



RULE-MAKING ORDER

CR-103 (June 2004)
(Implements RCW 34.05.360)

Agency: Insurance Commissioner

- Permanent Rule
- Emergency Rule

Effective date of rule:
Permanent Rules
 31 days after filing.
 Other (specify) _____ (If less than 31 days after filing, a specific finding under RCW 34.05.380(3) is required and should be stated below)

Effective date of rule:
Emergency Rules
 Immediately upon filing.
 Later (specify) _____

Any other findings required by other provisions of law as precondition to adoption or effectiveness of rule?
 Yes No If Yes, explain:

Purpose: These amendments restore the procedures and processes used by Commissioner to review individual rate filings prior to changes made by the legislature in 2000 to the Commissioner's authority to review individual health coverage rate filings. Carriers will be required to submit documentation of actuarial formulas, statistics, and assumptions in support of their rates for actuarial review of the Commissioner.

Insurance Commissioner Matter No. R 2008-08

Citation of existing rules affected by this order:
 Repealed:
 Amended: WAC 284-43-910, 284-43-925, 284.43.930, 284-43-945
 Suspended:

Statutory authority for adoption: RCW 48.02.060, 48.18.110, 48.44.020, 48.44.050, 48.46.060, 48.46.200

Other authority:

PERMANENT RULE ONLY (Including Expedited Rule Making)
 Adopted under notice filed as WSR 08-15-158 on July 23, 2008.
 Describe any changes other than editing from proposed to adopted version:

If a preliminary cost-benefit analysis was prepared under RCW 34.05.328, a final cost-benefit analysis is available by contacting:

Name: _____ phone () _____
 Address: _____ fax () _____
 e-mail _____

EMERGENCY RULE ONLY

- Under RCW 34.05.350 the agency for good cause finds:
- That immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.
 - That state or federal law or federal rule or a federal deadline for state receipt of federal funds requires immediate adoption of a rule.

Reasons for this finding:

Date adopted:
 September 25, 2008

NAME (TYPE OR PRINT)
 Mike Kreidler

SIGNATURE

TITLE
 Insurance Commissioner

CODE REVISER USE ONLY

CODE REVISER'S OFFICE
STATE OF WASHINGTON
FILED

SEP 25 2008

TIME 4:10 AM
 DATE 08-20-07

**Note: If any category is left blank, it will be calculated as zero.
No descriptive text.**

Count by whole WAC sections only, from the WAC number through the history note.
A section may be counted in more than one category.

The number of sections adopted in order to comply with:

Federal statute:	New	_____	Amended	_____	Repealed	_____
Federal rules or standards:	New	_____	Amended	_____	Repealed	_____
Recently enacted state statutes:	New	_____	Amended	_____	Repealed	_____

The number of sections adopted at the request of a nongovernmental entity:

New	_____	Amended	_____	Repealed	_____
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The number of sections adopted in the agency's own initiative:

New	<u>1</u>	Amended	<u>4</u>	Repealed	_____
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The number of sections adopted in order to clarify, streamline, or reform agency procedures:

New	_____	Amended	_____	Repealed	_____
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The number of sections adopted using:

Negotiated rule making:	New	_____	Amended	_____	Repealed	_____
Pilot rule making:	New	_____	Amended	_____	Repealed	_____
Other alternative rule making:	New	<u>1</u>	Amended	<u>4</u>	Repealed	_____

NEW SECTION

WAC 284-43-901 Authority and purpose. This subchapter is adopted under the general authority of RCW 48.02.060, 48.44.017, 48.44.020, 48.44.050, 48.46.060, 48.46.062, and 48.46.200. Its purpose is to provide guidelines for the implementation of RCW 48.44.017(2), 48.44.020(3), 48.44.022, 48.44.023, 48.44.040, 48.46.060 (4) and (6), 48.46.062(2), 48.46.064, and 48.46.066 as to the filing of contract forms by health care service contractors and health maintenance organizations and the calculations and evaluations of premium rates for these contracts.

AMENDATORY SECTION (Amending Matter No. R 2004-05, filed 3/3/05, effective 4/3/05)

WAC 284-43-910 Definitions. For the purpose of this subchapter:

(1) "Adjusted earned premium" means the amount of "earned premium" the "carrier" would have earned had the "carrier" charged current "premium rates" for all applicable "plans."

