GRANTS.GOV℠

Grant Application Package

Opportunity Title:	"Grants to States for Health Insurance Premium Review-C
Offering Agency:	Ofc of Consumer Information & Insurance Oversight
CFDA Number:	93.511
CFDA Description:	Affordable Care Act (ACA) Grants to States for Health I
Opportunity Number:	RFA-FD-10-999
Competition ID:	ADOBE-FORMS-B
Opportunity Open Date:	06/07/2010
Opportunity Close Date:	07/07/2010
Agency Contact:	Gladys Melendez-Bohler Grant Specialist E-mail: Gladys.Melendez-Bohler@fda.hhs.gov Phone: 301-827-7168

This electronic grants application is intended to be used to apply for the specific Federal funding opportunity referenced here.

If the Federal funding opportunity listed is not the opportunity for which you want to apply, close this application package by clicking on the "Cancel" button at the top of this screen. You will then need to locate the correct Federal funding opportunity, download its application and then apply.

This opportunity is only open to organizations, applicants who are submitting grant applications on behalf of a company, state, local or tribal government, academia, or other type of organization.

*** Application Filing Name:** Cycle 1 - Premium Review Grant

Mandatory Documents

Move Form to Complete

Move Form to Delete

Mandatory Documents for Submission

Budget Narrative Attachment Form
Key Contacts
Project/Performance Site Location(s)
Assurances for Non-Construction Programs (SF-42
Disclosure of Lobbying Activities (SF-LLL)
Attachments

Optional Documents

Basic Work Plan
Project Abstract Summary
Other Attachments Form

Move Form to Submission List

Move Form to Delete

Optional Documents for Submission

Instructions

1 **Enter a name for the application in the Application Filing Name field.**

- This application can be completed in its entirety offline; however, you will need to login to the Grants.gov website during the submission process.
- You can save your application at any time by clicking the "Save" button at the top of your screen.
- The "Save & Submit" button will not be functional until all required data fields in the application are completed and you clicked on the "Check Package for Errors" button and confirmed all data required data fields are completed.

2 **Open and complete all of the documents listed in the "Mandatory Documents" box. Complete the SF-424 form first.**

- It is recommended that the SF-424 form be the first form completed for the application package. Data entered on the SF-424 will populate data fields in other mandatory and optional forms and the user cannot enter data in these fields.

- The forms listed in the "Mandatory Documents" box and "Optional Documents" may be predefined forms, such as SF-424, forms where a document needs to be attached, such as the Project Narrative or a combination of both. "Mandatory Documents" are required for this application. "Optional Documents" can be used to provide additional support for this application or may be required for specific types of grant activity. Reference the application package instructions for more information regarding "Optional Documents".

- To open and complete a form, simply click on the form's name to select the item and then click on the => button. This will move the document to the appropriate "Documents for Submission" box and the form will be automatically added to your application package. To view the form, scroll down the screen or select the form name and click on the "Open Form" button to begin completing the required data fields. To remove a form/document from the "Documents for Submission" box, click the document name to select it, and then click the <= button. This will return the form/document to the "Mandatory Documents" or "Optional Documents" box.

- All documents listed in the "Mandatory Documents" box must be moved to the "Mandatory Documents for Submission" box. When you open a required form, the fields which must be completed are highlighted in yellow with a red border. Optional fields and completed fields are displayed in white. If you enter invalid or incomplete information in a field, you will receive an error message.

3 **Click the "Save & Submit" button to submit your application to Grants.gov.**

- Once you have properly completed all required documents and attached any required or optional documentation, save the completed application by clicking on the "Save" button.
- Click on the "Check Package for Errors" button to ensure that you have completed all required data fields. Correct any errors or if none are found, save the application package.
- The "Save & Submit" button will become active; click on the "Save & Submit" button to begin the application submission process.
- You will be taken to the applicant login page to enter your Grants.gov username and password. Follow all onscreen instructions for submission.

OMB Number: 4040-0004
Expiration Date: 03/31/2012

Application for Federal Assistance SF-424

* 1. Type of Submission:
- [ ] Preapplication
- [x] Application
- [ ] Changed/Corrected Application

* 2. Type of Application:
- [x] New
- [ ] Continuation
- [ ] Revision

* If Revision, select appropriate letter(s):

* Other (Specify):

* 3. Date Received: Completed by Grants.gov upon submission.

4. Applicant Identifier:

5a. Federal Entity Identifier:

5b. Federal Award Identifier:

State Use Only:

6. Date Received by State:

7. State Application Identifier:

8. APPLICANT INFORMATION:

* a. Legal Name: Washington State Insurance Commissioner

* b. Employer/Taxpayer Identification Number (EIN/TIN): 91-6001093

* c. Organizational DUNS: 8085985770000

d. Address:

* Street1:	5000 Capitol Blvd
Street2:	
* City:	Tumwater
County/Parish:	
* State:	WA: Washington
Province:	
* Country:	USA: UNITED STATES
* Zip / Postal Code:	98501-4426

e. Organizational Unit:

Department Name:

Division Name:

f. Name and contact information of person to be contacted on matters involving this application:

Prefix:	
* First Name:	Elizabeth
Middle Name:	
* Last Name:	Berendt
Suffix:	

Title: Deputy Commissioner

Organizational Affiliation:

* Telephone Number: 360-725-7117

Fax Number:

* Email: BethB@oic.wa.gov

Application for Federal Assistance SF-424

*** 9. Type of Applicant 1: Select Applicant Type:**

A: State Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

*** 10. Name of Federal Agency:**

Ofc of Consumer Information & Insurance Oversight

11. Catalog of Federal Domestic Assistance Number:

93.511

CFDA Title:

Affordable Care Act (ACA) Grants to States for Health Insurance Premium Review

*** 12. Funding Opportunity Number:**

RFA-FD-10-999

* Title:

"Grants to States for Health Insurance Premium Review-Cycle I" Office of Consumer Information and Insurance Oversight (OCIIO)

13. Competition Identification Number:

ADOBE-FORMS-B

Title:

14. Areas Affected by Project (Cities, Counties, States, etc.):

Add Attachment | Delete Attachment | View Attachment

*** 15. Descriptive Title of Applicant's Project:**

Premium Review Grant

Attach supporting documents as specified in agency instructions.

Add Attachments | Delete Attachments | View Attachments

Application for Federal Assistance SF-424

16. Congressional Districts Of:

* a. Applicant: WA-003

b. Program/Project: WA-003

Attach an additional list of Program/Project Congressional Districts if needed.

[Add Attachment] [Delete Attachment] [View Attachment]

17. Proposed Project:

* a. Start Date: 08/09/2010

* b. End Date: 09/30/2011

18. Estimated Funding ($):

* a. Federal	871,700.00
* b. Applicant	0.00
* c. State	0.00
* d. Local	0.00
* e. Other	0.00
* f. Program Income	0.00
* g. TOTAL	871,700.00

*** 19. Is Application Subject to Review By State Under Executive Order 12372 Process?**

☐ a. This application was made available to the State under the Executive Order 12372 Process for review on ________.

☐ b. Program is subject to E.O. 12372 but has not been selected by the State for review.

☒ c. Program is not covered by E.O. 12372.

*** 20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes," provide explanation in attachment.)**

☐ Yes ☒ No

If "Yes", provide explanation and attach

[Add Attachment] [Delete Attachment] [View Attachment]

21. *By signing this application, I certify (1) to the statements contained in the list of certifications and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 218, Section 1001)**

☒ ** I AGREE

** The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

Authorized Representative:

Prefix:

* First Name: Mike

Middle Name:

* Last Name: Kreidler

Suffix:

* Title: WA State Insurance Commissioner

* Telephone Number: 360-725-7103

Fax Number:

* Email: MBKreidler@oic.wa.gov

* Signature of Authorized Representative: Completed by Grants.gov upon submission.

* Date Signed: Completed by Grants.gov upon submission.

OMB Number: 4040-0003
Expiration Date: 7/30/2011

Key Contacts Form

*** Applicant Organization Name:** Washington State Insurance Commissioner

Enter the individual's role on the project (e.g., project manager, fiscal contact).

*** Contact 1 Project Role:** Project Director

Prefix:

* First Name: Elizabeth

Middle Name:

* Last Name: Berendt

Suffix:

Title: Deputy Commissioner

Organizational Affiliation:

* Street1: 5000 Capitol Blvd

Street2:

* City: Tumwater

County:

* State: WA: Washington

Province:

* Country: USA: UNITED STATES

* Zip / Postal Code: 98501-4426

* Telephone Number: 360-725-7117

Fax:

* Email: BethB@oic.wa.gov

Delete Entry | Next Person

OMB Number: 4040-0010
Expiration Date: 08/31/2011

Project/Performance Site Location(s)

Project/Performance Site Primary Location

☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name: Washington State Insurance Commissioner

DUNS Number: 8085985770000

* Street1: 5000 Capitol Blvd

Street2:

* City: Tumwater

County:

* State: WA: Washington

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: 985014426

* Project/ Performance Site Congressional District: WA-003

Project/Performance Site Location 1

☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name:

DUNS Number:

* Street1:

Street2:

* City:

County:

* State:

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code:

* Project/ Performance Site Congressional District:

Additional Location(s)

Add Attachment | Delete Attachment | View Attachment

ATTACHMENTS FORM

Instructions: On this form, you will attach the various files that make up your grant application. Please consult with the appropriate Agency Guidelines for more information about each needed file. Please remember that any files you attach must be in the document format and named as specified in the Guidelines.

Important: Please attach your files in the proper sequence. See the appropriate Agency Guidelines for details.

1) Please attach Attachment 1	Cover Sheet and Checkoff list	Add Attachment	Delete Attachment	View Attachment
2) Please attach Attachment 2	MK grant proposal cover ltr	Add Attachment	Delete Attachment	View Attachment
3) Please attach Attachment 3	Governor's Letter of Support	Add Attachment	Delete Attachment	View Attachment
4) Please attach Attachment 4	Appendix A RCWs.pdf	Add Attachment	Delete Attachment	View Attachment
5) Please attach Attachment 5	Appendix B WACs.pdf	Add Attachment	Delete Attachment	View Attachment
6) Please attach Attachment 6	Appendix C Rate filing detail	Add Attachment	Delete Attachment	View Attachment
7) Please attach Attachment 7	Appendix D Rate review result	Add Attachment	Delete Attachment	View Attachment
8) Please attach Attachment 8	Appendix E Individual rebate	Add Attachment	Delete Attachment	View Attachment
9) Please attach Attachment 9	Appendix F Current level of	Add Attachment	Delete Attachment	View Attachment
10) Please attach Attachment 10	Appendix G Recent enforcement	Add Attachment	Delete Attachment	View Attachment
11) Please attach Attachment 11	Appendix H Rate review expans	Add Attachment	Delete Attachment	View Attachment
12) Please attach Attachment 12	Appendix I Sample of Oregon's	Add Attachment	Delete Attachment	View Attachment
13) Please attach Attachment 13	Project Director Job Descript	Add Attachment	Delete Attachment	View Attachment
14) Please attach Attachment 14	Staff Roles and Org chart.pdf	Add Attachment	Delete Attachment	View Attachment
15) Please attach Attachment 15		Add Attachment	Delete Attachment	View Attachment

ATTACHMENT C

APPLICATION COVER SHEET AND CHECK-OFF LIST

Indentifying Information:

Grant Opportunity: **HHS Health Insurance Rate Review Grants-Cycle I**

DUNS #:_____8085985770000_____________________ Grant Award: $1 million_________

Applicant:_______Washington State Office of Insurance Commissioner___________________

Primary Contact Person, Name:____Elizabeth Berendt_________________________________

Telephone Number:___360-725-7117______________Fax number:___360-586-0759_______

Email address:______BethB@oic.wa.gov____

APPLICATION COVER SHEET AND CHECK-OFF LIST

REQUIRED CONTENTS

A complete proposal consists of the following material organized in the sequence below: Please ensure that the project narrative is page-numbered. The sequence is:

- ☒ Cover Sheet
- ☒ Forms/Mandatory Documents (Grants.gov).

  The following forms must be completed with an original signature and enclosed as part of the proposal:

- ☒ SF-424: Application for Federal Assistance
- ☒ SF-424A: Budget Information
- ☒ SF-424B: Assurances-Non-Construction Programs
- ☒ SF-LLL: Disclosure of Lobbying Activities
- ☒ Additional Assurance Certifications
- ☒ Required Letter of support and Memorandum of Agreement
- ☒ Applicant's Application Cover Letter
- ☒ Project Abstract
- ☒ Project Narrative
- ☒ Work plan and Time Line
- ☒ Proposed Budget (Narrative/Justifications)
- ☒ Required Appendices
- ☒ Resume/Job Description for Project Director and Assistant Director

MIKE KREIDLER
STATE INSURANCE COMMISSIONER

STATE OF WASHINGTON

OFFICE OF
INSURANCE COMMISSIONER

OLYMPIA OFFICE:
INSURANCE BUILDING
P.O. BOX 40258
OLYMPIA, WA 98504-0258
Phone: (360) 725-7000

July 6, 2010

The Honorable Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, D.C. 20201

Re: Premium Rate Review Grant

Dear Madame Secretary:

Please accept the enclosed premium rate review grant proposal from the State of Washington, for the grant period of August 9, 2010 through September 30, 2011. I am the insurance commissioner for the state of Washington. The Office of the Insurance Commissioner is an eligible entity for the grant, as it is the sole state agency responsible for regulating the business of insurance in Washington, which includes health plans offered and issued in the state.

I have designated Beth Berendt, deputy commissioner for Rates and Forms, as the project director. Her contact information is: 360-725-7117 (office); 360-586-0759 (fax); BethB@oic.wa.gov ; and PO Box 40255, Olympia WA 98504-0255.

The agency plans to treat this as a project, and contract or otherwise appropriately engage the resources necessary to accomplish the described activities under the grant.

The Office of the Insurance Commissioner has the authority under Washington State Law to oversee and coordinate the proposed activities under this grant, in compliance with both federal and state laws governing contracting and performing work using the federal funds.

We appreciate the opportunity to enhance the rate review process in Washington State, and to make it more transparent to consumers.

Sincerely,

Mike Kreidler
Insurance Commissioner

CHRISTINE O. GREGOIRE
Governor

STATE OF WASHINGTON
OFFICE OF THE GOVERNOR
P.O. Box 40002 • Olympia, Washington 98504-0002 • (360) 753-6780 • www.governor.wa.gov

July 2, 2010

The Honorable Kathleen Sebelius, Secretary
U.S. Department of Health & Human Services
200 Independence Avenue SW
Washington, D.C. 20201

Dear Secretary Sebelius:

I am writing in support of the Washington State Office of the Insurance Commissioner's grant proposal to improve the health insurance rate review and reporting process in our state. It is critical that health insurance premiums and rate filings are thoroughly evaluated through a comprehensive rate review process that is meaningful and transparent to you as well as the public, enrollees and policyholders.

Grant funds will significantly enhance our ability to conduct a meaningful and transparent rate review process and to analyze important data about Washington State's insurance market. This information will assist us with policy decisions about the effective implementation of other key provisions in the Patient Protection and Affordable Care Act such as the health insurance exchange.

I respectfully urge your thoughtful consideration of this proposal.

Sincerely,

Chris Gregoire

Christine O. Gregoire
Governor

APPENDIX A:

RCWs

The following statutes establish the framework for health plan rate review in Washington State:

Statutory community rating requirements for individual health plans

RCW 48.44.022 for HCSCs.

RCW 48.46.064 for HMOs.

RCW 48.20.028 for disability carriers.

Statutory community rating requirements for small group health plans

RCW 48.44.023 for HCSCs.

RCW 48.46.066 for HMOs.

RCW 48.21.045 for disability carriers.

Grounds for disapproval for health plans:

RCW 48.44.020 for HCSCs.

RCW 48.46.060 for HMOs.

RCW 48.18.110 for disability carriers.

Public disclosure of records

RCW 48.02.120

Full text of the statutes is on the following pages.

Full language of statutory community rating requirements for individual health plans

RCW 48.44.022

Calculation of premiums – Adjusted community rate – definitions.

