the commissioner. If the commissioner does not  
29 disapprove a rate filing within sixty days after the insurer has filed

1 the documents required in RCW 48.20.025(2) and any rules adopted  
2 pursuant thereto, the filing shall be deemed approved.

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

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

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

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

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

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

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

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

28 (f) If it fails to conform to minimum provisions or standards  
29 required by regulation made by the commissioner pursuant to chapter  
30 34.05 RCW; or

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

35 (3) In addition to the grounds listed in subsection (2) of this  
36 section, the commissioner may disapprove any (~~group~~) contract if the  
37 benefits provided therein are unreasonable in relation to the amount

1 charged for the contract. Rates, or any modification of rates  
2 effective on or after July 1, 2008, for individual health benefit plans  
3 may not be used until sixty days after they are filed with the  
4 commissioner. If the commissioner does not disapprove a rate filing  
5 within sixty days after the health care service contractor has filed  
6 the documents required in RCW 48.44.017(2) and any rules adopted  
7 pursuant thereto, the filing shall be deemed approved.

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

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

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

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

30 (2) All forms of health maintenance agreements issued by the  
31 organization to enrolled participants or other marketing documents  
32 purporting to describe the organization's comprehensive health care  
33 services shall comply with such minimum standards as the commissioner  
34 deems reasonable and necessary in order to carry out the purposes and  
35 provisions of this chapter, and which fully inform enrolled  
36 participants of the health care services to which they are entitled,

1 including any limitations or exclusions thereof, and such other rights,  
2 responsibilities and duties required of the contracting health  
3 maintenance organization.

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

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

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

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

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

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

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

25 (4) In addition to the grounds listed in subsection (2) of this  
26 section, the commissioner may disapprove any (~~group~~) agreement if the  
27 benefits provided therein are unreasonable in relation to the amount  
28 charged for the agreement. Rates, or any modification of rates  
29 effective on or after July 1, 2008, for individual health benefit plans  
30 may not be used until sixty days after they are filed with the  
31 commissioner. If the commissioner does not disapprove a rate filing  
32 within sixty days after the health maintenance organization has filed  
33 the documents required in RCW 48.46.062(2) and any rules adopted  
34 pursuant thereto, the filing shall be deemed approved.

35 (5) No health maintenance organization authorized under this  
36 chapter shall cancel or fail to renew the enrollment on any basis of an  
37 enrolled participant or refuse to transfer an enrolled participant from  
38 a group to an individual basis for reasons relating solely to age, sex,

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

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

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

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

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

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) "Declination rate" for an insurer means the percentage of the  
29 total number of applicants for individual health benefit plans received  
30 by that insurer in the aggregate in the applicable year which are not  
31 accepted for enrollment by that insurer based on the results of the  
32 standard health questionnaire administered pursuant to RCW  
33 48.43.018(2)(a).

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

1       ~~((d))~~ (e) "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))~~ (f) "Loss ratio" means incurred claims expense as a  
5 percentage of earned premiums.

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

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

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

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

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

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

23       (d) A certification by a member of the American academy of  
24 actuaries, or other person approved by the commissioner, that the  
25 adjusted community rate charged can be reasonably expected to result in  
26 a loss ratio that meets or exceeds the loss ratio standard  
27 ~~((established in subsection (7) of this section))~~ of seventy-four  
28 percent, minus the premium tax rate applicable to the insurer's  
29 individual health benefit plans under RCW 48.14.020.

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 insurer issuing or  
33 renewing individual health benefit plans in this state during the  
34 preceding calendar year shall file for review by the commissioner  
35 supporting documentation of its actual loss ratio and its actual  
36 declination rate for its individual health benefit plans offered or  
37 renewed in the state in aggregate for the preceding calendar year. The  
38 filing shall include aggregate earned premiums, aggregate incurred

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

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

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

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

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

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

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

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

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

36 ~~((+7))~~ (5) The loss ratio applicable to this section shall be  
37 ~~((seventy four percent))~~ the percentage set forth in the following

1 schedule that correlates to the insurer's actual declination rate in  
2 the preceding year, minus the premium tax rate applicable to the  
3 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>

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

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

13 (a) "Claims" means the cost to the health care service contractor  
14 of health care services, as defined in RCW 48.43.005, provided to a  
15 contract holder or paid to or on behalf of a contract holder in  
16 accordance with the terms of a health benefit plan, as defined in RCW  
17 48.43.005. This includes capitation payments or other similar payments  
18 made to providers for the purpose of paying for health care services  
19 for an enrollee.

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

25 (c) "Declination rate" for a health care service contractor means  
26 the percentage of the total number of applicants for individual health  
27 benefit plans received by that health care service contractor in the  
28 aggregate in the applicable year which are not accepted for enrollment  
29 by that health care service contractor based on the results of the  
30 standard health questionnaire administered pursuant to RCW  
31 48.43.018(2)(a).

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



1       ~~((d))~~ (e) "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))~~ (f) "Loss ratio" means incurred claims expense as a  
5 percentage of earned premiums.

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

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

11       ~~(3))~~ A health care service contractor ~~((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 contracts. At a  
15 minimum, the health care service contractor must provide the following  
16 supporting documentation:

17       (a) A description of the health care service contractor'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 care service contractor'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  
29 ~~((established in subsection (7) of this section))~~ of seventy-four  
30 percent, minus the premium tax rate applicable to the carrier's  
31 individual health benefit plans under RCW 48.14.0201.