(2) "Annualized earned premium" means the "earned premium" that would be earned in a twelve-month period if earned at the same rate as during the applicable period.

(3) "Anticipated loss ratio" means the "projected incurred claims" divided by the "projected earned premium."

(4) "Base rate" means the "premium" for a specific "plan," expressed as a monthly amount per "covered person or subscriber," prior to any adjustments for geographic area, age, family size, wellness activities, tenure, or any other factors as may be allowed.

(5) "Capitation expenses" means the amount paid to a provider or facility on a per "covered person" basis, or as part of risk-sharing provisions, for the coverage of specified health care services.

(6) "Carrier" means a health care service contractor or health maintenance organization.

(7) "Certificate" means the statement of coverage document furnished "subscribers" covered under a "group contract."

(8) "Claim reserves" means the "claims" that have been reported but not paid plus the "claims" that have not been reported but may be reasonably expected.

(9) "Claims" means the cost to the "carrier" of health care services provided to a "covered person" or paid to or on behalf of

the "covered person" in accordance with the terms of a "plan." This includes "capitation payments" or other similar payments made to providers or facilities for the purpose of paying for health care services for a "covered person."

(10) "Community rate" means the weighted average of all "premium rates" within a filing with the weights determined according to current enrollment.

(11) "Contract" means an agreement to provide health care services or pay health care costs for or on behalf of a "subscriber" or group of "subscribers" and such eligible dependents as may be included therein.

(12) "Contract form" means the prototype of a "contract" and any associated riders and endorsements filed with the commissioner by a health care service contractor or health maintenance organization.

(13) "Contribution to surplus, contingency charges, or risk charges" means the portion of the "projected earned premium" not associated directly with "claims" or "expenses."

(14) "Covered person" or "enrollee" has the same meaning as that contained in RCW 48.43.005.

(15) "Current community rate" means the weighted average of the "community rates" at the renewal or initial effective dates of each plan for the year immediately preceding the renewal period, with weights determined according to current enrollment.

(16) "Current enrollment" means the monthly average number and demographic makeup of the "covered persons" for the applicable contracts during the most recent twelve months for which information is available to the carrier.

(17) "Earned premium" means the "premium" plus any rate credits or recoupments, applicable to an accounting period whether received before, during, or after such period.

(18) "Expenses" means costs that include but are not limited to the following:

(a) Claim adjudication costs;

(b) Utilization management costs if distinguishable from "claims";

(c) Home office and field overhead;

(d) Acquisition and selling costs;

(e) Taxes; and

(f) All other costs except "claims."

(19) "Experience period" means the most recent twelve-month period from which the carrier accumulates the data to support a filing.

(20) "Extraordinary expenses" means "expenses" resulting from occurrences atypical of the normal business activities of the "carrier" that are not expected to recur regularly in the near future.

(21) "Group contract" or "group plan" means an agreement issued to an employer, corporation, labor union, association, trust, or other organization to provide health care services to employees or members of such entities and the dependents of such employees or members.

(22) "Incurred claims" means "claims" paid during the

applicable period plus the "claim reserves" as of the end of the applicable period minus the "claim reserves" as of the beginning of the applicable period. Alternatively, for the purpose of providing monthly data or trend analysis, "incurred claims" may be defined as the current best estimate of the "claims" for services provided during the applicable period.

(23) "Individual contract" means a "contract" issued to and covering an individual. An "individual contract" may include dependents.

(24) "Investment earnings" means the income, dividends, and realized capital gains earned on an asset.

(25) "Loss ratio" means "incurred claims" as a percentage of "earned premiums" before any deductions.

(26) "Medical care component of the consumer price index for all urban consumers" means the similarly named figure published monthly by the United States Bureau of Labor Statistics.

(27) "Net worth or reserves and unassigned funds" means the excess of assets over liabilities on a statutory basis.

(28) "Plan" means a "contract" that is a health benefit plan as defined in RCW 48.43.005 or a "contract" for limited health care services as defined in RCW 48.44.035.