(1) Except for health benefit plans covered under RCW 48.44.021, premium rates for health benefit plans for individuals shall be subject to the following provisions:

(a) The health care service contractor shall develop its rates based on an adjusted community rate and may only vary the adjusted community rate for:

(i) Geographic area;

(ii) Family size;

(iii) Age;

(iv) Tenure discounts; and

(v) Wellness activities.

(b) The adjustment for age in (a)(iii) of this subsection may not use age brackets smaller than five-year increments which shall begin with age twenty and end with age sixty-five. Individuals under the age of twenty shall be treated as those age twenty.

(c) The health care service contractor shall be permitted to develop separate rates for individuals age sixty-five or older for coverage for which medicare is the primary payer and coverage for which medicare is not the primary payer. Both rates shall be subject to the requirements of this subsection.

(d) The permitted rates for any age group shall be no more than four hundred twenty-five percent of the lowest rate for all age groups on January 1, 1996, four hundred percent on January 1, 1997, and three hundred seventy-five percent on January 1, 2000, and thereafter.

(e) A discount for wellness activities shall be permitted to reflect actuarially justified differences in utilization or cost attributed to such programs.

(f) The rate charged for a health benefit plan offered under this section may not be adjusted more frequently than annually except that the premium may be changed to reflect:

(i) Changes to the family composition;

(ii) Changes to the health benefit plan requested by the individual; or

(iii) Changes in government requirements affecting the health benefit plan.

(g) For the purposes of this section, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision, provided that the restrictions of benefits to network providers result in substantial differences in claims costs. This subsection does not restrict or enhance the portability of benefits as provided in RCW 48.43.015.

(h) A tenure discount for continuous enrollment in the health plan of two years or more may be offered, not to exceed ten percent.

(2) Adjusted community rates established under this section shall pool the medical experience of all individuals purchasing coverage, except individuals purchasing coverage under RCW 48.44.021, and shall not be required to be pooled with the medical experience of health benefit plans offered to small employers under RCW 48.44.023.

(3) As used in this section and RCW 48.44.023 "health benefit plan," "small employer," "adjusted community rates," and "wellness activities" mean the same as defined in RCW 48.43.005.

RCW 48.46.064

Calculation of premiums — Adjusted community rate — Definitions.

(1) Except for health benefit plans covered under RCW 48.46.063, premium rates for health benefit plans for individuals shall be subject to the following provisions:

(a) The health maintenance organization shall develop its rates based on an adjusted community rate and may only vary the adjusted community rate for:

(i) Geographic area;

(ii) Family size;

(iii) Age;

(iv) Tenure discounts; and

(v) Wellness activities.

(b) The adjustment for age in (a)(iii) of this subsection may not use age brackets smaller than five-year increments which shall begin with age twenty and end with age sixty-five. Individuals under the age of twenty shall be treated as those age twenty.

(c) The health maintenance organization shall be permitted to develop separate rates for individuals age sixty-five or older for coverage for which medicare is the primary payer and coverage for which medicare is not the primary payer. Both rates shall be subject to the requirements of this subsection.

(d) The permitted rates for any age group shall be no more than four hundred twenty-five percent of the lowest rate for all age groups on January 1, 1996, four hundred percent on January 1, 1997, and three hundred seventy-five percent on January 1, 2000, and thereafter.

(e) A discount for wellness activities shall be permitted to reflect actuarially justified differences in utilization or cost attributed to such programs.

(f) The rate charged for a health benefit plan offered under this section may not be adjusted more frequently than annually except that the premium may be changed to reflect:

(i) Changes to the family composition;

(ii) Changes to the health benefit plan requested by the individual; or

(iii) Changes in government requirements affecting the health benefit plan.

(g) For the purposes of this section, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision, provided that the restrictions of benefits to network providers result in substantial differences in claims costs. This subsection does not restrict or enhance the portability of benefits as provided in RCW 48.43.015.

(h) A tenure discount for continuous enrollment in the health plan of two years or more may be offered, not to exceed ten percent.

(2) Adjusted community rates established under this section shall pool the medical experience of all individuals purchasing coverage, except individuals purchasing coverage under *RCW 48.46.063, and shall not be required to be pooled with the medical experience of health benefit plans offered to small employers under RCW 48.46.066.

(3) As used in this section and RCW 48.46.066, "health benefit plan," "adjusted community rate," "small employer," and "wellness activities" mean the same as defined in RCW 48.43.005.

RCW 48.20.028

Calculation of premiums – Adjusted community rating method – Definitions.

(1) Premiums for health benefit plans for individuals shall be calculated using the adjusted community rating method that spreads financial risk across the carrier's entire individual product population, except the individual product population covered under RCW 48.20.029. All such rates shall conform to the following:

(a) The insurer shall develop its rates based on an adjusted community rate and may only vary the adjusted community rate for:

(i) Geographic area;

(ii) Family size;

(iii) Age;

(iv) Tenure discounts; and

(v) Wellness activities.

(b) The adjustment for age in (a)(iii) of this subsection may not use age brackets smaller than five-year increments which shall begin with age twenty and end with age sixty-five. Individuals under the age of twenty shall be treated as those age twenty.

(c) The insurer shall be permitted to develop separate rates for individuals age sixty-five or older for coverage for which medicare is the primary payer and coverage for which medicare is not the primary payer. Both rates shall be subject to the requirements of this subsection.

(d) The permitted rates for any age group shall be no more than four hundred twenty-five percent of the lowest

rate for all age groups on January 1, 1996, four hundred percent on January 1, 1997, and three hundred seventy-five percent on January 1, 2000, and thereafter.

(e) A discount for wellness activities shall be permitted to reflect actuarially justified differences in utilization or cost attributed to such programs not to exceed twenty percent.

(f) The rate charged for a health benefit plan offered under this section may not be adjusted more frequently than annually except that the premium may be changed to reflect:

(i) Changes to the family composition;

(ii) Changes to the health benefit plan requested by the individual; or

(iii) Changes in government requirements affecting the health benefit plan.

(g) For the purposes of this section, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision, provided that the restrictions of benefits to network providers result in substantial differences in claims costs. This subsection does not restrict or enhance the portability of benefits as provided in RCW 48.43.015.

(h) A tenure discount for continuous enrollment in the health plan of two years or more may be offered, not to exceed ten percent.

(2) Adjusted community rates established under this section shall pool the medical experience of all individuals purchasing coverage, except individuals purchasing coverage under RCW 48.20.029, and shall not be required to be pooled with the medical experience of health benefit plans offered to small employers under RCW 48.21.045.

(3) As used in this section, "health benefit plan," "adjusted community rate," and "wellness activities" mean the same as defined in RCW 48.43.005.

(4) This section shall not apply to premiums for health benefit plans covered under RCW 48.20.029.

Full language of statutory community rating requirements for small group health plans

RCW 48.44.023

Health plan benefits for small employers — Coverage — Exemption from statutory requirements — Premium rates — Requirements for providing coverage for small employers.

(1)(a) A health care services contractor offering any health benefit plan to a small employer, either directly or through an association or member-governed group formed specifically for the purpose of purchasing health care, may offer and actively market to the small employer a health benefit plan featuring a limited schedule of covered health care services. Nothing in this subsection shall preclude a contractor from offering, or a small employer from purchasing, other health benefit plans that may have more comprehensive benefits than those included in the product offered under this subsection. A contractor offering a health benefit plan under this subsection shall clearly disclose all covered benefits to the small employer in a brochure filed with the commissioner.

(b) A health benefit plan offered under this subsection shall provide coverage for hospital expenses and services rendered by a physician licensed under chapter 18.57 or 18.71 RCW but is not subject to the requirements of RCW 48.44.225, 48.44.240, 48.44.245, 48.44.290, 48.44.300, 48.44.310, 48.44.320, 48.44.325, 48.44.330, 48.44.335, 48.44.344, 48.44.360, 48.44.400, 48.44.440, 48.44.450, and 48.44.460.

(2) Nothing in this section shall prohibit a health care service contractor from offering, or a purchaser from seeking, health benefit plans with benefits in excess of the health benefit plan offered under subsection (1) of this section. All forms, policies, and contracts shall be submitted for approval to the commissioner, and the rates of any plan offered under this section shall be reasonable in relation to the benefits thereto.

(3) Premium rates for health benefit plans for small employers as defined in this section shall be subject to the following provisions:

(a) The contractor shall develop its rates based on an adjusted community rate and may only vary the adjusted community rate for:

(i) Geographic area;

(ii) Family size;

(iii) Age; and

(iv) Wellness activities.

(b) The adjustment for age in (a)(iii) of this subsection may not use age brackets smaller than five-year increments, which shall begin with age twenty and end with age sixty-five. Employees under the age of twenty shall be treated as those age twenty.

(c) The contractor shall be permitted to develop separate rates for individuals age sixty-five or older for coverage for which medicare is the primary payer and coverage for which medicare is not the primary payer. Both rates shall be subject to the requirements of this subsection (3).

(d) The permitted rates for any age group shall be no more than four hundred twenty-five percent of the lowest rate for all age groups on January 1, 1996, four hundred percent on January 1, 1997, and three hundred seventy-five percent on January 1, 2000, and thereafter.

(e) A discount for wellness activities shall be permitted to reflect actuarially justified differences in utilization or cost attributed to such programs. Up to a twenty percent variance may be allowed for small employers that develop and implement a wellness program or activities that directly improve employee wellness. Employers shall document program activities with the carrier and may, after three years of implementation, request a reduction in premiums based on improved employee health and wellness. While carriers may review the employer's claim history when making a determination regarding whether the employer's wellness program has improved employee health, the carrier may not use maternity or prevention services claims to deny the employer's request. Carriers may consider issues such as improved productivity or a reduction in absenteeism due to illness if submitted by the employer for consideration. Interested employers may also work with the carrier to develop a wellness program and a means to track improved employee health.

(f) The rate charged for a health benefit plan offered under this section may not be adjusted more frequently than annually except that the premium may be changed to reflect:

(i) Changes to the enrollment of the small employer;

(ii) Changes to the family composition of the employee;

(iii) Changes to the health benefit plan requested by the small employer; or

(iv) Changes in government requirements affecting the health benefit plan.

(g) Rating factors shall produce premiums for identical groups that differ only by the amounts attributable to plan design, with the exception of discounts for health improvement programs.

(h) For the purposes of this section, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision, provided that the restrictions of benefits to network providers result in substantial differences in claims costs. A carrier may develop its rates based on claims costs due to network provider reimbursement schedules or type of network. This subsection does not restrict or enhance the portability of benefits as provided in RCW 48.43.015.

(i) Adjusted community rates established under this section shall pool the medical experience of all groups purchasing coverage, including the small group participants in the health insurance partnership established in RCW 70.47A.030. However, annual rate adjustments for each small group health benefit plan may vary by up to plus or minus four percentage points from the overall adjustment of a carrier's entire small group pool, such overall adjustment to be approved by the commissioner, upon a showing by the carrier, certified by a member of the American academy of actuaries that: (i) The variation is a result of deductible leverage, benefit design, or provider network characteristics; and (ii) for a rate renewal period, the projected weighted average of all small group benefit plans will have a revenue neutral effect on the carrier's small group pool. Variations of greater than four percentage points are subject to review by the commissioner, and must be approved or denied within sixty days of submittal. A variation that is not denied within sixty days shall be deemed approved. The commissioner must provide to the carrier a detailed actuarial justification for any denial within thirty days of the denial.

(j) For health benefit plans purchased through the health insurance partnership established in chapter 70.47A RCW:

(i) Any surcharge established pursuant to RCW 70.47A.030(2)(e) shall be applied only to health benefit plans purchased through the health insurance partnership; and

(ii) Risk adjustment or reinsurance mechanisms may be used by the health insurance partnership program to redistribute funds to carriers participating in the health insurance partnership based on differences in risk attributable to individual choice of health plans or other factors unique to health insurance partnership participation. Use of such mechanisms shall be limited to the partnership program and will not affect small group health plans offered outside the partnership.

(4) Nothing in this section shall restrict the right of employees to collectively bargain for insurance providing benefits in excess of those provided herein.

(5)(a) Except as provided in this subsection, requirements used by a contractor in determining whether to provide coverage to a small employer shall be applied uniformly among all small employers applying for coverage or receiving coverage from the carrier.

(b) A contractor shall not require a minimum participation level greater than:

(i) One hundred percent of eligible employees working for groups with three or less employees; and

(ii) Seventy-five percent of eligible employees working for groups with more than three employees.

(c) In applying minimum participation requirements with respect to a small employer, a small employer shall not consider employees or dependents who have similar existing coverage in determining whether the applicable percentage of participation is met.

(d) A contractor may not increase any requirement for minimum employee participation or modify any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

(e) Minimum participation requirements and employer premium contribution requirements adopted by the health insurance partnership board under RCW 70.47A.110 shall apply only to the employers and employees who purchase health benefit plans through the health insurance partnership.

(6) A contractor must offer coverage to all eligible employees of a small employer and their dependents. A contractor may not offer coverage to only certain individuals or dependents in a small employer group or to only part of the group. A contractor may not modify a health plan with respect to a small employer or any eligible employee or

dependent, through riders, endorsements or otherwise, to restrict or exclude coverage or benefits for specific diseases, medical conditions, or services otherwise covered by the plan.

RCW 48.46.066

Health plan benefits for small employers — Coverage — Exemption from statutory requirements — Premium rates — Requirements for providing coverage for small employers.

(1)(a) A health maintenance organization offering any health benefit plan to a small employer, either directly or through an association or member-governed group formed specifically for the purpose of purchasing health care, may offer and actively market to the small employer a health benefit plan featuring a limited schedule of covered health care services. Nothing in this subsection shall preclude a health maintenance organization from offering, or a small employer from purchasing, other health benefit plans that may have more comprehensive benefits than those included in the product offered under this subsection. A health maintenance organization offering a health benefit plan under this subsection shall clearly disclose all the covered benefits to the small employer in a brochure filed with the commissioner.

(b) A health benefit plan offered under this subsection shall provide coverage for hospital expenses and services rendered by a physician licensed under chapter 18.57 or 18.71 RCW but is not subject to the requirements of RCW 48.46.275, 48.46.280, 48.46.285, 48.46.350, 48.46.355, 48.46.375, 48.46.440, 48.46.480, 48.46.510, 48.46.520, and 48.46.530.

(2) Nothing in this section shall prohibit a health maintenance organization from offering, or a purchaser from seeking, health benefit plans with benefits in excess of the health benefit plan offered under subsection (1) of this section. All forms, policies, and contracts shall be submitted for approval to the commissioner, and the rates of any plan offered under this section shall be reasonable in relation to the benefits thereto.

(3) Premium rates for health benefit plans for small employers as defined in this section shall be subject to the following provisions:

(a) The health maintenance organization shall develop its rates based on an adjusted community rate and may only vary the adjusted community rate for:

(i) Geographic area;

(ii) Family size;

(iii) Age; and

(iv) Wellness activities.

(b) The adjustment for age in (a)(iii) of this subsection may not use age brackets smaller than five-year increments, which shall begin with age twenty and end with age sixty-five. Employees under the age of twenty shall be treated as those age twenty.

(c) The health maintenance organization shall be permitted to develop separate rates for individuals age sixty-five or older for coverage for which medicare is the primary payer and coverage for which medicare is not the primary payer. Both rates shall be subject to the requirements of this subsection (3).

(d) The permitted rates for any age group shall be no more than four hundred twenty-five percent of the lowest rate for all age groups on January 1, 1996, four hundred percent on January 1, 1997, and three hundred seventy-five percent on January 1, 2000, and thereafter.

(e) A discount for wellness activities shall be permitted to reflect actuarially justified differences in utilization or cost attributed to such programs. Up to a twenty percent variance may be allowed for small employers that develop and implement a wellness program or activities that directly improve employee wellness. Employers shall document program activities with the carrier and may, after three years of implementation, request a reduction in premiums based on improved employee health and wellness. While carriers may review the employer's claim history when making a determination regarding whether the employer's wellness program has improved employee health, the carrier may not use maternity or prevention services claims to deny the employer's request. Carriers may consider issues such as improved productivity or a reduction in absenteeism due to illness if submitted by the employer for consideration. Interested employers may also work with the carrier to develop a wellness program and a means to track improved employee health.

