

**ESSB 5261** - H COMM AMD

By Committee on Health Care & Wellness

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.

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

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

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

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

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

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

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

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

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

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

33       (3) In addition to the grounds listed in subsection (2) of this  
34 section, the commissioner may disapprove any (~~group~~) contract if the  
35 benefits provided therein are unreasonable in relation to the amount  
36 charged for the contract. Rates, or any modification of rates  
37 effective on or after July 1, 2008, for individual health benefit plans

1 may not be used until sixty days after they are filed with the  
2 commissioner.

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

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

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

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

25 (2) All forms of health maintenance agreements issued by the  
26 organization to enrolled participants or other marketing documents  
27 purporting to describe the organization's comprehensive health care  
28 services shall comply with such minimum standards as the commissioner  
29 deems reasonable and necessary in order to carry out the purposes and  
30 provisions of this chapter, and which fully inform enrolled  
31 participants of the health care services to which they are entitled,  
32 including any limitations or exclusions thereof, and such other rights,  
33 responsibilities and duties required of the contracting health  
34 maintenance organization.

35 (3) Subject to the right of the health maintenance organization to  
36 demand and receive a hearing under chapters 48.04 and 34.05 RCW, the

1 commissioner may disapprove an individual or group agreement form for  
2 any of the following grounds:

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

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

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

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

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

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

20 (4) In addition to the grounds listed in subsection (2) of this  
21 section, the commissioner may disapprove any (~~group~~) agreement if the  
22 benefits provided therein are unreasonable in relation to the amount  
23 charged for the agreement. Rates, or any modification of rates  
24 effective on or after July 1, 2008, for individual health benefit plans  
25 may not be used until sixty days after they are filed with the  
26 commissioner.

27 (5) No health maintenance organization authorized under this  
28 chapter shall cancel or fail to renew the enrollment on any basis of an  
29 enrolled participant or refuse to transfer an enrolled participant from  
30 a group to an individual basis for reasons relating solely to age, sex,  
31 race, or health status. Nothing contained herein shall prevent  
32 cancellation of an agreement with enrolled participants (a) who violate  
33 any published policies of the organization which have been approved by  
34 the commissioner, or (b) who are entitled to become eligible for  
35 medicare benefits and fail to enroll for a medicare supplement plan  
36 offered by the health maintenance organization and approved by the  
37 commissioner, or (c) for failure of such enrolled participant to pay

1 the approved charge, including cost-sharing, required under such  
2 contract, or (d) for a material breach of the health maintenance  
3 agreement.

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

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

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

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

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

21 (c) "Declination rate" for an insurer means the percentage of the  
22 total number of applicants for individual health benefit plans received  
23 by that insurer in the aggregate in the applicable year which are not  
24 accepted for enrollment by that insurer based on the results of the  
25 standard health questionnaire administered pursuant to RCW  
26 48.43.018(2)(a).

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

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

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

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

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

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

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

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

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

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

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

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

36           (a) At the expiration of a thirty-day period beginning with the  
37 date the filing is received by the commissioner, the filing shall be

1 deemed approved unless prior thereto the commissioner contests the  
2 calculation of the actual loss ratio.

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

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

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

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

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

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

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

30 ~~((+7+))~~ (5) The loss ratio applicable to this section shall be  
31 ~~((seventy-four-percent))~~ the percentage set forth in the following  
32 schedule that correlates to the health care service contractor's actual  
33 declination rate in the preceding year, minus the premium tax rate  
34 applicable to the insurer's individual health benefit plans under RCW  
35 48.14.020.