(29) "Premium" has the same meaning as that contained in RCW 48.43.005.

(30) "Premium rate" means the "premium" per "subscriber" or "covered person" obtained by adjusting the "base rate" for geographic area, family size, age, wellness activities, or any other factors as may be allowed.

(31) "Projected earned premium" means the "earned premium" that would be derived from applying the proposed "premium rates" to the current enrollment.

(32) "Projected incurred claims" means the estimate of "incurred claims" for the rate renewal period based on the current enrollment.

(33) "Proposed community rate" means the weighted average of the "community rates" at the renewal dates of each plan for the renewal period, with weights determined according to current enrollment.

(34) "Provider" has the same meaning as that contained in RCW 48.43.005.

(35) "Rate renewal period" means the period for which the proposed "premium rates" are intended to remain in effect.

(36) "Rate schedule" means the schedule of all "base rates" for "plans" included in the filing.

(37) "Requested increase in the community rate" means the amount, expressed as a percentage, by which the "proposed community rate" exceeds the "current community rate."

(38) "Service type" means the category of service for which "claims" are paid, such as hospital, professional, dental, prescription drug, or other.

(39) "Small group contracts" or "small group plans" means the class of "group contracts" issued to "small employers," as that term is defined in RCW 48.43.005.

(40) "Staffing data" means statistics on the number of

providers and associated compensation required to provide a fixed number of services or provide services to a fixed number of "covered persons."

(41) "Subscriber" means a person on whose behalf a "contract" or "certificate" is issued.

(42) "Unit cost data" means statistics on the cost per health care service provided to a "covered person."

(43) "Utilization data" means statistics on the number of services used by a fixed number of "covered persons" over a fixed length of time.

AMENDATORY SECTION (Amending Matter No. R 2004-05, filed 3/3/05, effective 4/3/05)

WAC 284-43-925 General contents of all filings. Each filing required by WAC 284-43-920 must be submitted with the filing transmittal form prescribed by and available from the commissioner. The form must include the name of the filing entity, its address, identification number, the type of filing being submitted, the form name or group name and number, and other relevant information. Filings also must include the information required on the filing summary set forth in WAC 284-43-945 for individual and small group plans and rate schedules or as set forth in WAC 284-43-950 for group plans and rate schedules other than those for small groups.

AMENDATORY SECTION (Amending Matter No. R 2004-05, filed 3/3/05, effective 4/3/05)

WAC 284-43-930 Contents of individual and small group filings. Under RCW 48.44.022 and 48.46.064 the experience of all individual plans must be pooled. Under RCW 48.44.023 and 48.46.066 the experience of all small group plans must be pooled. Filings for individual plans must include each individual plan rate schedule. Filings for small group plans must include base rates and annual base rate changes in dollar and percentage amounts for each small group plan. Each individual and small group filing must include the following information and documents:

(1) An actuarially sound estimate of incurred claims. Experience data, assumptions, and justifications of the carrier's projected incurred claims must be provided in a manner consistent with the carrier's rate-making methodology and incorporate the following elements:

(a) A brief description of the carrier's rate-making methodology, including identification of the data used and the

kinds of assumptions and projections made.

(b) The number of subscribers by family size, or covered persons for the plans included in the filing. These figures must be shown for each month or quarter of the experience period and the prior two periods if not included in previous filings. This data must be presented in aggregate for the plans included in the filing and in aggregate for all of the carrier's plans.

(c) Earned premium for each month or quarter of the experience period and the prior two periods if not included in previous filings, for the plans included in the filing.

(d) An estimate of the adjusted earned premium for each month or quarter of the experience period and prior two periods for the plans included in the filing.

(e) Claims data for each month or quarter of the experience period and the prior two periods. Examples of claims data are incurred claims, capitation payments, utilization data, unit cost data, and staffing data. The specific data elements included in the filing must be consistent with the carrier's rate-making methodology.

(f) Documentation and justification of any adjustments made to the experience data.

(g) Documentation and justification of the factors and methods used to forecast incurred claims.