(f) The rate charged for a health benefit plan offered under this section may not be adjusted more frequently than annually except that the premium may be changed to reflect:

(i) Changes to the enrollment of the small employer;

(ii) Changes to the family composition of the employee;

(iii) Changes to the health benefit plan requested by the small employer; or

(iv) Changes in government requirements affecting the health benefit plan.

(g) Rating factors shall produce premiums for identical groups that differ only by the amounts attributable to plan design, with the exception of discounts for health improvement programs.

(h) For the purposes of this section, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision, provided that the restrictions of benefits to network providers result in substantial differences in claims costs. A carrier may develop its rates based on claims costs due to network provider reimbursement schedules or type of network. This subsection does not restrict or enhance the portability of benefits as provided in RCW 48.43.015.

(i) Adjusted community rates established under this section shall pool the medical experience of all groups purchasing coverage, including the small group participants in the health insurance partnership established in RCW 70.47A.030. However, annual rate adjustments for each small group health benefit plan may vary by up to plus or minus four percentage points from the overall adjustment of a carrier's entire small group pool, such overall adjustment to be approved by the commissioner, upon a showing by the carrier, certified by a member of the American academy of actuaries that: (i) The variation is a result of deductible leverage, benefit design, or provider network characteristics; and (ii) for a rate renewal period, the projected weighted average of all small group benefit plans will have a revenue neutral effect on the carrier's small group pool. Variations of greater than four percentage points are subject to review by the commissioner, and must be approved or denied within sixty days of submittal. A variation that is not denied within sixty days shall be deemed approved. The commissioner must provide to the carrier a detailed actuarial justification for any denial within thirty days of the denial.

(j) For health benefit plans purchased through the health insurance partnership established in chapter 70.47A RCW:

(i) Any surcharge established pursuant to RCW 70.47A.030(2)(e) shall be applied only to health benefit plans purchased through the health insurance partnership; and

(ii) Risk adjustment or reinsurance mechanisms may be used by the health insurance partnership program to redistribute funds to carriers participating in the health insurance partnership based on differences in risk attributable to individual choice of health plans or other factors unique to health insurance partnership participation. Use of such mechanisms shall be limited to the partnership program and will not affect small group health plans offered outside the partnership.

(4) Nothing in this section shall restrict the right of employees to collectively bargain for insurance providing benefits in excess of those provided herein.

(5)(a) Except as provided in this subsection, requirements used by a health maintenance organization in determining whether to provide coverage to a small employer shall be applied uniformly among all small employers applying for coverage or receiving coverage from the carrier.

(b) A health maintenance organization shall not require a minimum participation level greater than:

(i) One hundred percent of eligible employees working for groups with three or less employees; and

(ii) Seventy-five percent of eligible employees working for groups with more than three employees.

(c) In applying minimum participation requirements with respect to a small employer, a small employer shall not consider employees or dependents who have similar existing coverage in determining whether the applicable percentage of participation is met.

(d) A health maintenance organization may not increase any requirement for minimum employee participation or modify any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

(e) Minimum participation requirements and employer premium contribution requirements adopted by the health insurance partnership board under RCW 70.47A.110 shall apply only to the employers and employees who purchase health benefit plans through the health insurance partnership.

(6) A health maintenance organization must offer coverage to all eligible employees of a small employer and their dependents. A health maintenance organization may not offer coverage to only certain individuals or dependents in a small employer group or to only part of the group. A health maintenance organization may not modify a health plan with respect to a small employer or any eligible employee or dependent, through riders, endorsements or otherwise, to restrict or exclude coverage or benefits for specific diseases, medical conditions, or services otherwise covered by the plan.

RCW 48.21.045

Health plan benefits for small employers — Coverage — Exemption from statutory requirements — Premium rates — Requirements for providing coverage for small employers — Definitions.

(1)(a) An insurer offering any health benefit plan to a small employer, either directly or through an association or member-governed group formed specifically for the purpose of purchasing health care, may offer and actively market to the small employer a health benefit plan featuring a limited schedule of covered health care services. Nothing in this subsection shall preclude an insurer from offering, or a small employer from purchasing, other health benefit plans that may have more comprehensive benefits than those included in the product offered under this subsection. An insurer offering a health benefit plan under this subsection shall clearly disclose all covered benefits to the small employer in a brochure filed with the commissioner.

(b) A health benefit plan offered under this subsection shall provide coverage for hospital expenses and services rendered by a physician licensed under chapter 18.57 or 18.71 RCW but is not subject to the requirements of RCW 48.21.130, 48.21.140, 48.21.141, 48.21.142, 48.21.144, 48.21.146, 48.21.160 through 48.21.197, 48.21.200, 48.21.220, 48.21.225, 48.21.230,48.21.235 , 48.21.244, 48.21.250, 48.21.300, 48.21.310, or48.21.320 .

(2) Nothing in this section shall prohibit an insurer from offering, or a purchaser from seeking, health benefit plans with benefits in excess of the health benefit plan offered under subsection (1) of this section. All forms, policies, and contracts shall be submitted for approval to the commissioner, and the rates of any plan offered under this section shall be reasonable in relation to the benefits thereto.

(3) Premium rates for health benefit plans for small employers as defined in this section shall be subject to the following provisions:

(a) The insurer shall develop its rates based on an adjusted community rate and may only vary the adjusted community rate for:

(i) Geographic area;

(ii) Family size;

(iii) Age; and

(iv) Wellness activities.

(b) The adjustment for age in (a)(iii) of this subsection may not use age brackets smaller than five-year increments, which shall begin with age twenty and end with age sixty-five. Employees under the age of twenty shall be treated as those age twenty.

(c) The insurer shall be permitted to develop separate rates for individuals age sixty-five or older for coverage for which medicare is the primary payer and coverage for which medicare is not the primary payer. Both rates shall be subject to the requirements of this subsection (3).

(d) The permitted rates for any age group shall be no more than four hundred twenty-five percent of the lowest rate for all age groups on January 1, 1996, four hundred percent on January 1, 1997, and three hundred seventy-five percent on January 1, 2000, and thereafter.

(e) A discount for wellness activities shall be permitted to reflect actuarially justified differences in utilization or cost attributed to such programs. Up to a twenty percent variance may be allowed for small employers that develop and implement a wellness program or activities that directly improve employee wellness. Employers shall document program activities with the carrier and may, after three years of implementation, request a reduction in premiums

based on improved employee health and wellness. While carriers may review the employer's claim history when making a determination regarding whether the employer's wellness program has improved employee health, the carrier may not use maternity or prevention services claims to deny the employer's request. Carriers may consider issues such as improved productivity or a reduction in absenteeism due to illness if submitted by the employer for consideration. Interested employers may also work with the carrier to develop a wellness program and a means to track improved employee health.

(f) The rate charged for a health benefit plan offered under this section may not be adjusted more frequently than annually except that the premium may be changed to reflect:

(i) Changes to the enrollment of the small employer;

(ii) Changes to the family composition of the employee;

(iii) Changes to the health benefit plan requested by the small employer; or

(iv) Changes in government requirements affecting the health benefit plan.

(g) Rating factors shall produce premiums for identical groups that differ only by the amounts attributable to plan design, with the exception of discounts for health improvement programs.

(h) For the purposes of this section, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision, provided that the restrictions of benefits to network providers result in substantial differences in claims costs. A carrier may develop its rates based on claims costs due to network provider reimbursement schedules or type of network. This subsection does not restrict or enhance the portability of benefits as provided in RCW 48.43.015.

(i) Adjusted community rates established under this section shall pool the medical experience of all small groups purchasing coverage, including the small group participants in the health insurance partnership established in RCW 70.47A.030. However, annual rate adjustments for each small group health benefit plan may vary by up to plus or minus four percentage points from the overall adjustment of a carrier's entire small group pool, such overall adjustment to be approved by the commissioner, upon a showing by the carrier, certified by a member of the American academy of actuaries that: (i) The variation is a result of deductible leverage, benefit design, or provider

network characteristics; and (ii) for a rate renewal period, the projected weighted average of all small group benefit plans will have a revenue neutral effect on the carrier's small group pool. Variations of greater than four percentage points are subject to review by the commissioner, and must be approved or denied within sixty days of submittal. A variation that is not denied within sixty days shall be deemed approved. The commissioner must provide to the carrier a detailed actuarial justification for any denial within thirty days of the denial.

(j) For health benefit plans purchased through the health insurance partnership established in chapter 70.47A RCW:

(i) Any surcharge established pursuant to RCW 70.47A.030(2)(e) shall be applied only to health benefit plans purchased through the health insurance partnership; and

(ii) Risk adjustment or reinsurance mechanisms may be used by the health insurance partnership program to redistribute funds to carriers participating in the health insurance partnership based on differences in risk attributable to individual choice of health plans or other factors unique to health insurance partnership participation. Use of such mechanisms shall be limited to the partnership program and will not affect small group health plans offered outside the partnership.

(4) Nothing in this section shall restrict the right of employees to collectively bargain for insurance providing benefits in excess of those provided herein.

(5)(a) Except as provided in this subsection, requirements used by an insurer in determining whether to provide coverage to a small employer shall be applied uniformly among all small employers applying for coverage or receiving coverage from the carrier.

(b) An insurer shall not require a minimum participation level greater than:

(i) One hundred percent of eligible employees working for groups with three or less employees; and

(ii) Seventy-five percent of eligible employees working for groups with more than three employees.

(c) In applying minimum participation requirements with respect to a small employer, a small employer shall not consider employees or dependents who have similar existing coverage in determining whether the applicable percentage of participation is met.

(d) An insurer may not increase any requirement for minimum employee participation or modify any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

(e) Minimum participation requirements and employer premium contribution requirements adopted by the health insurance partnership board under RCW 70.47A.110 shall apply only to the employers and employees who purchase health benefit plans through the health insurance partnership.

(6) An insurer must offer coverage to all eligible employees of a small employer and their dependents. An insurer may not offer coverage to only certain individuals or dependents in a small employer group or to only part of the group. An insurer may not modify a health plan with respect to a small employer or any eligible employee or dependent, through riders, endorsements or otherwise, to restrict or exclude coverage or benefits for specific diseases, medical conditions, or services otherwise covered by the plan.

(7) As used in this section, "health benefit plan," "small employer," "adjusted community rate," and "wellness activities" mean the same as defined in RCW 48.43.005.

Full language of grounds for disapproval for health plans:

RCW 48.44.020

Contracts for services — Examination of contract forms by commissioner — Grounds for disapproval — Liability of participant.

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

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

any of the following grounds:

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

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

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

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

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

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

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

(3) In addition to the grounds listed in subsection (2) of this section, the commissioner may disapprove any contract if the benefits provided therein are unreasonable in relation to the amount charged for the contract. Rates, or any modification of rates effective on or after July 1, 2008, for individual health benefit plans may not be used until sixty days after they are filed with the commissioner. If the commissioner does not disapprove a rate filing within sixty days after the health care service contractor has filed the documents required in RCW 48.44.017(2) and any rules adopted pursuant thereto, the filing shall be deemed approved.

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

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

RCW 48.46.060

Prepayment agreements — Standards for forms and documents — Grounds for disapproval — Cancellation or failure to renew — Filing of agreement forms.

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

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

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

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

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

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

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

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

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

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

(5) No health maintenance organization authorized under this chapter shall cancel or fail to renew the enrollment on any basis of an enrolled participant or refuse to transfer an enrolled participant from a group to an individual basis for reasons relating solely to age, sex, race, or health status. Nothing contained herein shall prevent cancellation of an agreement with enrolled participants (a) who violate any published policies of the organization which have been approved by the commissioner, or (b) who are entitled to become eligible for medicare benefits and fail to enroll for a medicare supplement plan offered by the health maintenance organization and approved by the commissioner, or (c) for failure of such enrolled participant to pay the approved charge, including cost-sharing, required under such contract, or (d) for a material breach of the health maintenance agreement.

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

RCW 48.18.110

Grounds for disapproval.

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

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

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

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

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

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

(2) In addition to the grounds for disapproval of any such form as provided in subsection (1) of this section, the commissioner may disapprove any form of disability insurance policy if the benefits provided therein are unreasonable in relation to the premium charged. Rates, or any modification of rates effective on or after July 1, 2008, for individual health benefit plans may not be used until sixty days after they are filed with the commissioner. If the commissioner does not disapprove a rate filing within sixty days after the insurer has filed the documents required in RCW 48.20.025(2) and any rules adopted pursuant thereto, the filing shall be deemed approved.

RCW 48.02.120

Records.

(1) The commissioner shall preserve in permanent form records of his or her proceedings, hearings, investigations, and examinations, and shall file such records in his or her office.

(2) The records of the commissioner and insurance filings in his or her office shall be open to public inspection, except as otherwise provided by this code.

(3) Actuarial formulas, statistics, and assumptions submitted in support of a rate or form filing by an insurer, health care service contractor, or health maintenance organization or submitted to the commissioner upon his or her request shall be withheld from public inspection in order to preserve trade secrets or prevent unfair competition.

APPENDIX B:

WACs

The following administrative rules establish the framework for health plan rate review in Washington State:

WAC 284-43-910 through WAC 284-43-945 detail the data and summary requirements for HCSCs and HMOs for individual and small group plans.

WAC 284-43-920 and WAC 284-43-950 detail the filing requirements for HCSCs and HMOs for large group health plans.

Chapter 284-60 WAC details the requirements disability carriers are subject to when offering health plans.

Full text of the above code is on the following pages.

WAC 248-43-910

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.

WAC 284-73-915

Demonstration that benefits provided are not reasonable in relation to the amount charged for a contract per RCW 48.44.020 and 48.46.060.

(1) The provisions of this section are in addition to the requirements set forth in RCW 48.44.022, 48.44.023, 48.46.064, and 48.46.066.

(2) Benefits will be found not to be unreasonable if the projected earned premium for the rate renewal period is equal to the following:

(a) An actuarially sound estimate of incurred claims associated with the filing for the rate renewal period, where the actuarial estimate of claims recognizes, as applicable, the savings and costs associated with managed care provisions of the plans included in the filing; plus

(b) An actuarially sound estimate of prudently incurred expenses associated with the plans included in the filing for the rate renewal period, where the estimate is based on an equitable and consistent expense allocation or assignment methodology; plus

(c) An actuarially sound provision for contribution to surplus, contingency charges, or risk charges, where the justification recognizes the carrier's investment earnings on assets other than those related to claim reserves or other similar liabilities; minus

(d) An actuarially sound estimate of the forecasted investment earnings on assets related to claim reserves or other similar liabilities for the plans included in the filing for the rate renewal period.

(3) The contribution to surplus, contingency charges, or risk charges in subsection (2)(c) of this section, will not be required to be less than zero.

WAC 284-43-920

When a carrier is required to file.

(1) Carriers must file with the commissioner every contract form and rate schedule and modification of a contract form and rate schedule:

(a) Before the contract form is offered for sale to the public and before the rate schedule is used; and

(b) Within thirty days after the end of an eighteen-month period during which a previous filing has remained unchanged for such period, including contract forms filed prior to the effective date of this regulation.

(2) Filings of negotiated contract forms, and applicable rate schedules, that are placed into effect at time of negotiation or that have a retroactive effective date are not required to be filed in accordance with subsection (1)(a) and (b) of this section, but must be filed within thirty working days after the earlier of:

(a) The date group contract negotiations are completed; or

(b) The date renewal premiums are implemented.

(3) An explanation for any filing delayed beyond the thirty-day period as described in subsection (2) of this section must be given on the filing document as set forth in WAC 284-43-950.

(4) If written confirmation of the commissioner's final action is desired, the carrier must submit with the filing duplicate copies of the filing transmittal and cover letter, along with a return self-addressed, stamped envelope. The

duplicate transmittal will note the commissioner's final action and will be returned to the sender in the return envelope enclosed with the filing.

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.

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.

WAC 284-43-935

Experience records.