1	<u>Actual Declination Rate</u>	<u>Loss Ratio</u>
2	<u>Under Six Percent (6%)</u>	<u>Seventy-Four Percent (74%)</u>
3	<u>Six Percent (6%) or more (but less than Seven Percent)</u>	<u>Seventy-Five Percent (75%)</u>
4	<u>Seven Percent (7%) or more (but less than Eight Percent)</u>	<u>Seventy-Six Percent (76%)</u>
5	<u>Eight Percent (8%)</u>	<u>Seventy-Seven Percent (77%)</u>

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

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

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

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

22       (c) "Declination rate" for an insurer means the percentage of the  
23 total number of applicants for individual health benefit plans received  
24 by that insurer in the aggregate in the applicable year which are not  
25 accepted for enrollment by that insurer based on the results of the  
26 standard health questionnaire administered pursuant to RCW  
27 48.43.018(2)(a).

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



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

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

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

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

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

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

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

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

29        ~~(5))~~ (3) By the last day of May each year any health care service  
30 contractor issuing or renewing individual health benefit plans in this  
31 state during the preceding calendar year shall file for review by the  
32 commissioner supporting documentation of its actual loss ratio and its  
33 actual declination rate for its individual health benefit plans offered  
34 or renewed in this state in aggregate for the preceding calendar year.  
35 The filing shall include aggregate earned premiums, aggregate incurred  
36 claims, and a certification by a member of the American academy of  
37 actuaries, or other person approved by the commissioner, that the

1 actual loss ratio has been calculated in accordance with accepted  
2 actuarial principles.

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

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

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

14 ~~((+6))~~ (4) If the actual loss ratio for the preceding calendar  
15 year is less than the loss ratio standard established in subsection  
16 ~~((+7))~~ (5) of this section, a remittance is due and the following  
17 shall apply:

18 (a) The health care service contractor shall calculate a percentage  
19 of premium to be remitted to the Washington state health insurance pool  
20 by subtracting the actual loss ratio for the preceding year from the  
21 loss ratio 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  
38 schedule that correlates to the health care service contractor's actual

1 declination rate in the preceding year, minus the premium tax rate  
2 applicable to the health care service contractor's individual health  
3 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%)</u>	<u>Seventy-Seven Percent (77%)</u>

9 **Sec. 6.** RCW 48.46.062 and 2001 c 196 s 12 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 maintenance organization  
14 of health care services, as defined in RCW 48.43.005, provided to an  
15 enrollee or paid to or on behalf of the enrollee in accordance with the  
16 terms of a health benefit plan, as defined in RCW 48.43.005. This  
17 includes capitation payments or other similar payments made to  
18 providers for the purpose of paying for health care services for an  
19 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 an insurer means the percentage of the  
26 total number of applicants for individual health benefit plans received  
27 by that insurer in the aggregate in the applicable year which are not  
28 accepted for enrollment by that insurer based on the results of the  
29 standard health questionnaire administered pursuant to RCW  
30 48.43.018(2)(a).

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

35 ~~((d))~~ (e) "Incurred claims expense" means claims paid during the

1 applicable period plus any increase, or less any decrease, in the  
2 claims reserves.

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

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

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

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

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

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

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

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

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

33 ~~(5))~~ (3) By the last day of May each year any health maintenance  
34 organization issuing or renewing individual health benefit plans in  
35 this state during the preceding calendar year shall file for review by  
36 the commissioner supporting documentation of its actual loss ratio and  
37 its actual declination rate for its individual health benefit plans  
38 offered or renewed in the state in aggregate for the preceding calendar

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

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

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

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

17 ~~((+6))~~ (4) If the actual loss ratio for the preceding calendar  
18 year is less than the loss ratio standard established in subsection  
19 ~~((+7))~~ (5) of this section, a remittance is due and the following  
20 shall apply:

21 (a) The health maintenance organization shall calculate a  
22 percentage of premium to be remitted to the Washington state health  
23 insurance pool by subtracting the actual loss ratio for the preceding  
24 year from the loss ratio established in subsection ~~((+7))~~ (5) of this  
25 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 maintenance organization's  
6 actual declination rate in the preceding year, minus the premium tax  
7 rate applicable to the health maintenance organization's individual  
8 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%)</u>	<u>Seventy-Seven Percent (77%)</u>

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

17 Correct the title.

--- END ---