SB 5261 - S AMD **111**
By Senators Rockefeller, Keiser

ADOPTED 03/09/2007

1 On page 5, after line 13, strike all of sections 4 and 5 and insert
2 the following:

3 "**Sec. 4.** RCW 48.20.025 and 2003 c 248 s 8 are each amended to read
4 as follows:
5 (1) The definitions in this subsection apply throughout this
6 section unless the context clearly requires otherwise.
7 (a) "Claims" means the cost to the insurer of health care services,
8 as defined in RCW 48.43.005, provided to a policyholder or paid to or
9 on behalf of the policyholder in accordance with the terms of a health
10 benefit plan, as defined in RCW 48.43.005. This includes capitation
11 payments or other similar payments made to providers for the purpose of
12 paying for health care services for a policyholder.
13 (b) "Claims reserves" means: (i) The liability for claims which
14 have been reported but not paid; (ii) the liability for claims which
15 have not been reported but which may reasonably be expected; (iii)
16 active life reserves; and (iv) additional claims reserves whether for
17 a specific liability purpose or not.
18 (c) "Earned premiums" means premiums, as defined in RCW 48.43.005,
19 plus any rate credits or recoupments less any refunds, for the
20 applicable period, whether received before, during, or after the
21 applicable period.
22 (d) "Incurred claims expense" means claims paid during the
23 applicable period plus any increase, or less any decrease, in the
24 claims reserves.
25 (e) "Loss ratio" means incurred claims expense as a percentage of
26 earned premiums.
27 (f) "Reserves" means: (i) Active life reserves; and (ii)
28 additional reserves whether for a specific liability purpose or not.
29 (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 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 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) of this section.

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

(5) 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) If the actual loss ratio for the preceding calendar year is less than the loss ratio established in subsection (7) 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) 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)(a) of this section or the determination by an administrative law judge under subsection (5)(c) of this section.

(7) 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 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 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) of this section.

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

1 (5) By the last day of May each year any health care service
2 contractor issuing or renewing individual health benefit plans in this
3 state during the preceding calendar year shall file for review by the
4 commissioner supporting documentation of its actual loss ratio for its
5 individual health benefit plans offered or renewed in this state in
6 aggregate for the preceding calendar year. The filing shall include
7 aggregate earned premiums, aggregate incurred claims, and a
8 certification by a member of the American academy of actuaries, or
9 other person approved by the commissioner, that the actual loss ratio
10 has been calculated in accordance with accepted actuarial principles.
11 (a) At the expiration of a thirty-day period beginning with the
12 date the filing is received by the commissioner, the filing shall be
13 deemed approved unless prior thereto the commissioner contests the
14 calculation of the actual loss ratio.
15 (b) If the commissioner contests the calculation of the actual loss
16 ratio, the commissioner shall state in writing the grounds for
17 contesting the calculation to the health care service contractor.
18 (c) Any dispute regarding the calculation of the actual loss ratio
19 shall upon written demand of either the commissioner or the health care
20 service contractor be submitted to hearing under chapters 48.04 and
21 34.05 RCW.
22 (6) If the actual loss ratio for the preceding calendar year is
23 less than the loss ratio standard established in subsection (7) of this
24 section, a remittance is due and the following shall apply:
25 (a) The health care service contractor shall calculate a percentage
26 of premium to be remitted to the Washington state health insurance pool
27 by subtracting the actual loss ratio for the preceding year from the
28 loss ratio established in subsection (7) of this section.
29 (b) The remittance to the Washington state health insurance pool is
30 the percentage calculated in (a) of this subsection, multiplied by the
31 premium earned from each enrollee in the previous calendar year.
32 Interest shall be added to the remittance due at a five percent annual
33 rate calculated from the end of the calendar year for which the
34 remittance is due to the date the remittance is made.
35 (c) All remittances shall be aggregated and such amounts shall be
36 remitted to the Washington state high risk pool to be used as directed
37 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)(a) of this section or the determination by an administrative law judge under subsection (5)(c) of this section.

(7) 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

1 purposes only, a notice of its schedule of rates for its individual
2 agreements with the commissioner prior to use.
3 (3) A health maintenance organization shall file with the notice
4 required under subsection (2) of this section supporting documentation
5 of its method of determining the rates charged. The commissioner may
6 request only the following supporting documentation:
7 (a) A description of the health maintenance organization's rate-
8 making methodology;
9 (b) An actuarially determined estimate of incurred claims which
10 includes the experience data, assumptions, and justifications of the
11 health maintenance organization's projection;
12 (c) The percentage of premium attributable in aggregate for
13 nonclaims expenses used to determine the adjusted community rates
14 charged; and
15 (d) A certification by a member of the American academy of
16 actuaries, or other person approved by the commissioner, that the
17 adjusted community rate charged can be reasonably expected to result in
18 a loss ratio that meets or exceeds the loss ratio standard established
19 in subsection (7) of this section.
20 (4) The commissioner may not disapprove or otherwise impede the
21 implementation of the filed rates.
22 (5) By the last day of May each year any health maintenance
23 organization issuing or renewing individual health benefit plans in
24 this state during the preceding calendar year shall file for review by
25 the commissioner supporting documentation of its actual loss ratio for
26 its individual health benefit plans offered or renewed in the state in
27 aggregate for the preceding calendar year. The filing shall include
28 aggregate earned premiums, aggregate incurred claims, and a
29 certification by a member of the American academy of actuaries, or
30 other person approved by the commissioner, that the actual loss ratio
31 has been calculated in accordance with accepted actuarial principles.
32 (a) At the expiration of a thirty-day period beginning with the
33 date the filing is received by the commissioner, the filing shall be
34 deemed approved unless prior thereto the commissioner contests the
35 calculation of the actual loss ratio.
36 (b) If the commissioner contests the calculation of the actual loss
37 ratio, the commissioner shall state in writing the grounds for
38 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) If the actual loss ratio for the preceding calendar year is less than the loss ratio standard established in subsection (7) 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) 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)(a) of this section or the determination by an administrative law judge under subsection (5)(c) of this section.

(7) 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."

On page 1, line 2 of the title, after "rates;" insert "and"

On page 1, beginning on line 3 of the title, after "48.44.020," strike the remainder of the title and insert "48.46.060, 48.20.025, 48.44.017, and 48.46.062."

EFFECT: Deletes the Commissioner's ability to review surplus when

reviewing a rate increase. Increases the carrier loss ratio requirement from 74% (minus 2% premium tax) to 77% (minus 2% premium tax).

--- END ---