(1) For each plan, carriers must maintain the following records for five years:

(a) Incurred claims;

(b) Earned premiums; and

(c) Expenses.

(2) Such records must include data for rider and endorsement forms that are used with the contract forms. Separate data may be maintained for each rider or endorsement form as appropriate. For recordkeeping purposes, carriers may combine experience under contract forms that provide substantially similar coverage.

WAC 284-43-940

Evaluating experience data.

In determining the credibility and appropriateness of experience data, consideration will be given to all relevant factors, including:

(1) Statistical credibility of the amount charged and services and benefits paid, such as low exposure, low loss frequency, and recoupment;

(2) Actual and projected trends relative to changes in medical costs and changes in utilization;

(3) The mix of business by risk classification; and

(4) Adverse selection or lapse factors reasonably expected in connection with revisions to plan provisions, services, benefits, and amount charged.

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:		

WAC 284-43-950

Summary for group contract filings other than small group contract filings.

GROUPS OTHER THAN SMALL GROUPS FILING SUMMARY

Carrier Name	
Address	
Contract Holder/Pool Category and Name (Check One Box)	☐ Single Employer Group:
	Employer Name:
	☐ Multiemployer other than Association/Trust Groups
	Group Pool Name:
	☐ Association/Trust Groups

	Association/Trust Group Name:
Contract Form Number	
Rate Form Number (if different from Contract Form Number)	
Product Name	

If additional space is required to list the contract/rate form number and product name, attach a separate sheet.

Rate Renewal Period:	From:		To:
Date Submitted:			
Type of Filing (Check One Box)	☐ New Group Contract		☐ Revision of Existing Group Contract

Proposed Rate Schedules: Attach a separate sheet to list all proposed tier rates.

Rate Summary

Current Rate (Composite per employee or per member)	$ per member per month
Percentage Rate Change	%
New Rate	$ per member per month
Average Number of Enrollees Each Month During the Experience Period (If the average number of enrollees is equal to or less than fifty, explain why this is not a small group, as defined in RCW 48.43.005.)	
Anticipated Loss Ratio	%

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

Summary of Contract Experience

	Experience Period	First Prior Period	Second Prior Period
	From To	From To	From To
Member Months			
Billed Premium			
Incurred Claims			
Expenses			
Gain/Loss			
Experience Refund/Credit or Recoupment			
Earned Premium (Billed Premium -/ Refund/Credit or Recoupment)			
Loss Ratio Percentage			

Attach comments or additional information.	
Preparer's Information	
Name:	
Title:	
Telephone Number:	

Chapter 284-60 WAC

Disability insurance loss ratios

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.

(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.

WAC 284-60-020

Purpose.

The purpose of this regulation is to:

(1) Establish loss ratio standards for the purpose of implementing the authority of the commissioner to disapprove and to withdraw approval of disability policy forms which are not returning or are not expected to return a reasonable proportion of the premiums in the form of benefits, pursuant to RCW 48.18.110(2), 48.19.010(2), 48.70.030 and 48.70.040.

(2) Define certain practices in the use of policy forms and in the making of disability insurance rates to be unfair, deceptive and discriminatory practices, pursuant to RCW 48.01.030, 48.18.480 and 48.30.010.

WAC 284-60-030

Definitions.

(1) The "expected loss ratio" is a prospective calculation and shall be calculated as the projected "benefits incurred" divided by the projected "premiums earned" and shall be based on the actuary's best projections of the future experience within the "calculating period."

(2) The "actual loss ratio" is a retrospective calculation and shall be calculated as the "benefits incurred" divided by the "premiums earned," both measured from the beginning of the "calculating period" to the date of the loss ratio calculations.

(3) The "overall loss ratio" shall be calculated as the "benefits incurred" divided by the "premiums earned" over the entire "calculating period" and may involve both retrospective and prospective data.

(4) The "calculating period" shall be the time span over which the actuary expects the premium rates, whether level or increasing, to remain adequate in accordance with his best estimate of future experience and during which the actuary does not expect to request a rate increase.

(5) The "benefits incurred" shall be the "claims incurred" plus any increase (or less any decrease) in the "reserves."

(6) The "claims incurred" shall mean:

(a) Claims paid during the accounting period; plus

(b) The change in the liability for claims which have been reported but not paid; plus

(c) The change in the liability for claims which have not been reported but which may reasonably be expected.

The "claims incurred" shall not include expenses incurred in processing the claims, home office or field overhead, acquisition and selling costs, taxes or other expenses, contributions to surplus, or profit.

(7) The "reserves," as referred to in this regulation, shall include:

(a) Active life disability reserves;

(b) Additional reserves whether for a specific liability purpose or not;

(c) Contingency reserves;

(d) Reserves for select morbidity experience; and

(e) Increased reserves which may be required by the commissioner.

(8) The "premiums earned" shall mean the premiums, less experience credits, refunds or dividends, applicable to an accounting period whether received before, during or after such period.

(9) Renewal provisions are defined as follows:

(a) "Guaranteed renewable" -- Renewal cannot be declined by the insurance company for any reason, but the insurance company can revise rates on a class basis.

(b) "Noncancellable" -- Renewal cannot be declined nor can rates be revised by the insurance company.

WAC 284-60-040

Grouping of policy forms for purposes of rate making and requests for rate increase.

(1) The actuary responsible for setting premium rates shall group similar policy forms, including forms no longer being marketed, in the pricing calculations. Such grouping shall rely on the judgment of the pricing actuary and be satisfactory to the commissioner. Among the factors which shall be considered are similar claims experience, types of benefits, reserves, margins for contingencies, expenses and profit, and equity between policyholders. Such

grouping shall enhance statistical reliability and improve the likelihood of premium adequacy without introducing elements of discrimination in violation of RCW 48.18.480.

(2) The insureds under similar policy forms are grouped at the time of rate making in accord with RCW 48.18.480 because they are expected to have substantially like insuring, risk and exposure factors and expense elements. The morbidity and mortality experience of these insureds will, as a group, deteriorate over time. It is hereby defined to be an unfair and discriminatory practice, pursuant to RCW 48.01.030, 48.18.480 and 48.30.010, to withdraw a form from its assigned grouping by reason only of the deteriorating health of the people insured thereunder.

(3) One or more of the policy forms grouped for rate making purposes may, by random chance, experience significantly higher or more frequent claims than the other forms. It is hereby defined to be an unfair and discriminatory practice, pursuant to RCW 48.01.030, 48.18.480 and 48.30.010, to deviate from the assigned grouping of policy forms for pricing purposes at the time of requesting a rate increase unless the actuary can justify to the satisfaction of the commissioner that a different grouping is more equitable because of some previously unrecognized and nonrandom distinction between forms or between groups of insureds.

(4) Successive policy forms of similar benefits are sometimes introduced by the insurers for the purpose of keeping up with trends in hospital costs, new developments in medical practice, additional supplemental benefits offered by competitors, and other reasons. While this is commendable, policyholders who can not qualify for the new improved policies, or to whom the new benefits are not offered, are left insured and isolated as a high risk group under the prior form and soon become subject to massive rate increases. It is hereby defined to be an unfair and discriminatory practice, pursuant to RCW 48.01.030, 48.18.480 and 48.30.010, to fail to combine successive generic policy forms and to fail to combine policy forms of similar benefits covering generations of policyholders in the calculation of premium rates and loss ratios.

WAC 284-60-050

Loss ratio requirements for individual disability insurance forms.

The following standards and requirements apply to individual disability insurance forms:

(1) Benefits shall be deemed reasonable in relation to the premiums if the overall loss ratio is at least sixty percent over a calculating period chosen by the insurer and satisfactory to the commissioner.

(2) The calculating period may vary with the benefit and renewal provisions. The company may be required to demonstrate the reasonableness of the calculating period chosen by the actuary responsible for the premium calculations. A brief explanation of the selected calculating period shall accompany the filing.

(3) Policy forms, the benefits of which are particularly exposed to the effects of inflation and whose premium income may be particularly vulnerable to an eroding persistency and other similar forces, shall use a relatively short calculating period reflecting the uncertainties of estimating the risks involved. Policy forms based on more dependable statistics may employ a longer calculating period. The calculating period may be the lifetime of the contract for guaranteed renewable and noncancellable policy forms if such forms provide benefits which are supported by reliable statistics and which are protected from inflationary or eroding forces by such factors as fixed dollar coverages, inside benefit limits, or the inherent nature of the benefits. The calculating period may be as short as one year for coverages which are based on statistics of minimal reliability or which are highly exposed to inflation.

(4) A request for a rate increase to be effective at the end of the calculating period shall include a comparison of the actual to the expected loss ratios, shall employ any accumulation of reserves in the determination of rates for the new calculating period, and shall account for the maintenance of such reserves for future needs. The request for the rate increase shall be further documented by the expected loss ratio for the new calculating period.

(5) A request for a rate increase submitted during the calculating period shall include a comparison of the actual to the expected loss ratios, a demonstration of any contributions to and support from the reserves, and shall account for the maintenance of such reserves for future needs. If the experience justifies a premium increase it

shall be deemed that the calculating period has prematurely been brought to an end. The rate increase shall further be documented by the expected loss ratio for the next calculating period.

(6) The commissioner may approve a series of two or three smaller rate increases in lieu of one large increase. These should be calculated to reduce lapses and anti-selection that often result from large rate increases. A demonstration of such calculations, whether for a single rate increase or for a series of smaller rate increases, satisfactory to the commissioner, shall be attached to the filing.

(7) Companies shall review their experience periodically and file appropriate rate revisions in a timely manner to reduce the necessity of later filing of exceptionally large rate increases.

WAC 284-60-060

Loss ratio requirement for group and blanket disability insurance policy forms and manual rates.

The following standards and requirements apply to group and blanket disability insurance policy forms and manual rates:

(1) Specified disease group insurance shall generate at least a seventy-five percent loss ratio regardless of the size of the group.

(2) Group disability insurance, other than specified disease insurance, as to which the insureds pay all or substantially all of the premium shall generate loss ratios no lower than those set forth in the following table.

Number of Certificate Holders at Issue, Renewal or Rerating	Minimum Overall Loss Ratio
9 or less	60%
10 to 24	65%
25 to 49	70%
50 to 99	75%
100 or more	80%

(3) Group disability policy forms, other than for specified disease insurance, for issue to single employers insuring less than one hundred lives shall generate loss ratios no lower than those set forth in subsection (2) of this section for groups of the same size.

(4) The calculating period may vary with the benefit and premium provisions. The company may be required to demonstrate the reasonableness of the calculating period chosen by the actuary responsible for the premium calculations.

(5) A request for a rate increase submitted at the end of the calculating period shall include a comparison of the actual to the expected loss ratios and shall employ any accumulation of reserves in the determination of rates for the selected calculating period and account for the maintenance of such reserves for future needs. The request for the rate increase shall be further documented by the expected loss ratio for the new calculating period.

(6) A request for a rate increase submitted during the calculating period shall include a comparison of the actual to the expected loss ratios, a demonstration of any contributions to or support from the reserves, and shall account for the maintenance of such reserves for future needs. If the experience justifies a premium increase it shall be deemed that the calculating period has prematurely been brought to an end. The rate increase shall further be documented by the expected loss ratio for the next calculating period.

(7) The commissioner may approve a series of two or three smaller rate increases in lieu of one larger increase. These should be calculated to reduce the lapses and antiselection that often result from large rate increases. A demonstration of such calculations, whether for a single rate increase or a series of smaller rate increases, satisfactory to the commissioner, shall be attached to the filing.

(8) Companies shall review their experience periodically and file appropriate rate revisions in a timely manner to reduce the necessity of later filing of exceptionally large rate increases.

WAC 284-60-070

Experience records.

Insurers shall maintain records of earned premiums and incurred benefits for each policy year for each policy, rider, endorsement and similar form which were combined for purposes of premium calculations, including the reserves. Records shall also be maintained of the experience expected in the premium calculations. Notwithstanding the foregoing, with proper justification, the commissioner may accept approximation of policy year experience based on calendar year data.

WAC 284-60-080

Evaluating experience data.

In determining the credibility and appropriateness of experience data, due consideration shall be given to all relevant factors including:

(1) Statistical credibility of premiums and benefits such as low exposure or low loss frequency;

(2) Past and projected trends relative to the kind of coverage, such as inflation in medical expenses, economic cycles affecting disability income experience, inflation in expense charges and others;

(3) The concentration of experience at early policy durations where select morbidity and preliminary term reserves are applicable and where loss ratios are expected to be substantially higher or lower than in later policy durations;

(4) The mix of business by risk classification;

(5) The expected lapses and antiselection at the time of rate increases.

WAC 284-60-090

Special circumstances.

Loss ratios other than those indicated in WAC 284-60-050 and 284-60-060 may be approved with satisfactory actuarial demonstrations. Examples of coverages where the commissioner may grant special considerations are:

(1) Short term nonrenewable policy forms such as airline trip or student accident.

(2) Policy forms exposed to high risk of claim fluctuation because of the low loss frequency, or the catastrophic or experimental nature of the coverage.

(3) Individual guaranteed renewable and noncancellable policy forms, but the loss ratio shall not be less than those set forth in the following table in lieu of those specified in WAC 284-60-050. In the calculation of loss ratios for such policies the reserves, except those required by RCW 48.12.030 (3)(a), shall be excluded from consideration as benefits incurred.

	Guaranteed Renewable	Noncancellable
Medical Expense	55%	50%
Loss of Income and Other	50%	45%

(4) Cases where higher than usual expenses are expected because of peculiar administrative or geographic circumstances.

(5) Freestanding group or blanket contracts for benefits which are normally written in conjunction with other benefits.

WAC 284-60-100

Effective date.

This regulation shall become effective on September 1, 1983, and shall apply to all policy, rider, endorsement, and similar forms and rate schedule filings subject to this regulation submitted on or after said date.

APPENDIX C:

Detailed Description of Information to be Submitted to Support Individual and Small Group Rate Filings

For individual rate filings, the following information stated in RCW 48.44.017(2) for HCSCs, RCW 48.46.062(2) for HMOs, and RCW 48.20.025(2) for disability carriers are required as part of the rate filings:

(a) A description of the carrier'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 of seventy-four percent, minus the premium tax rate applicable to the carrier's individual health benefit plans.

All HCSCs and HMOs are also required to submit the following information under WAC 284-43-930 for individual and small group rate filings:

(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).

APPENDIX D:

Rate Review Results

TABLE 1: Demonstrating Rate Review Results For Individual Market Rate Review

HCSCS & HMOS INDIVIDUAL MARKET						
Company	Requested Effective Date	Actual Effective Date	Average Increase Requested	Average Increase Accepted	Enrollment	Enrollment as of
Premera BlueCross	6/1/2009	6/1/2009	9.58%	6.11%		Dec-08
Lifewise Health Plan	1/1/2010	1/1/2010	7.40%	5.50%		Dec-08
Regence BlueShield	7/1/2008	8/1/2008	18.00%	17.80%		Dec-07
Asuris Northwest Health	7/1/2008	8/1/2008	18.00%	17.80%	(b)(4)	Dec-07
Group Health Cooperative	7/1/2008	7/1/2008	9.80%	9.70%		Dec-07
	7/1/2010	7/1/2010	9.40%	8.20%		Dec-10
Regence BC BS of Oregon	3/1/2009	3/1/2009	27.30%	27.10%		Dec-07

APPENDIX D:

Rate Review Results (continued)

TABLE 2: Demonstrating Rate Review Activity in Small Group Market

HCSCS & HMOS SMALL GROUP MARKET					
Company	Requested Effective Date	Actual Effective Date	Average Increase Requested	Average Increase Granted	Average
Premera Blue Cross	8/1/2005	8/1/2005	9.43%	8.25%	(b)(4)
	3/1/2008	3/1/2008	20.42%	19.08%	
	7/1/2010	7/1/2010	21.36%	20.57%	
Regence BlueShield	1/1/2006	1/1/2006	6.00%	3.20%	
	1/1/2007	1/1/2007	11.50%	9.90%	
Asuris Northwest Health	1/1/2006	1/1/2006	6.00%	3.20%	
	1/1/2007	1/1/2007	11.50%	9.90%	
Regence BC BS of Oregon	1/1/2006	1/1/2006	13.40%	-3.50%	
KPS Health Plans	1/1/2008	1/1/2008	15.60%	14.90%	
PacifiCare of Washington	1/1/2008	1/1/2008	29.20%	22.90%	

APPENDIX E:

Description of the Individual Rate Rebate Process

Washington State law requires that by May 31 of each year, carriers issuing or renewing individual health benefit plans in this state during the preceding calendar year must file for review by the commissioner supporting documentation of its actual loss ratio and its actual declination rate for its individual health benefit plans offered or renewed in this 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.