(2) An actuarially sound estimate of prudently incurred expenses. Experience data, assumptions, and justifications must be provided by the carrier as follows:

(a) A breakdown of the carrier's expenses allocated or assigned to the plans included in the filing for the experience period or for the period corresponding to the most recent "annual statement";

(i) An expense breakdown at least as detailed as the annual statement schedule "Underwriting and Investment Exhibit, Part 3, Analysis of Expenses" as revised from time to time;

(ii) The allocation and assignment methodology used in (a)(i) of this subsection may be based on readily available data and easily applied calculations;

(b) Identification of any extraordinary experience period expenses; and

(c) Documentation and justification of the assignment or allocation of expenses to the plans included in the filing; and

(d) Documentation and justification of forecasted changes in expenses.

(3) An actuarially sound provision for contribution to surplus, contingency charges, or risk charges. Assumptions and justifications must be provided by the carrier as follows:

(a) The methodology, justification, and calculations used to determine the contribution to surplus, contingency charges, or risk charges included in the proposed base rates; and

(b) The carrier's net worth or reserves and unassigned surplus at the beginning and end of the experience period.

(4) An actuarially sound estimate of forecasted investment earnings on assets related to claim reserves or other similar liabilities. The carrier must include documentation and

justification of forecasted investment earnings identified in dollars, and as a percentage of total premiums and the amount credited to the plans included in the filing.

(5) Adjustment of the base rate. Experience data, assumptions, justifications, and methodology descriptions must be provided and must include:

(a) Justifications for adjustments to the base rate, supported by data if appropriate, attributable to geographic region, age, family size, tenure discounts, and wellness activities;

(b) Justifications, supported by data if appropriate, of any other factors or circumstances used to adjust the base rates; and

(c) Description of the methodology used to adjust the base rate to obtain the premium rate for a specific individual or group, which is detailed enough to allow the commissioner to replicate the calculation of premium rates if given the necessary data.

(6) Actuarial certification. Certification by an actuary, as required by RCW 48.44.017(2), 48.44.023(3), 48.46.062(2) and 48.46.066(3).

(7) The requirements of subsections (1) through (6) of this section may be waived or modified upon the finding by the commissioner that a plan contains or involves unique provisions or circumstances and that the requirements represent an extraordinary administrative burden on the carrier.

AMENDATORY SECTION (Amending Matter No. R 2004-05, filed 3/3/05, effective 4/3/05)

WAC 284-43-945 Summary for individual and small group contract filings.

INDIVIDUAL AND SMALL GROUP FILING SUMMARY

Carrier Name	_____
Address	_____

Carrier Identification Number	_____

Rate Renewal Period:	From _____	To _____
Date Submitted:	_____	

Proposed Rate Summary

Current community rate	_____	per month
Proposed community rate	_____	per month
Percentage change	_____	%

Portion of carrier's total enrollment affected	_____	%
Portion of carrier's total premium revenue affected	_____	%

Components of Proposed Community Rate

	Dollars Per Month	% of Total
a) Claims		
b) Expenses		
c) Contribution to surplus, contingency charges, or risk charges		
d) Investment earnings		
e) Total (a + b + c - d)		

Summary of Pooled Experience

	Experience Period		First Prior Period		Second Prior Period	
	From	To	From	To	From	To
Member Months						
Earned Premium						
Paid Claims						
Beginning Claim Reserve						
Ending Claim Reserve						
Incurred Claims						
Expenses						
Gain/Loss						
Loss Ratio Percentage						

General Information

1. Trend Factor Summary

Type of Service	Annual Trend Assumed	Portion of Claim Dollars
Hospital	_____ %	_____ %
Professional	_____ %	_____ %
Prescription Drugs	_____ %	_____ %
Dental	_____ %	_____ %
Other	_____ %	_____ %

2. List the effective date and the rate of increase for all rate changes in the past three rate periods.

1) _____ 2) _____ 3) _____
 Date % Date % Date %

3. Since the previous filing, have any changes been made to the factors or methodology for adjusting base rates?

Geographic Area Yes No
 Family Size Yes No

Age Yes No
Wellness Activities Yes No
Other (specify) Yes No

4. Attach a table showing the base rate for each plan affected by this filing.

5. Attach comments or additional information.

6. Preparer's Information

Name: _____

Title: _____

Telephone Number: _____