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

34       ~~(5))~~ (3) By the last day of May each year any health care service  
35 contractor issuing or renewing individual health benefit plans in this  
36 state during the preceding calendar year shall file for review by the  
37 commissioner supporting documentation of its actual loss ratio and its  
38 actual declination rate for its individual health benefit plans offered

1 or renewed in this state in aggregate for the preceding calendar year.  
2 The filing shall include aggregate earned premiums, aggregate incurred  
3 claims, and a certification by a member of the American academy of  
4 actuaries, or other person approved by the commissioner, that the  
5 actual loss ratio has been calculated in accordance with accepted  
6 actuarial principles.

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

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

14 (c) Any dispute regarding the calculation of the actual loss ratio  
15 shall upon written demand of either the commissioner or the health care  
16 service contractor be submitted to hearing under chapters 48.04 and  
17 34.05 RCW.

18 ~~((+6+))~~ (4) If the actual loss ratio for the preceding calendar  
19 year is less than the loss ratio standard established in subsection  
20 ~~((+7+))~~ (5) of this section, a remittance is due and the following  
21 shall apply:

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

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

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

35 (d) Any remittance required to be issued under this section shall  
36 be issued within thirty days after the actual loss ratio is deemed  
37 approved under subsection ~~((+5+))~~ (3)(a) of this section or the

1 determination by an administrative law judge under subsection ((+5+))  
2 (3)(c) of this section.

3 ((+7+)) (5) The loss ratio applicable to this section shall be  
4 ((seventy-four percent)) the percentage set forth in the following  
5 schedule that correlates to the health care service contractor's actual  
6 declination rate in the preceding year, minus the premium tax rate  
7 applicable to the health care service contractor's individual health  
8 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>

14 **Sec. 6.** RCW 48.46.062 and 2001 c 196 s 12 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 health maintenance organization  
19 of health care services, as defined in RCW 48.43.005, provided to an  
20 enrollee or paid to or on behalf of the enrollee in accordance with the  
21 terms of a health benefit plan, as defined in RCW 48.43.005. This  
22 includes capitation payments or other similar payments made to  
23 providers for the purpose of paying for health care services for an  
24 enrollee.

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

30 (c) "Declination rate" for a health maintenance organization means  
31 the percentage of the total number of applicants for individual health  
32 benefit plans received by that health maintenance organization in the  
33 aggregate in the applicable year which are not accepted for enrollment  
34 by that health maintenance organization based on the results of the  
35 standard health questionnaire administered pursuant to RCW  
36 48.43.018(2)(a).

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

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

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

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

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

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

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

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

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

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

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

1       ~~(5)~~) (3) By the last day of May each year any health maintenance  
2 organization issuing or renewing individual health benefit plans in  
3 this state during the preceding calendar year shall file for review by  
4 the commissioner supporting documentation of its actual loss ratio and  
5 its actual declination rate for its individual health benefit plans  
6 offered or renewed in the state in aggregate for the preceding calendar  
7 year. The filing shall include aggregate earned premiums, aggregate  
8 incurred claims, and a certification by a member of the American  
9 academy of actuaries, or other person approved by the commissioner,  
10 that the actual loss ratio has been calculated in accordance with  
11 accepted actuarial principles.

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

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

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

23       ~~((6))~~ (4) If the actual loss ratio for the preceding calendar  
24 year is less than the loss ratio standard established in subsection  
25 ~~((7))~~ (5) of this section, a remittance is due and the following  
26 shall apply:

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

32       (b) The remittance to the Washington state health insurance pool is  
33 the percentage calculated in (a) of this subsection, multiplied by the  
34 premium earned from each enrollee in the previous calendar year.  
35 Interest shall be added to the remittance due at a five percent annual  
36 rate calculated from the end of the calendar year for which the  
37 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))~~ (3)(a) of this section or the  
7 determination by an administrative law judge under subsection ~~((+5))~~  
8 (3)(c) of this section.

9 ~~((+7))~~ (5) The loss ratio applicable to this section shall be  
10 ~~((seventy-four percent))~~ the percentage set forth in the following  
11 schedule that correlates to the health maintenance organization's  
12 actual declination rate in the preceding year, minus the premium tax  
13 rate applicable to the health maintenance organization's individual  
14 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>

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

23 NEW SECTION. Sec. 8. (1) The office of the insurance commissioner  
24 shall explore the feasibility of entering into a multistate health  
25 insurance plan compact for the purpose of providing affordable health  
26 insurance coverage for persons purchasing individual health coverage.  
27 The office of the insurance commissioner shall propose model state  
28 legislation that each participating state would enact prior to entering  
29 into the multistate health insurance plan compact. If federal  
30 legislation is necessary to permit the operation of the multistate  
31 health insurance plan, the office of the insurance commissioner shall  
32 identify needed changes in federal statutes and rules.

33 (2) The office of the insurance commissioner shall report the  
34 findings and recommendations of the feasibility study to the

1 appropriate committees of the senate and house of representatives by  
2 December 1, 2008."

3 Correct the title.

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