If the actual loss ratio for the preceding calendar year is less than the required loss ratio standard (as stated in the narrative under Retrospective Review and Rebates in the Individual Market), a remittance is due and the following shall apply:

(a) The carrier 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 required loss ratio (as stated in the narrative under Retrospective Review and Rebates in the Individual Market).

(b) The remittance to the Washington state health insurance pool is the percentage calculated in (a), 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 or the determination by an administrative law judge if there is any dispute regarding the calculation of the actual loss ratio.

APPENDIX F:

Current Level of Effort for the Rate Review Process

Table 1: Individual Market

		Annual Salary	Annual Benefits
	Actuary 3	$ 139,248.00	$ 25,301.82
30.00%	of time spent on individual	$ 41,774.40	$ 7,590.55
	Deputy Commissioner	$ 105,768.00	$ 22,975.64
3.75%	of time spent on individual	$ 3,966.30	$ 861.59
	Actuary 3	$ 128,111.00	$ 24,761.38
3.00%	of time spent on individual	$ 3,843.33	$ 742.84
	Actuary 2	$ 108,792.00	$ 23,243.96
1.00%	of time spent on individual	$ 1,087.92	$ 232.44
	Actuarial Analyst 2	$ 61,632.00	$ 17,257.06
0.00%	of time spent on individual	$ -	$ -
	Total resources spent on individual rate filings	$ 50,671.95	$ 9,427.41

Table 2: Small Group Market

		Annual Salary	Annual Benefits
	Actuary 3	$ 139,248.00	$ 25,301.82
22.00%	of time spent on small group	$ 30,634.56	$ 5,566.40
	Deputy Commissioner	$ 105,768.00	$ 22,975.64
1.20%	of time spent on small group	$ 1,269.22	$ 275.71
	Actuary 3	$ 128,111.00	$ 24,761.38
6.00%	of time spent on small group	$ 7,686.66	$ 1,485.68
	Actuary 2	$ 108,792.00	$ 23,243.96
0.00%	of time spent on small group	$ -	$ -
	Actuarial Analyst 2	$ 61,632.00	$ 17,257.06
0.00%	of time spent on small group	$ -	$ -
	Total resources spent on small group rate filings	$ 39,590.44	$ 7,327.79

Table 3: Large Group Market

%	Position	Annual Salary	Annual Benefits
	Actuary 3	$ 139,248.00	$ 25,301.82
3.00%	of time spent on large group	$ 4,177.44	$ 759.05
	Deputy Commissioner	$ 105,768.00	$ 22,975.64
0.50%	of time spent on large group	$ 528.84	$ 114.88
	Actuary 3	$ 128,111.00	$ 24,761.38
1.00%	of time spent on large group	$ 1,281.11	$ 247.61
	Actuary 2	$ 108,792.00	$ 23,243.96
14.00%	of time spent on large group	$ 15,230.88	$ 3,254.15
	Actuarial Analyst 2	$ 61,632.00	$ 17,257.06
10.00%	of time spent on large group	$ 6,163.20	$ 1,725.71
	Total resources spent on large group rate filings	$ 27,381.47	$ 6,101.41

Table 4: Undifferentiated Resources Spent

%	Position	Annual Salary	Annual Benefits
	ITS6	$ 87,096.00	$ 20,556.46
100.00%		$ 87,096.00	$ 20,556.46
	ITS4	$ 71,496.00	$ 18,535.22
50.00%		$ 35,748.00	$ 9,267.61
	Mgmt Analyst 4	$ 61,632.00	$ 17,535.00
30.00%		$ 18,489.60	$ 5,260.50
	Ins Tech 3	$ 38,556.00	$ 14,267.32
100.00%		$ 38,556.00	$ 14,267.32
	Total resources spent	$ 179,889.60	$ 49,351.89

APPENDIX G:

Recent Enforcement Actions

Company	Domestic?	Number of affected policy holders	Violation
Kaiser Foundation Health Plan of the Northwest & Kaiser Permanente Health Alternatives	No	Unknown	Market Conduct Exam: found use of an unfiled rate model. Fined $10,000 for market conduct violations as a whole (there were others in addition to the rate violations). Order No. 09-0020.
Premera Blue Cross and LifeWise Health Plan of Washington	Yes, see below for market share information.	Unknown	Market Conduct Exam: Found use of unfiled or approved rates. Fined $80,000 with $50,000 suspended as a whole (there were other violations in addition to the rate violations.) Order No. 09-0015
Regence BlueShield, Asuris Northwest Health, and Regence BlueCross BlueShield of Oregon	Yes, see below for market share information.	(b)(4)	Failure to timely file fully-negotiated plan rates. Fined $200,000 with $75,000 suspended as a whole (there were other violations in addition to the rate violation). Order No. 09-0116
RiverSource Life Insurance Company	No		Failed to file rates for one form. Fined $25,000 with $10,000 suspended. Order No. 09-0039.
Vision Service Plan	Yes, see below for market share information.	6 groups.	Market Conduct Examination: found use of rates for 6 groups prior to filing those rates with the OIC. Fined $14,750. Order No. 08-0060.
Washington Dental Service	Yes, see below for market share information.	(b)(4) in 2008 ne.	Repeated failure to timely file rates for negotiated contracts in 2006, 2007, and 2008. . $50,000 fine with $25,000 suspended as a whole (there were other violations in addition to the rate violations). Order No. 08-0109.
Willamette Dental of Washington, Inc.	Yes, see below for market share information.	8 groups	Market conduct exam: found use of unapproved Rates. Fined $30,000 with $10,000 suspended as a whole (there were other violations in addition to the rate violations). Order No. 08-0010.

Market Share: The Office of Insurance Commissioner does not have market share information for non-domestic companies. 2009 market share information for domestic companies is in the table below.

State of Washington
Office of Insurance Commissioner
2009 Washington Market Share and Loss Ratio
Line of Business: Accident and Health

All Domestic Authorized Companies
Zero Premium Companies Excluded

All Dollars in Thousands

Company Name	NAIC Code	Dom	Type(1)	Premiums Written	Market Share (2)	Premiums Earned	Losses Incurred(3)	Loss Ratio	Enrollment(4)
Aetna Hlth Inc WA Corp	47060	WA	HCSC	$5,920	0.04%	$5,921	$5,027	84.90%	846
Arcadian Hlth Plan Inc	12151	WA	HCSC	$32,336	0.24%	$32,336	$25,724	79.55%	3,360
Asuris NW Hlth	47350	WA	HCSC	$218,865	1.60%	$219,354	$196,609	89.63%	73,513
Columbia United Providers Inc	47047	WA	HCSC	$97,519	0.71%	$97,519	$82,467	84.57%	43,780
Community Hlth Plan of WA	47049	WA	HCSC	$558,581	4.08%	$558,581	$489,647	87.66%	263,701
Dental Hlth Serv	47490	WA	LHCSC	$8,199	0.06%	$0	$4,297	0.00%	23,863
Farmers New World Life Ins Co	63177	WA	L&D	$806	0.01%	$801	$117	14.60%	
Great Republic Life Ins Co	67482	WA	L&D	$1,710	0.01%	$1,875	$2,592	138.29%	
Group Hlth Coop	95672	WA	HMO	$1,999,205	14.62%	$1,996,419	$1,796,341	89.98%	352,274
Group Hlth Options Inc	47055	WA	HCSC	$640,436	4.68%	$639,182	$552,318	86.41%	189,301
KPS Hlth Plans	53872	WA	HCSC	$146,063	1.07%	$146,063	$134,498	92.08%	38,819
Lifewise Assur Co	94188	WA	L&D	$28,085	0.21%	$27,929	$17,538	62.79%	
LifeWise Hlth Plan of WA	52633	WA	HCSC	$210,235	1.54%	$210,246	$160,965	76.56%	78,092
Molina Hlthcare of WA Inc	96270	WA	HMO	$725,766	5.31%	$725,766	$600,946	82.80%	334,175
North Coast Life Ins Co	67059	WA	L&D	$0	0.00%	$0	$0	0.00%	
Pacific Visioncare WA Inc	47100	WA	LHCSC	$13	0.00%	$13	$14	108.36%	
Pacificare of WA Inc	48038	WA	HCSC	$417,931	3.06%	$417,577	$331,097	79.29%	42,852
Premera Blue Cross	47570	WA	HCSC	$2,026,196	14.82%	$2,023,053	$1,756,581	86.83%	521,327
Puget Sound Hlth Partners	12909	WA	HCSC	$53,351	0.39%	$0	$44,812	0.00%	4,462
Regence BlueShield	53902	WA	HCSC	$2,400,318	17.55%	$2,394,442	$2,042,985	85.32%	723,146
Symetra Life Ins Co	68608	WA	L&D	$22,905	0.17%	$22,872	$22,521	98.47%	
Timber Products Manufacturers Trust	12239	WA	MEWA	$6,741	0.05%	$6,741	$5,761	85.47%	4,138
Vision Serv Plan	47317	WA	LHCSC	$26,281	0.19%	$26,281	$20,477	77.92%	566,177
Washington Dental Serv	47341	WA	HCSC	$425,121	3.11%	$424,102	$379,415	89.46%	858,469
Washington State Auto Dealers Ins Tr	12609	WA	MEWA	$607	0.00%	$558	($917)	-164.27%	
Willamette Dental of WA Inc	47050	WA	LHCSC	$42,316	0.31%	$42,316	$38,831	91.77%	112,305
Totals (Loss Ratio is average)(5)				$10,095,506	73.82%	$10,019,945	$8,710,663	86.93%	4,234,600

(1)L&D=Life and Disability Ins. Co., P&C=Property and Casualty Ins. Co., HMO=Health Maintenance Organization, HCSC=Health Care Service Contractor, LHCSC=Limited HCSC, F=Fraternal, MEWA=Multiple Employer Welfare Arrangement
(2)Market Share is based on all authorized Washington companies' written premiums.
(3)Includes Risk Revenue-related claims and benefits. However, Premiums Written and Premiums Earned do not include Risk Revenue.
(4) Enrollment only provided by companies filing the NAIC Health blank.
(5)Totals do not represent all health coverage in Washington.

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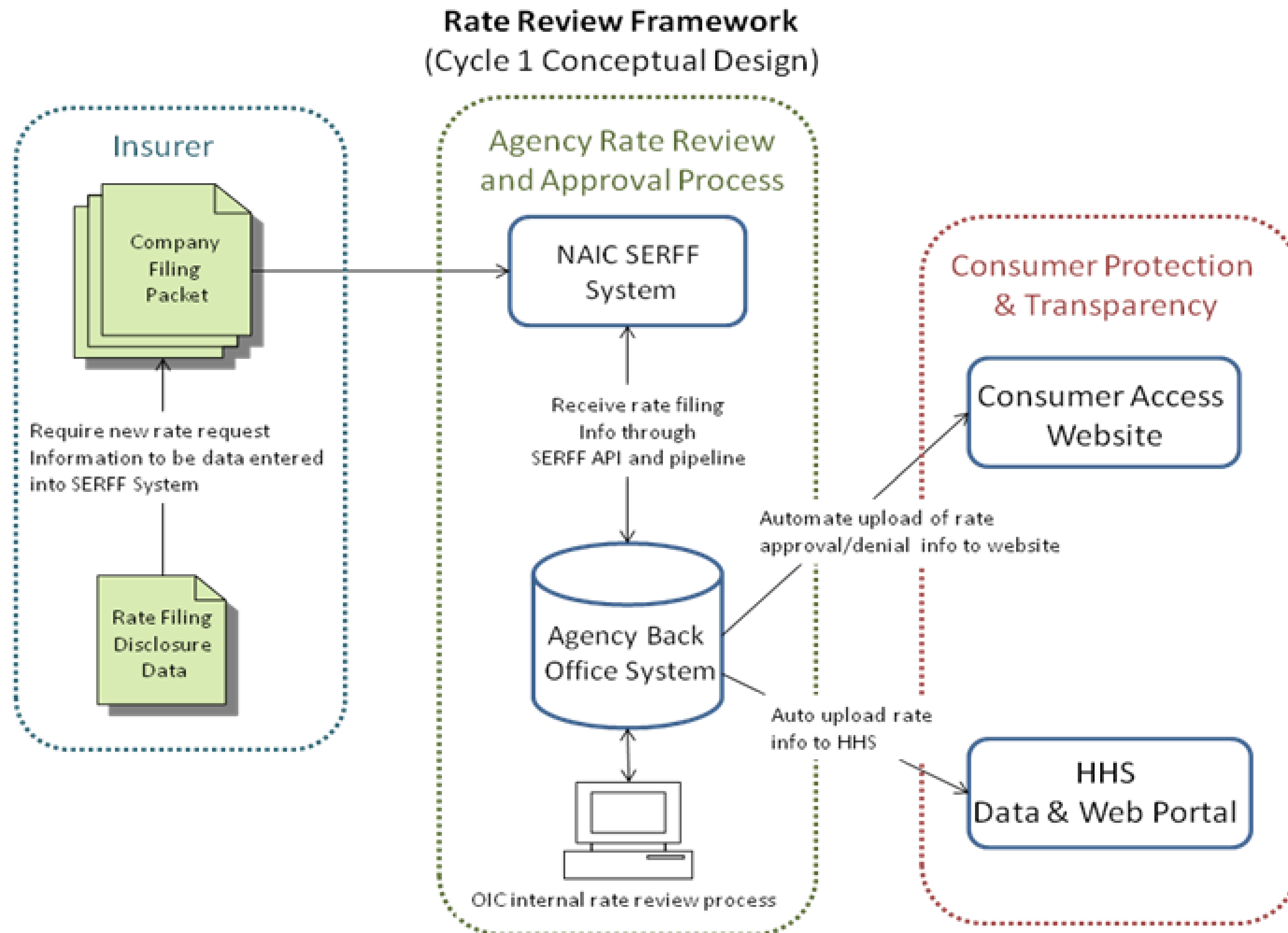
APPENDIX H:

Planned Expansion of Rate Review Framework



APPENDIX I:

Sample of Oregon's Rate Posting Method

Exhibit 1
OAR 836-053-0910

Rate Filing Summary
Life Wise Health Plan of Oregon
Individual Health Benefit Plan Renewal

The Oregon Insurance Division must approve the rates of all health benefits plans in the individual, small employer and portability markets.

Rate Request:

- Proposed rate increase: 15.0 percent from one year earlier*.
- Effective Date: 09/01/2010
- Oregonians Impacted: 28,917

*This does not mean that your rates will increase/decrease by this average amount. Rates are affected by the ages of the people covered, where they live, whether family members are covered and the date your policy renews.

Basis for rate request:

- Medical and prescription costs: Medical costs increased by 15.7 percent since last year and prescriptions costs increased by 15.7 percent during the same period.
- Medical and prescription benefits: No change to benefits.

Premium vs. Claims**

- Individual health plan premiums received: $73,832,948
- Individual health plan claims paid: $57,617,209
- Individual health plan medical profit: $1,351,187

**Calendar Year 2009 Reported Financial including Portability

Projected results of the proposed rate
A health insurance premium is made up of three pieces: the claims cost, administrative costs, and profit. If the requested rate change is approved Life Wise Health Plan of Oregon projects:

- **Claims costs:** Will change from 75.5 percent to 74.9 percent.
- **Administrative costs:** Will change from 22.5 percent to 24.1 percent.
- **Profit:** Will change from 2.0 percent to 1.0 percent.

