RULE-MAKING ORDER

CR-103P (May 2009)
(Implements RCW 34.05.360)

Agency: Office of the Insurance Commissioner

Permanent Rule Only

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)**

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

Purpose: Implementing the requirements of SSB 6536

Insurance Commissioner Matter No. R 2016-06

Citation of existing rules affected by this order:
Repealed:
Amended: WAC 284-43-6000; WAC 284-43-6010; WAC 284-43-6020; WAC 284-43-6060; WAC 284-43-6200; WAC 284-43-6500; and WAC 284-60-010
Suspended:

Statutory authority for adoption: RCW 48.02.060, 48.44.050, 48.46.200

Other authority: Chapter 156, Laws of 2016 – effective 3/31/16

PERMANENT RULE (Including Expedited Rule Making)
Adopted under notice filed as WSR 16-16-054 on July 27, 2016.
Describe any changes other than editing from proposed to adopted version: None

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

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Date adopted: November 4, 2016

NAME (TYPE OR PRINT)
Mike Kreidler

SIGNATURE
Mike Kreidler

TITLE
Insurance Commissioner

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: November 04, 2016
TIME: 11:44 AM

WSR 16-23-019

(COMPLETE REVERSE SIDE)

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Federal statute:	New	_____	Amended	_____	Repealed	_____
Federal rules or standards:	New	_____	Amended	_____	Repealed	_____
Recently enacted state statutes:	New	_____	Amended	7	Repealed	_____

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

New _____ Amended _____ Repealed _____

The number of sections adopted in the agency's own initiative:

New _____ Amended _____ Repealed _____

The number of sections adopted in order to clarify, streamline, or reform agency procedures:

New _____ Amended _____ Repealed _____

The number of sections adopted using:

Negotiated rule making:	New	_____	Amended	7	Repealed	_____
Pilot rule making:	New	_____	Amended	_____	Repealed	_____
Other alternative rule making:	New	_____	Amended	_____	Repealed	_____

AMENDATORY SECTION (Amending WSR 16-01-081, filed 12/14/15, effective 12/14/15)

WAC 284-43-6000 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, and 48.43.733. 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, 48.18.110, 48.18.480, and 48.43.733 as to the filing of ((~~contract forms~~)) grandfathered individual and small group health plans applicable under RCW 48.44.017, 48.44.022, and 48.44.023 by health care service contractors ((~~and~~)), grandfathered individual and small group health plans applicable under RCW 48.46.062, 48.46.064, and 48.46.066 by health maintenance organizations, stand-alone dental plans and stand-alone vision plans offered by health care service contractors, health maintenance organizations, and disability carriers to individuals and small groups, and the calculations and evaluations of premium rates for these contracts.

AMENDATORY SECTION (Amending WSR 16-01-081, filed 12/14/15, effective 12/14/15)

WAC 284-43-6010 Applicability and scope. This subchapter applies to grandfathered individual and small group health benefit plans ((~~as defined in RCW 48.43.005, and contracts for limited health care services as defined in RCW 48.44.035,~~)) offered by health care service contractors and health maintenance organizations transacting business in this state under chapter 48.44 or 48.46 RCW((~~. It~~)), stand-alone dental plans and stand-alone vision plans. This subchapter applies to such plans purchased directly by individuals((~~,~~)) and small employers((~~, large employers and other organizations~~)).

AMENDATORY SECTION (Amending WSR 16-01-081, filed 12/14/15, effective 12/14/15)

WAC 284-43-6020 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) "Grandfathered" has the same meaning as that contained in RCW 48.43.005.

(22) "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)~~)) (23) "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)~~)) (24) "Individual contract" means a "contract" issued to and covering an individual. An "individual contract" may include dependents.

((~~(24)~~)) (25) "Investment earnings" means the income, dividends, and realized capital gains earned on an asset.

((~~(25)~~)) (26) "Loss ratio" means "incurred claims" as a percentage of "earned premiums" before any deductions.

((~~(26)~~)) (27) "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)~~)) (28) "Net worth or reserves and unassigned funds" means the excess of assets over liabilities on a statutory basis.

((~~(28)~~)) (29) "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)~~)) (30) "Premium" has the same meaning as that contained in RCW 48.43.005.

((~~(30)~~)) (31) "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)~~)) (32) "Projected earned premium" means the "earned premium" that would be derived from applying the proposed "premium rates" to the current enrollment.

((~~(32)~~)) (33) "Projected incurred claims" means the estimate of "incurred claims" for the rate renewal period based on the current enrollment.

((~~(33)~~)) (34) "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)~~)) (35) "Provider" has the same meaning as that contained in RCW 48.43.005.

((~~(35)~~)) (36) "Rate renewal period" means the period for which the proposed "premium rates" are intended to remain in effect.

((~~(36)~~)) (37) "Rate schedule" means the schedule of all "base rates" for "plans" included in the filing.

((~~(37)~~)) (38) "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)~~)) (39) "Service type" means the category of service for which "claims" are paid, such as hospital, professional, dental, prescription drug, or other.

((~~(39)~~)) (40) "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)~~)) (41) "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)~~)) (42) "Stand-alone dental plan" means coverage for a set of benefits limited to oral care including, but not necessarily limited to, pediatric oral care.