Job Description for Project Director

Job Description: The Project Director, who is also the Deputy Commissioner for the Rates and Forms division of the WA Office of Insurance Commissioner, provides leadership in setting and managing the Rates and Forms Division priorities and programs including: developing an operational plan to best utilize staff and other resources allocated to the division and planning the division's activities in order to achieve the priorities and strategies identified in the agency's strategic plan. The business functions of the Rates and Forms division include Actuarial Services involving actuarial review of rate filings and financial examinations, policy/contract and other form review for legal compliance with state and federal law, insurance related statistical and data analysis and reporting, health plan provider network reporting, and adequacy analysis. This position is responsible for assuring that WA state meets the national standards for efficiency of product and review through implementing national sped to market initiatives. The position is also the Commissioner's designated representative to the Interstate Insurance Product Review Commission (IIPRC) and liaison to the NAIC. This position is the highest authority within OIC with designated responsibility to grant final approval to insurance companies for the use of all insurance products and rates in the state. The position is charged with assuring that companies comply with the rate and form insurance laws of the state and recommends enforcement and corrective action against companies that fail to comply.

Percentage of Time Worked: It is expected that the Project Director will spend approximately 10% of her time on duties directly related to the Premium Review Grant project and 90% on existing responsibilities.

The agency does not have an Assistant Director position.

Roles and Responsibilities of Dedicated Project Staff

The OIC plans to integrate project and contract staff with existing agency staff to accomplish the proposed activities. Subject matter experts within the agency will confirm the current system and process requirements, and will be provide requirements for the build portion of the project. Our goal is to minimize the time spent by actuarial and policy staff so that they can accomplish their regular position functions. To this end, we anticipate three project hires – a project manager, an actuary, and a health insurance outreach and education manager.

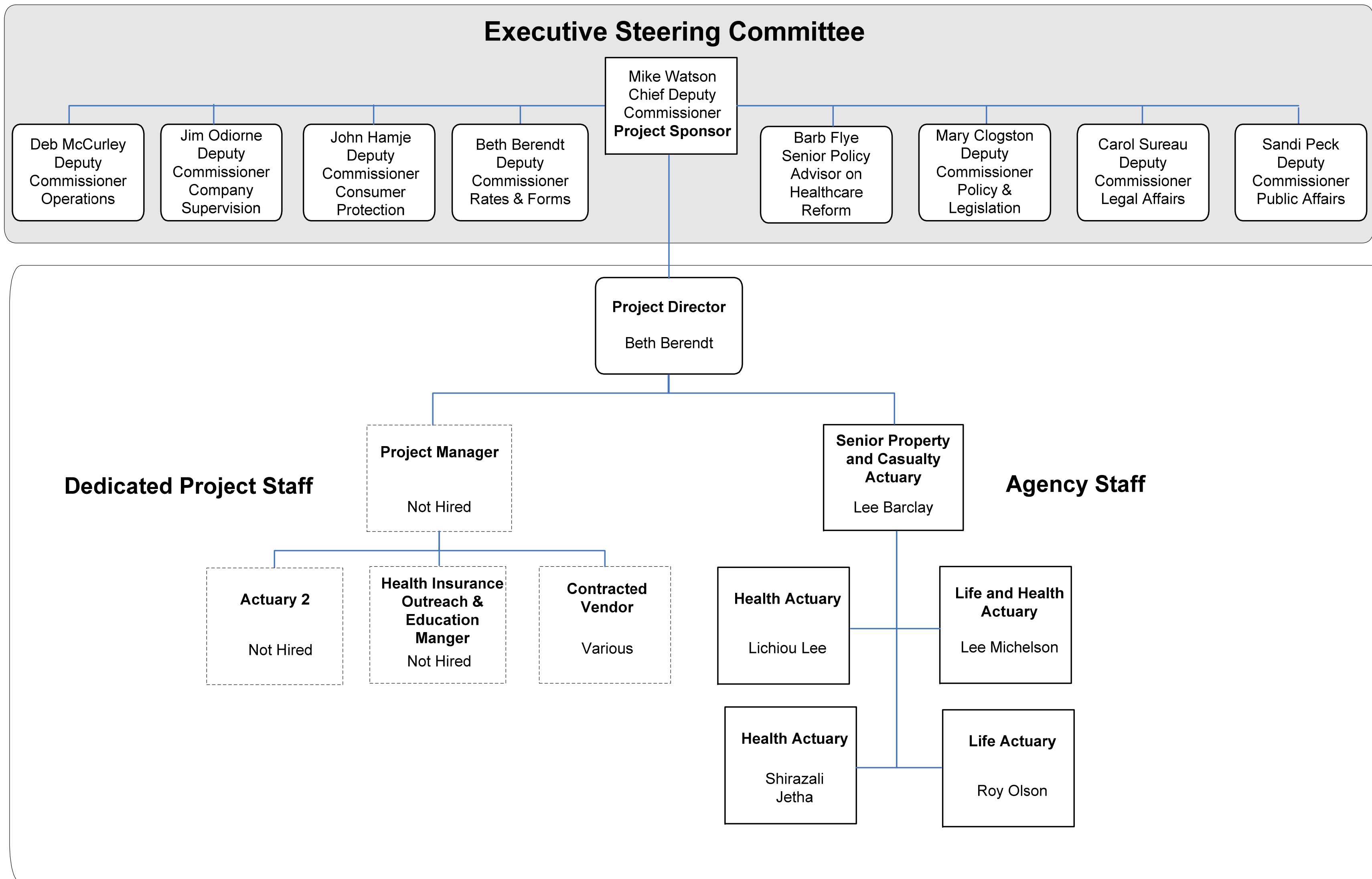
Project Manager: The Project Manager is 100% dedicated to the project and will be responsible for overseeing and coordinating the work activities of all agency and project staff assigned to the cycle 1 effort. Serving in this role, the Project Manager is charged with executing the work plan activities required to accomplish the cycle 1 deliverables on time and within budget. In addition to leading the traditional aspects of the project team, the Project Manager is also responsible for planning and coordinating the participation of cycle 1 stakeholders, including insurers, NAIC, HHS and impacted consumers and nonprofit groups. This position is unique in that the Project Manager will have the added responsibility to ensuring that stakeholder participation remains an integral part of overall project effort. As required by the grant opportunity, the Project Manager will undertake all required project reporting to HHS.

Actuary 2: This project position is 100% dedicated to the project and will be responsible for supporting the SIMBA-SERFF enhancement team in finalizing the rating information reporting requirements, performing actuarial analysis to verify the accuracy and consistency of data submitted through SERFF against the actual rate filing submitted by insurers during the early reporting periods of cycle 1, assisting the outreach manager regarding the technical details of health plan rating requirements, providing actuarial support to the agency's lead actuary as they presents actuarial analysis to external stakeholders like HHS, NAIC, legislatures and consumers, and, in consultation with the NAIC conduct focused research regarding the

various choices of rating requirements for large group, including presenting the research findings to agency Executive Leadership to support the agency's deliberation regarding choice of rating requirements.

Health Insurance Outreach and Education Manager: This project position is 100% dedicated to the project and will be responsible for health plan outreach and education developed through the project, with special emphasis on building and managing web content for the new health insurance rate website in collaboration with technology and web design staff. Specifically, the project envisions this person collaborating with multiple agency programs to create outreach and education strategy on health plan rates under the Patient Protection and Affordable Care Act, increasing consumer transparency by working with diverse agency business units, including actuarial staff, to translate complicated health plan rate information into material that the average consumer can understand, developing external and internal (training) communications materials, and interacting with issuers on their information they provide on rates to consumer.

Cycle 1 Rate Review Organization Chart



OMB Number: 0980-0204
Expiration Date: 12/31/2009

Objective Work Plan

Project:

Premium Review Grant

* Year: 1

* Funding Agency Goal:

Enhance the agency's rate review process by collecting detailed rate review information from insurers and increasing transparency to Washington consumers.

* Objective:

Improve the agency's rate review processes and data collections capability to enhance transparency for consumers, policyholders and HHS.

* Results or Benefits Expected:

Improved analysis, review and approval of rate filing. Ability to provide additional information for improved consumer understanding and transparency about the rate review process.

* Activities	* Position Responsible	* Time Period Begin	* Time Period End	* Non-Salary Personnel Hours
Project 1 – Gather, verify and document agency back office data system changes necessary to capture and store additional rating data elements and changes to inbound SERFF API interface	• Project Manager • Contracted Vendor	08/16/2010	11/01/2010	300
Project 1 – Implement system changes in agency back office data system and inbound SERFF API interface	• Project Manager • Contracted Vendor	11/02/2010	01/15/2011	430
Project 1 – System and integration testing of agency back office and inbound SERFF API interface data exchange and verify accuracy and constancy of submitted rate information	• Project Manager • Contracted Vendor • Actuary	01/16/2011	05/01/2011	300
Project 1 – “Go live” with agency back office data system and inbound SERFF API interface changes	• Project Manager • Contracted Vendor • Actuary	05/02/2011	05/15/2011	120

OMB Number: 0980-0204
Expiration Date: 12/31/2009

Objective Work Plan

* Activities	* Position Responsible	* Time Period Begin	* Time Period End	* Non-Salary Personnel Hours
Project 2 – Document and design system requirements for consumer rate review website for displaying new rate data elements	• Project Manager • Contracted Vendor • Health Ins Outreach & Education Manager	01/01/2011	03/15/2011	250
Project 2 – Develop consumer access website and interface to agency back office data system	• Project Manager • Contracted Vendor • Health Ins Outreach & Education Manager	03/16/2011	06/10/2011	250
Project 2 – Website usability testing, prepare outreach communication material and consumer Q&A content	• Project Manager • Contracted Vendor • Health Ins Outreach & Education Manager	06/08/2011	08/01/2011	260
Project 2 – Analyze HHS reporting requirements. May be included in the functionality changes contemplated with the SERFF reporting changes. Report and interface development to HHS. HHS report implementation data monitoring and review.	• Project Manager • Health Ins Outreach & Education Manager	03/05/2011	09/11/2011	470

* Criteria for Evaluating Results or Benefits Expected:

OIC will be able to accept into the agency's back office business system additional rating information, the data elements described in the HHS grant award document, from insurers via the NAIC's SERFF system. After each rate review process has been completed by actuarial staff, consumers will be able to search and view information about insurer rate request on the agency's website.

OMB Number: 0980-0204
Expiration Date: 12/31/2009

Objective Work Plan

You may attach up to 17 additional Objective Work Plan forms here. To extract, fill and attach each additional form, follow these steps:

- Select the "Select to Extract the Objective Work Plan Attachment" button below.

- Save the file using a descriptive name to help you remember the content of the supplemental form that you are creating. When assigning a name to the file, please remember to give it the extension ".pdf" (for example, "Objective_1.pdf"). If you do not name your file with the ".pdf" extension you will be unable to open it later, using Adobe Reader.

- Use the "Open Form" tool on Adobe Reader to open the new form you just saved.

- Enter your additional Objective information in this supplemental form, similar to the Objective Work Plan form that you see in the main body of your application.

- When you have completed entering information in the supplemental form, save and close it.

- Return to this page and attach the saved supplemental form you just filled in, to one of the blocks provided on this "attachments" form.

Important: Attach additional Objective Work Plan forms, using the blocks below. Please remember that the files you attach must be Objective Work Plan PDF forms that were previously extracted using the process outlined above. Attaching any other type of file may result in the inability to submit your application to Grants.gov. Note: It is important to attach completed forms only. Attach ONLY PDF (.pdf) forms where ALL required fields are filled out. Incomplete or missing data will cause your application to be rejected.

Select to extract the Objective Work Plan Attachment

1) Please attach Attachment 1		Add Attachment	Delete Attachment	View Attachment
2) Please attach Attachment 2		Add Attachment	Delete Attachment	View Attachment
3) Please attach Attachment 3		Add Attachment	Delete Attachment	View Attachment
4) Please attach Attachment 4		Add Attachment	Delete Attachment	View Attachment
5) Please attach Attachment 5		Add Attachment	Delete Attachment	View Attachment
6) Please attach Attachment 6		Add Attachment	Delete Attachment	View Attachment
7) Please attach Attachment 7		Add Attachment	Delete Attachment	View Attachment
8) Please attach Attachment 8		Add Attachment	Delete Attachment	View Attachment
9) Please attach Attachment 9		Add Attachment	Delete Attachment	View Attachment
10) Please attach Attachment 10		Add Attachment	Delete Attachment	View Attachment
11) Please attach Attachment 11		Add Attachment	Delete Attachment	View Attachment
12) Please attach Attachment 12		Add Attachment	Delete Attachment	View Attachment
13) Please attach Attachment 13		Add Attachment	Delete Attachment	View Attachment
14) Please attach Attachment 14		Add Attachment	Delete Attachment	View Attachment
15) Please attach Attachment 15		Add Attachment	Delete Attachment	View Attachment
16) Please attach Attachment 16		Add Attachment	Delete Attachment	View Attachment
17) Please attach Attachment 17		Add Attachment	Delete Attachment	View Attachment

OMB Number: 4040-0003
Expiration Date: 09/30/2011

Project Abstract

The Project Abstract must not exceed one page and must contain a summary of the proposed activity suitable for dissemination to the public. It should be a self-contained description of the project and should contain a statement of objectives and methods to be employed. It should be informative to other persons working in the same or related fields and insofar as possible understandable to a technically literate lay reader. This Abstract must not include any proprietary/confidential information.

* Please click the add attachment button to complete this entry.

Add Attachment | Delete Attachment | View Attachment

Project_Abstract.pdf

Project Abstract

Improving the collection of data to provide the basis for increased consumer transparency and awareness about the cost and quality of health care is a means of bringing long-term improvement to the financing of the healthcare system. The Washington State Office of the Insurance Commissioner (OIC) is excited and committed to participate in this grant opportunity, and looks forward to the continued partnership with the National Association of Insurance Commissioners (NAIC) to strengthen Washington State's rate review processes and transparency to consumers.

For Cycle 1 of the States Health Insurance Premium Review grant, the OIC proposes two discrete, but interrelated, projects to enhance our current health insurance rate review process.

The first project would be to expand the functionality of the OIC's existing policy and rate filing tracking system to accept more detailed rate information from health insurers. The agency currently receives insurer filings directly into its policy and rate filing tracking system through an interface with the NAIC's System for Electronic Rate and Form Filings (SERFF). The agency plans to continue its partnership with the NAIC by supporting the association's efforts to expand the functionality of the current SERFF reporting system. The expansion will allow insurers to file detailed rate request information directly into SERFF, allowing the OIC to aggregate and report data. This enhancement will enable the OIC to electronically download the detailed rate information from SERFF directly into the agency's filing tracking system, creating a streamlined filing process for insurers. The proposed enhancement will provide the means for insurers to uniformly submit required rating detail to the OIC (and other states) using systems and processes that currently exist. Additionally, along with helping the agency perform its rate review process, it will increase transparency to Washington State consumers and meet the data collection and reporting needs established by the Secretary of the U.S. Department of Health and Human Services (HHS). The estimated budget to accomplish this project is $605,896.

The second project is designed to enhance transparency to Washington State consumers by creating a Consumer Care website that includes plan rates, rate justification and an explanation of how premium is calculated based on rates. The information will be consumer-driven and presented in a format that is easily understood by the public. Today, the agency collects a limited amount of rate information that can be publicly disclosed; it is shared with consumers upon their request. For Cycle 1, the agency will develop a website where more detailed rate information will be posted in a standardized, easy-to-understand format. The website will display average rate increases requested and accepted by year, market type (individual, small group), and product type. As the agency gains the authority to release additional rate information to the public, the website will be expanded to include additional information, such as the number of people enrolled, number of members affected, earned premiums in each policy form and overall annual medical trend factor assumptions. The estimated budget to accomplish this project is $215,804.

Project Narrative File(s)

*** Mandatory Project Narrative File Filename:** Project Narrative.pdf

Add Mandatory Project Narrative File | Delete Mandatory Project Narrative File | View Mandatory Project Narrative File

To add more Project Narrative File attachments, please use the attachment buttons below.

Add Optional Project Narrative File | Delete Optional Project Narrative File | View Optional Project Narrative File

Project Narrative

a) Current health insurance rate review capacity and process

<u>General health insurance rate regulation information</u>

The Washington State Office of Insurance Commissioner (OIC) currently regulates three types of health insurance companies (also known as *carriers*): disability insurers, health care service contractors (HCSCs) and health maintenance organizations (HMOs). The types of products issued by these carriers are generally very similar, in that health insurance benefits are frequently delivered through networks of providers. The benefit design of the carrier's health plan may vary from tightly-managed care of a traditional HMO to the more popular point-of-service or preferred provider plans.

The Washington State market is heavily dominated by non-profit HCSCs (including Blue Cross/Blue Shield plans) and a large HMO. These are domestic companies domiciled in our state. We estimate they control over 80% of the health insurance market. The large "for profit" national carriers do not have a significant market share in Washington, but do provide a significant amount of the third party administrative services to self-insured employer health plans.

All of these carriers may issue individual, small group and large group health insurance products in Washington State as long as they comply with the various regulatory requirements for the products (i.e. contract form filings, rate filings, network submissions, etc.) The three largest carriers in our state are active in all three markets.

Rating Rules – Individual and Small Group Products: Washington State performs in-depth rate review of small group and individual product rates prior to their implementation. All carriers are required to comply with the adjusted community rating requirements for individual and small group lines of business. This means that, in this state, each carrier's rates are based on the individual companies' pooled or combined medical experience in the individual market. Rates for companies in the small group market are based on each company's pooled or combined medical experience in that market. The adjusted community rate for individual health plans may only vary for geographic area, family size, age, tenure discounts, and wellness activities. The adjustment for age may not

use age brackets smaller than five-year increments. The increments begin with age 20 and end at age 65. Individuals under the age of 20 must be treated the same as those at age 20. The permitted ratio from the highest age band rate to any age band rate cannot be more than 375%. Statutory community rating requirements for individual health plans are found in state law – Revised Code of Washington (RCW) 48.44.022 for HCSCs, RCW 48.46.064 for HMOs, and RCW 48.20.028 for disability carriers. More detail on these laws can be found in Appendix A.

For the small group health plans, the adjusted community rate may only vary for geographic area, family size, age, and wellness activities. The adjustment for age may not use age brackets smaller than five-year increments. The increments begin at age 20 and end at age 65. Employees under the age of 20 are treated the same as those at age 20. The permitted ratio from the highest age band rate to any age band rate cannot be more than 375%. The statutory community rating requirements for small group health plans are found in state law – RCW 48.44.023 for HCSCs, RCW 48.46.066 for HMOs, and RCW 48.21.045 for disability carriers.

In addition to the adjusted community rating requirements, the individual and small group plans for HCSCs and HMOs are subject to data and summary requirements under Washington Administrative Code (WAC) 284-43-930 through 284-43-950. Health plans offered by disability carriers are subject to the requirements under Chapter 284-60. WAC detail can be found in Appendix B.

Rating Rules – Large Group Rates: Although rates for large groups – defined as 51 employees or greater – must be filed with the agency, Washington State does not currently have rate review requirements in place for large group plans offered by HCSCs or HMOS. These companies traditionally negotiate rates with large groups, and market competition tends to moderate the rates. Large group health plans offered by disability carriers are subject to the loss ratio and pooling requirements under WAC Chapter 284-60, and the rate filing is reviewed for compliance with the minimum loss ratio standards that vary by group size up to 80% for groups of 100 certificates or more. The state will evaluate its overall rate review processes for large groups when Health and Human Services (HHS) promulgates rules on the new Federal Requirements for Medical Loss Ratios and other rating standards.

Health insurance rate review and filing requirements

Rate Filing Submission Data: A detailed description of the data required to be submitted by carriers in support of an individual or small group rate filing is shown in Appendix C. In general, this is designed to provide the OIC's actuary with sufficient information to understand the rate-making methodology used by the carrier's pricing actuary, and to verify the reasonableness of the rate request. These requirements are set forth in statute and rule, but the agency does not have a standard rate filing form. This is due, in part, to the complex nature of the information submitted, and our desire to allow some flexibility in the filing process to meet the individual needs of the pricing actuary.

The OIC regrets that it is unable to provide a sample of an actual rate filing at this time, due to the prohibition against public disclosure of actuarial formulas, statistics and assumptions submitted in support of a rate or form filing. See state law – RCW 48.02.120(3) in Appendix A.

Comprehensive Description of the Rate Review Process: The OIC currently employs three actuaries and one actuarial analyst who perform rate review of health insurance products in addition to other duties. Carriers are required to submit their rate filings electronically using the National Association of Insurance Commissioners' (NAIC) System for Electronic Rate and Form Filings (SERFF) filing system. This automated SERFF system is configured to require carriers to complete a series of checklists and attach the supporting documents and data required for rate review. Upon receipt, the filing is screened for completeness and then assigned to an OIC actuary for review.

As shown in Appendix C, the company is required to submit detailed information and data to support the rate filing. The carrier's pricing actuary prepares this documentation as well as actuarial certifications. This information and data is reviewed by the OIC's actuary and tested for reasonableness. Comparisons are made to the carrier's annual financial statements for consistency in data reporting and, if available, the results of the company's most recent financial examination by the OIC. In addition to reviewing the data and community rating requirements submitted as part of the rate filing, the OIC actuary's individual and small group rate filing review process includes evaluation of the carrier's medical loss ratio, medical trend, expenses breakdown, and projected profits. The OIC's

actuaries independently calculate trend and other factors to test the pricing actuary's assumptions for reasonableness. Finally, the OIC actuary checks the pricing actuary's calculations to identify and correct inadvertent arithmetic errors.

Rate review is an iterative process, and the OIC actuaries frequently correspond or meet with the carrier's pricing actuary and require modifications to the original rate filing documents, if they are viewed as incomplete, inaccurate or in violation of state law. The OIC actuaries also consult financial data available through the insurer's financial statements – as well other national data sources – to confirm that the data contained within the rate filing is accurate and reasonable. As a result, carriers may be required to submit several corrections or changes to the filing during the review period, in response to the OIC's requests for revision and resubmission.

Due to time constraints imposed by state law and the marketplace, it is important that the agency begin and complete its rate review process in a timely manner to prevent unreasonable rates from being implemented by the carriers.

Under Washington State insurance law, individual health plan rate filings, rates or modification of rates may not be used until 60 days after they are filed with the commissioner. If the commissioner does not disapprove a rate filing within 60 days after the carrier has filed the required documents, the filing is deemed approved. (See grounds for disapproval under state law – RCW 48.44.020 for HCSCs, RCW 48.46.060 for HMOs, and RCW 48.10.110 for disability carriers.)

OIC staff begins to review every individual rate filing within two weeks after it is submitted, and they have consistently finished the review within 60 days of submittal, thus preventing carriers from "deeming approval" of unreasonable rates. As you can see from Table 1 in Appendix D, there were seven instances since July 2008 where carriers' original individual rate increase requests were reduced.

For all other small group filings and disability insurer large group filings, the commissioner may disapprove the underlying 'form' (policy) if the benefits provided therein are unreasonable in relation to premium charged. The practical effect of this requirement is that the issuer may not continue to sell the product or renew contracts until it has satisfied the OIC's rate concerns, precluding the carriers from implementing a rate increase.

Since timely review of small group rates filings is also important to prevent the implementation of unreasonable rate increases, agency staff also reviews every small group rate filing within three weeks after the rate filing is submitted. Since carriers have usually filed small group rate filings 90 to 120 days before the effective date, OIC staff has consistently finished the review of the small group rate filing before the carrier's proposed effective date. As you can see from Table 2 in Appendix D, there are 10 instances since 2005 when small group rate increases were reduced.

As a general practice in Washington State, individual and small group rates are usually approved, modified, or rejected prospectively; there are no refunds to policyholders, since the proposed rate filings are reviewed or denied before the effective date. If rate changes are denied or reduced after they are implemented, refunds to consumers would be required.

Retrospective Review and Rebates in the Individual Market: Washington State does have a retrospective review process for individual rates mandated by state law – RCW 48.20.025, 48.44.017, and 48.46.062. If a carrier fails to achieve the minimum required loss ratio, (as shown in the table below) a rebate of sorts is required. If a carrier's medical loss ratio for the individual line of business in the previous year is less than the figure listed in the chart below, a remittance must be sent to the Washington State Health Insurance Pool. There is no rebate to the insured.

Actual Declination Rate*	Loss Ratio
<6%	74%
At least 6%, but < 7%	75%
At least 7%, but < 8%	76%
≥ 8%	77%

*Declination rate means the percentage of the total number of applicants to the individual health plan in the applicable year who were declined coverage due to failing the standard health questionnaire required by Washington state law.

Additional information about the individual premium rebate process is located in Appendix E.

Resources and capacity for reviewing health insurance rates

Information technology and systems capacity: The NAIC's SERFF is the initial point of entry for rate filing information in Washington State. Beginning in 2003, the OIC embarked on a multi-year IT system and business process transformation effort that resulted in the successful delivery of a new enterprise-wide "back office" data system, numerous e-commerce and consumer self-service online capabilities, and full integration with SERFF. As of July 1, 2010, all health filings submitted in Washington State are now required to be submitted though SERFF, shortening the time it takes to process policy and rate information and make it available to the public. The Cycle 1 grant objectives are very much in alignment with the agency's current business and technical direction of increasing consumer transparency of the policy and rate review process.

Budget and Personnel: The budget for the agency for state fiscal year (FY) 2010 is $24,886,000. The OIC's operating costs are funded by a regulatory surcharge that is paid in June of each year by authorized insurers, health care service contractors, health maintenance organizations, multiple employer welfare arrangements, title companies, and alien reinsurers. This money is deposited into a dedicated account to pay the OIC's operating costs for the following fiscal year. In calendar year 2009, salary and benefit expenditures totalled $369,741.96 for health insurance rate review. A breakdown of these expenditures by health insurance markets is as follows:

	Salary	Benefits		Total
Individual	$ 50,671.95	$ 9,427.41		$ 60,099.36
Small group	$ 39,590.44	$ 7,327.79		$ 46,918.23
Large group	$ 27,381.47	$ 6,101.41		$ 33,482.88
undifferentiated	$ 179,889.60	$ 49,351.89		$ 229,241.49
				$ 369,741.96

The agency's technical and business staffing and system support requirements for the rate and form review process (e.g., SERFF interface and the agency's core back-office data system created in 2003) include one senior level IT system support technician, one senior level IT network/server administrator, one management analyst, three insurance technicians, three actuaries, one actuarial analyst, and one deputy commissioner. These positions spend anywhere from 5 to 100% of their time on the health care rate review process, as detailed in Appendix F.

A deputy commissioner, two actuary 3's, one actuary 2, and an actuarial analyst are specifically responsible for rate review. The deputy commissioner has experience with public sector insurance regulation and public and private insurance employee benefits purchasing, including health insurance. A college degree is a requirement for this position. The actuary 3's have a BS or MS in Mathematics or similar qualifying field of study, and membership in the American Academy of Actuaries and the Society of Actuaries are maintained. Additionally, one of the actuary 3's is a Chartered Enterprise Risk Analyst. The actuary 2 holds membership in the American Academy of Actuaries and the Society of Actuaries, is a Chartered Life Underwriter, and holds a PhD in Mathematics. The actuarial analyst has a BS in Mathematics with a specialization in actuarial science and has passed two Society of Actuaries examinations.

In 2009, the agency received 640 health insurance rate filings – 56 individual, 21 small group and 563 large group. The OIC does not collect data in a way that enables the agency to determine the average time it takes to complete the review process for the rate filings that are subject to the Patient Protection and Affordable Care Act. However, data on a similar set of filings may be helpful. For all HMO and HCSC rate filings approved or accepted by the OIC in 2009, the average time to complete the review process (from receipt of filing to final action) was 33.2 days.

Consumer protections

Rate filings are generally not publicly disclosed. According to Washington State law RCW 48.02.120(3), all actuarial formulas, statistics, and assumptions submitted in support of a rate or form filing by an insurer, health care service contractor, or health maintenance organization or submitted to the commissioner upon his request are considered proprietary and not releasable to the public. However, a schedule of proposed rates for all individual health plans in Washington State on the OIC's consumer web page.

Agency staff respond to public questions about rates and provide them with the average rate change for a particular individual plan, an estimate of the number of people impacted, and general financial information for the health plan – for instance, how much money the health carrier may have lost in the individual market or if a rate change is due to a benefit change or medical claims.

Summaries of rate changes are not offered in plain language for consumers. Most of the details behind a rate change cannot be released to the public. Most carriers provide their enrollees with at least 30 days' notice of a rate change, with a limited explanation, but they are not required by Washington State law to do so. There are no official comment periods, public meetings and/or hearings on rates. The OIC does receive complaints from consumers regarding premium rate increases, and may contact a carrier on a consumer's behalf. In the last two years, the agency has received 605 consumer calls regarding rates. OIC staff provided 422 of the callers with information about what generated the rate increases, and when appropriate, with options for finding and purchasing insurance. The remaining 183 calls led to investigations by the agency. The vast majority of these dealt with concerns over the legality of increasing rates in individual, small group and association plans. Following these investigations, OIC staff provided most callers with general information about the law and the increases, including whether the rates in question were accepted by the agency.

Examination and oversight

The OIC enforces rating and rate filing rules in several ways. The agency has a market conduct oversight program, and staff in this area performs targeted investigations of all companies in the Washington State market, conducting a continuum of examination actions up to and including a full market conduct examination of a company. OIC staff investigates and resolves consumer complaints regarding rates, including determining whether the rates charged are consistent with the rates filed. They conduct full reviews of all rate filings, including investigating any inconsistencies with prior filings that may indicate noncompliance with Washington rate laws. Please see Appendix G for a detailed listing of recent enforcement actions.

b) Proposed rate review enhancements for health insurance

ASSURANCE: The *Washington State Office of Insurance Commissioner assures that any grant funding awarded as a result of this application will be used to develop or make improvements to existing rate review and approval practices as well as transparency in that process.*

The OIC has identified two discrete, but interrelated projects to enhance the agency's current rate review process. The first project would be to augment the existing IT framework (SIMBA) to enable it to receive additional information from SERFF, thus enhancing the rate review process. The enhanced framework would provide the means for insurers to uniformly submit required rating detail to the OIC, using systems and processes that already exist, and for the agency to complete the necessary review and make this information significantly more transparent to Washington State consumers and HHS. The second project would focus on enhancing transparency to Washington State consumers by creating a Consumer Care website, enabling comparison of plan rates, rate justification and an explanation of how premium is calculated based on rates.

SIMBA augmentation: Today, the agency's SIMBA – SERFF interface is limited in its ability to support rate review. While documents reside in the system, rate review is largely a manual process, and very little systems functionality exists to support and report on rate review activity. The NAIC is planning systems enhancements to SERFF to support the new federal requirements; part of the proposal includes systems design and programming to enable SIMBA to interface with SERFF after these changes occur. As part of the proposed enhancements built into SERFF, we received the following proposal from the NAIC:

1) A description of the anticipated SERFF changes, which includes modifying SERFF to address data collection and reporting requirements, such as:

   a. State options to indicate premium review grant participation
   b. Company profile changes to incorporate company type
   c. State-maintained indicator for rate filing requests meeting the HHS threshold for 'unreasonable'
   d. Addition of field to indicate product types

e. Company-maintained product information, including product name, HHS id, and product status, which will allow companies to track products and apply them to filings.

f. A new set of fields added to the Rate/Rule schedule items to provide HIPR data on a policy form basis.

g. Changes to the State API to accommodate retrieval of the data elements added above and to allow for updates of appropriate data elements via the State API.

2) A plan to incorporate the submission of the Rate Filing Disclosure Form and Justification of the Rate Filing (currently being reviewed by the NAIC B Committee as a recommendation to the HHS as requirements to be filed under provisions of *Section 2794 of the Public Service Act, which was added in Section 1003 of* the Patient Protection and Affordable Care Act if a rate request falls under the definition of 'unreasonable'). The estimate provided by the NAIC would also allow the Rate Filing Disclosure Form, or similar document, to be filed regardless of whether the rate request falls under the definition of 'unreasonable,' in case states want to require this form as part of their efforts to increase transparency of the rate review process.