(43) "Stand-alone vision plan" means coverage for a set of benefits limited to vision care including, but not necessarily limited to, materials.

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

((~~(42)~~)) (45) "Unit cost data" means statistics on the cost per health care service provided to a "covered person."

((~~(43)~~)) (46) "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 WSR 16-01-081, filed 12/14/15, effective 12/14/15)

WAC 284-43-6060 General contents of all filings. Each filing required by WAC ((~~284-43-920~~)) 284-43-6560 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~~)) 284-43-6660 for individual and small group plans and rate schedules or as set forth in WAC ((~~284-43-950~~)) 284-43-6540 for group plans and rate schedules other than those for small groups.

AMENDATORY SECTION (Amending WSR 16-01-081, filed 12/14/15, effective 12/14/15)

WAC 284-43-6200 Geographic rating area factor development. (1) For nongrandfathered individual or small group health plans offered, issued or renewed on or after January 1, 2014, if an issuer elects to adjust its premium rates based on geographic area, the issuer must use the geographic rating areas designated in WAC ((~~284-170-252~~)) 284-43-6700.

(2) The premium ratio for the highest cost geographic rating area, when compared to the lowest cost geographic rating area, must not be more than 1.15.

(a) King County is the index geographic rating area for purposes of calculating the premium ratio. The geographic rating area factor for the index area must be set at 1.00.

(b) A health-status related factor may not be used to establish a rating factor for a geographic rating area. Health factor means any of the following:

(i) Health status of enrollees or the population in an area;

(ii) Medical condition of enrollees or the population in an area, including both physical and mental illnesses;

(iii) Claims experience;

(iv) Health services utilization in the area;

(v) Medical history of enrollees or the population in an area;

(vi) Genetic information of enrollees or the population in an area;

(vii) Disability status of enrollees or the population in an area;

(viii) Other evidence of insurability applicable to the area.

(3) Assignment of a factor to a geographic rating area must be actuarially sound and based on provider reimbursement differences. An issuer must fully document the basis for the assigned rating factors in the actuarial memo submitted with a rate filing.

(4) The geographic rating area factors must be applied uniformly to individuals or small groups applying for or receiving coverage from the issuer.

(5) For out-of-state enrollees covered under a health benefit plan issued to a Washington resident, an issuer must apply the geographic rating area factor based on the primary subscriber's Washington residence. For out-of-state enrollees who are covered under a health benefit plan issued through an employer whose primary place of business is Washington, an issuer must apply the geographic rating area factor based on the employer's primary place of business.

(6) This section does not apply to stand alone dental plans offered on the Washington health benefit exchange.

AMENDATORY SECTION (Amending WSR 16-03-018, filed 1/8/16, effective 1/8/16)

WAC 284-43-6500 Applicability and scope. This subchapter is adopted under the general authority of RCW 48.02.060. This subchapter applies to health benefit plans as defined in RCW 48.43.005 ((~~and~~)), contracts for limited health care services as defined in RCW 48.44.035, stand-alone dental plans and stand-alone vision plans. This subchapter also applies to plans ((~~issued or renewed on or after January 1, 2016,~~)) offered by carriers under the requirements of ((~~chapter 19, Laws of 2015~~)) RCW 48.43.733.

NEW SECTION

The following sections of the Washington Administrative Code are decodified and recodified as follows:

Old WAC Number	New WAC Number
284-43-6060	284-43-6580
284-43-6080	284-43-6600

284-43-6120	284-43-6620
284-43-6140	284-43-6640
284-43-6160	284-43-6660
284-43-6200	284-43-6680
284-43-6220	284-43-6700

AMENDATORY SECTION (Amending WSR 83-14-002, filed 6/23/83, effective 9/1/83)

WAC 284-60-010 Scope. (1) This regulation, WAC 284-60-010 through 284-60-100, applies to all insurers and to every disability insurance policy form filed for approval in this state after August 31, 1983, except:

(a) Additional indemnity and premium waiver forms for use only in conjunction with life insurance policies;

(b) Medicare supplement policy forms which are regulated by chapter 284-55 WAC;

(c) Credit insurance policy forms issued pursuant to chapter 48.34 RCW;

(d) Group policy forms other than:

(i) Specified disease policy forms((~~,~~));

(ii) Policy forms, other than loss of income forms, as to which all or substantially all, of the premium is paid by the individuals insured thereunder((~~,~~));

(iii) Policy forms, other than loss of income forms, for issue to single employers insuring less than one hundred employees((~~;~~)).

(e) Policy forms filed by health care service contractors or health maintenance organizations;

(f) Policy forms initially approved before September 1, 1983, including subsequent requests for rate increases and modifications of rate manuals;

(g) Health plans other than:

(i) Grandfathered individual health plans;

(ii) Grandfathered small group health plans.

(h) Stand-alone dental only plans; and

(i) Stand-alone vision only plans.

(2) Approvals of policy forms of the types subject to this regulation approved before September 1, 1983, and which are not in compliance with the provisions of this regulation on January 1, 1985, are hereby withdrawn as of January 1, 1985, and such forms shall not thereafter be used for new issues.