3) A commitment to provide additional training to state personnel on the new SERFF enhancements that will support the grant requirements.

4) NAIC support for making non-confidential rate disclosures and/or rate filing information available to the public, as required and permitted.

5) NAIC commitment to explore the development of management reporting systems for data reporting within the SERFF system, if HHS will accept reports directly from SERFF, including basic trending reports. The workflow on a health filing that requires the enhanced data reporting fields will vary from the existing SERFF workflow. States will set preferences that will indicate the level of data they would like to require. Fields exposed to the industry during the filing creation process are determined by these state preferences. The overall workflow will be changed in that the filer will now be required to tie schedule items (such as rates and policy forms) to a specific product. This will allow for the reporting of data based on the product the consumer will ultimately be offered. A significant portion of the project hours will be devoted to aggregating the collected data into the reports required by HHS. An interface to allow HHS to access reports from SERFF is included within the estimate, should that be a requirement.

To accomplish the necessary system changes and SERFF integration activities within the time constraints of cycle 1, the OIC intends to augment existing IT capacity on a short-term basis using contracted vendors. Augmenting agency IT capacity using vendor resources is a proven resourcing model used by the agency since 2003. While the OIC does have sufficient IT capacity to support current systems, the agency does not have sufficient capacity to solely make the necessary system changes and enhancements within the time constraints of Cycle 1. The OIC has long-standing vendor relationships in place that are used repeatedly to deliver major IT system implementations on time and within budget. As a planned outcome of all IT system implementations and upgrades involving contracted vendors, the agency's investment plans and contracts include transition activities to ensure that ongoing system maintenance responsibilities are completely transferred to agency IT staff, thus eliminating any dependency on the vendor to maintain IT systems.

All system changes and enhancements required to meet the objectives of Cycle 1 will follow the agency's existing software development and system delivery lifecycle and methodologies. The agency uses the scrum software development methodology and applies a "best practices" approach to system regression testing, software configuration and release management. The agency's IT application manager would manage the delivery of all system changes required for Cycle 1, including coordinating with the NAIC to make necessary SERFF interface changes. The IT manager would oversee all vendor contract management and budget activities for the system upgrade component. At least one senior level system development architect would be assigned to oversee the soft development work of the contracted vendors who will be working on the Cycle 1 system changes. System and usability testing would be performed through a combination of key business staff and contracted testers.

The OIC intends to continue its partnership and use of the NAIC's SERFF system as the "point of entry" for insurers to submit rate requests. The diagram in Appendix H illustrates the agency's planned expansion of the rate review framework. The enhanced framework provides the means for insurers to uniformly submit required rating detail to the agency, using systems and processes that already exist, and for the OIC to complete the necessary review and make this information significantly more transparent to the public and HHS.

Delivery Timeline: The NAIC plans to implement the SERFF enhancements incorporating HHS reporting requirements in a phased approach, with the first release to occur within three months of the receipt of HHS requirements for the uniform template for reporting. The initial release will focus on implementing the means for data collection; subsequent releases will incorporate reporting needs. Releasing functionality in this manner will allow a period of time during which data can then be submitted by insurers prior to any required reporting to HHS, thus avoiding manual data collection processes. Based on the requirements known at this time, the development will occur over an eight-month period, beginning when the NAIC receives the reporting template and supporting documentation.

Creation of Consumer Care website: The Cycle 1 grant objectives are very much in alignment with the agency's current business and technical direction to increase consumer transparency of the policy and rate review process. A limited amount of the information the agency collects in rate filings today is public, and it is shared with consumers, if they request it. For Cycle 1, OIC staff will develop a website where this information can be posted in a standard form similar to Oregon's posts, as shown below and in Appendix I. This information will include:

- Company name
- Number of policy forms covered by filing
- Policy form numbers covered by filing
- What market filing covers (individual, small group, or large group)
- Type of insurer
- Annual rate
- Average rate increase initially requested
- Review outcome
- Average rate increase approved
- Effective date of rate increase
- Whether the products are open or closed
- Any changes in member cost-sharing
- Any changes in member benefits

OREGON Health Rate Filings and Public Comments

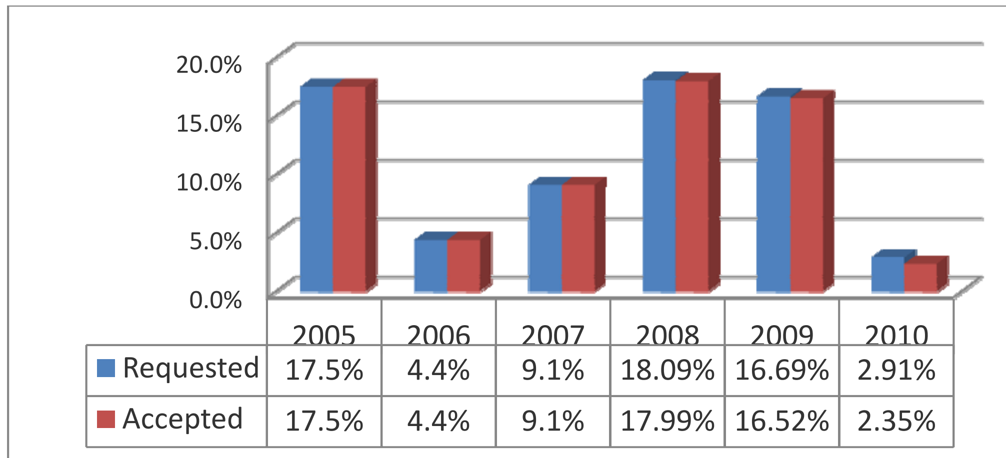
Questions? Call our consumer insurance advocates at 503-947-7984 or toll-free at 1-888-877-4894.

Displaying 1 - 25 (27 total) Prev | Next 2

Company Name	NAIC #	Type of Insurance	Submission Date	Effective Date	Decision Date	Status	Rate Filing Documents	State Tracking #
REGENCE BLUECROSS BLUESHIELD OF OREGON	54933	SMALL GRP HLTH PLANS	11/25/2009	04/01/2010	01/08/2010	APPROVED	View Request View Comments View Decision	GH 0529 08
REGENCE BLUECROSS BLUESHIELD OF OREGON	54933	MAJOR MEDICAL POLICY	12/07/2009	04/01/2010	02/08/2010	APPROVED	View Request View Comments View Decision	HL 0260 08
REGENCE BLUECROSS BLUESHIELD OF OREGON	54933	SMALL GRP HLTH PLANS	02/11/2010	07/01/2010	03/18/2010	APPROVED	View Request View Comments View Decision	GH 0529 08
REGENCE BLUECROSS BLUESHIELD OF OREGON	54933	MAJOR MEDICAL POLICY	03/30/2010	07/01/2010	05/06/2010	APPROVED	View Request View Comments View Decision	HL 0260 08
REGENCE BLUECROSS BLUESHIELD OF OREGON	54933	SMALL GRP HLTH PLANS	06/14/2010			PENDING	View Request View Comments Make Comment	GH 0529 08

Agency staff also will post average rate increases requested and accepted by year, market type (individual, small group), and product type, in a format similar to the chart below.

Individual rate changes by year



If the agency receives authority to release all rate information to the public, staff will expand information available on the Consumer Care website to include:

- Number of people enrolled
- Number of policyholders or members affected by each policy form
- Total earned premiums in each policy form
- Total incurred claims in each policy form
- Overall annual medical trend factor assumptions

- Aggregate data in the rate filing, by market segment, product type, number of policyholders and number of covered lives affected.

c) Plan for Reporting to the Secretary on Rate Increase Patterns

COMPLIANCE WITH SECTION 2794: *The Washington State Office of Insurance Commissioner attests that it will comply with the reporting requirements outlined in Section 2794 of the Public Health Service Act, by collecting and reporting the data to the Secretary of the Department Health and Human Services, to the extent that the OIC has the authority and the collected information is releasable.*

Trend data for plan years 2009 – 2011: Overall annual medical trend factor assumptions for all benefit categories combined are in the rate filings, but are not releasable under Washington State law. Annual insurance trends by separate benefit category, providing the amount of the projected trend attributable to the use of certain types of services (claims), price inflation or fees and risk is not currently captured in Washington State's rate filings.

Budget Narrative File(s)

*** Mandatory Budget Narrative Filename:** Budget Narrative.pdf

Add Mandatory Budget Narrative | Delete Mandatory Budget Narrative | View Mandatory Budget Narrative

To add more Budget Narrative attachments, please use the attachment buttons below.

Add Optional Budget Narrative | Delete Optional Budget Narrative | View Optional Budget Narrative

Budget Narrative

Current state funding for health insurance rate review efforts: In calendar year 2009, salary and benefit expenditures totaled $369,741.96 for health insurance rate review, broken out as follows:

	Salary	Benefits		Total
Individual	$ 50,671.95	$ 9,427.41		$ 60,099.36
Small group	$ 39,590.44	$ 7,327.79		$ 46,918.23
Large group	$ 27,381.47	$ 6,101.41		$ 33,482.88
undifferentiated	$ 179,889.60	$ 49,351.89		$ 229,241.49
				$ 369,741.96

Estimated Funding Requirements: Total estimated funding requirements for the grant period totals $871,700, broken out as follows:

Budget Activity/Object	Project 1 SIMBA/SERFF Interface	Project 2 Rate Review Website	Line Item Total
Personnel	$212,576	$104,000	$316,576
Fringe Benefits	$78,624	$28,080	$106,704
Travel	$20,000	$0	$357,420
Equipment	$19,500	$0	$19,500
Supplies	$1,500	$0	$1,500
Contractual	$273,696	$83,724	$20,000
Other (SERFF chargeback)	$50,000	$0	$50,000
Total	$655,896	$215,804	**$871,700**

The request for funding includes three fulltime project positions for 13 months, including benefits, supplies and equipment. The positions include a Project Manager who will oversee all activities of projects 1 and 2, a Senior Actuary to support the agency's enhanced rate review processes and analysis, and a Health Insurance Outreach and Education Manager to coordinate the agency's outreach efforts aimed at improving transparency for consumers into the rate review process. Given the complexities of

cycle 1, OIC anticipates hiring a skilled Project Manager who has demonstrated experience leading projects that encompass significant stakeholder management, implementing complex policy changes, facilitating business process transformation and coordinating changes to IT systems. The salary expenditure for the Project Manager has been set at a maximum burn rate of $11,200 per month. The actuarial review process used by the agency will change significantly as a result of cycle 1, including how the agency reviews and verifies rates received from insurers through the National Association of Insurance Commissioner's (NAIC) System for Electronic Rate and Form Filing (SERFF) system. To support this effort, OIC intends to retain the support of a senior Actuary at a maximum burn rate of $11,200 per month. The salary expenditure for the Health Insurance Outreach and Education Manager to coordinate the agency's outreach efforts has been set at a maximum burn rate of $8,000 per month.

The budget request also includes funding to complete required IT system enhancements for the agency using contracted vendors and budget support for the NAIC to complete the necessary changes to the SERFF tracking system. At the time of grant submittal, the NAIC has estimated a cost of $18,808 per state to complete the anticipated changes to the SERFF tracking system. The agency is reserving an additional $31,000 contingency budget for the NAIC SERFF changes, because it is unknown at this time if all states will participate in funding the required changes to SERFF. This contingency request ensures we will have additional funding should the per state costs turn out to be greater than originally planned. Lastly, a small budget amount has been allocated to fund anticipated travel costs of agency staff that may be required to attend NAIC national meetings on improving rate review processes and SERFF enhancement training session. This dedicated travel budget is needed due to state budget constraints – the state legislature passed ESHB 2921, prohibiting the use of state funds for out-of-state travel for state employees, unless specifically exempted by Office of Financial Management.

BUDGET INFORMATION - Non-Construction Programs

OMB Approval No. 4040-0006
Expiration Date 07/30/2010

SECTION A - BUDGET SUMMARY

	Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
			Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1.	Project 1 - SIMBA/ SERFF Interface	93.511	$	$	$ 655,896.00	$	$ 655,896.00
2.	Project 2 - Rate Review Website	93.511			215,804.00		215,804.00
3.							
4.							
5.	Totals		$	$	$ 871,700.00	$	$ 871,700.00

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY				Total (5)
	(1) Project 1 - SIMBA/ SERFF Interface	(2) Project 2 - Rate Review Website	(3)	(4)	
a. Personnel	$ 212,576.00	$ 104,000.00	$	$	$ 316,576.00
b. Fringe Benefits	78,624.00	28,080.00			106,704.00
c. Travel	20,000.00	0.00			20,000.00
d. Equipment	19,500.00	0.00			19,500.00
e. Supplies	1,500.00	0.00			1,500.00
f. Contractual	273,696.00	83,724.00			357,420.00
g. Construction	0.00				
h. Other	0.00				
i. Total Direct Charges (sum of 6a-6h)	605,896.00	215,804.00			$ 821,700.00
j. Indirect Charges					$
k. TOTALS (sum of 6i and 6j)	$ 605,896.00	$ 215,804.00	$	$	$ 821,700.00
7. Program Income	$	$	$	$	$

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SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e)TOTALS
8.	$	$	$	$
9.				
10.				
11.				
12. TOTAL (sum of lines 8-11)	$	$	$	$

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	$	$	$	$	$
14. Non-Federal	$				
15. TOTAL (sum of lines 13 and 14)	$	$	$	$	$

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

(a) Grant Program	FUTURE FUNDING PERIODS (YEARS)			
	(b)First	(c) Second	(d) Third	(e) Fourth
16.	$	$	$	$
17.				
18.				
19.				
20. TOTAL (sum of lines 16 - 19)	$	$	$	$

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges:

22. Indirect Charges:

23. Remarks:

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ASSURANCES - NON-CONSTRUCTION PROGRAMS

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PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

NOTE: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant, I certify that the applicant:

1. Has the legal authority to apply for Federal assistance and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project cost) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States and, if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C.§§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U. S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee- 3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and, (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally-assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally-assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clean Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and, (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead-based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations, and policies governing this program.

* SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	* TITLE
Completed on submission to Grants.gov	WA State Insurance Commissioner
* APPLICANT ORGANIZATION	* DATE SUBMITTED
Washington State Insurance Commissioner	Completed on submission to Grants.gov

DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C.1352

Approved by OMB
0348-0046

1. * Type of Federal Action:
- [ ] a. contract
- [x] b. grant
- [ ] c. cooperative agreement
- [ ] d. loan
- [ ] e. loan guarantee
- [ ] f. loan insurance

2. * Status of Federal Action:
- [ ] a. bid/offer/application
- [x] b. initial award
- [ ] c. post-award

3. * Report Type:
- [x] a. initial filing
- [ ] b. material change

4. Name and Address of Reporting Entity:

- [x] Prime
- [ ] SubAwardee

** Name* Office of Insurance Commissioner

** Street 1* 5000 Capitol Blvd *Street 2*

** City* Tumwater *State* WA: Washington *Zip* 98501-4426

Congressional District, if known:

5. If Reporting Entity in No.4 is Subawardee, Enter Name and Address of Prime:

6. * Federal Department/Agency:

Ofc of Consumer Information & Insurance

7. * Federal Program Name/Description:

Affordable Care Act (ACA) Grants to States for Health Insurance Premium Review

CFDA Number, *if applicable:* 93.511

8. Federal Action Number, *if known:*

9. Award Amount, *if known:*

$

10. a. Name and Address of Lobbying Registrant:

Prefix ** First Name* n/a *Middle Name*

** Last Name* n/a *Suffix*

** Street 1* *Street 2*

** City* *State* *Zip*

b. Individual Performing Services (including address if different from No. 10a)

Prefix ** First Name* n/a *Middle Name*

** Last Name* n/a *Suffix*

** Street 1* *Street 2*

** City* *State* *Zip*

11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when the transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

*** Signature:** Completed on submission to Grants.gov

***Name:** *Prefix* ** First Name* Mike *Middle Name*

** Last Name* Kreidler *Suffix*

Title: WA State Insurance Commissioner **Telephone No.:** **Date:** Completed on submission to Grants.gov

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