Speed to Market Tools for General Disability Rate Filings

# Purpose

Speed to Market (STM) Tools provide guidance for preparing a rate filing. Although using the information in this document does not guarantee that your rate filing will be approved, it will expedite the review of your filing by providing information in a predictable way and avoiding common objections that extend the reviewing process.

# Scope

The guidance in this document **applies** to the following list of types of insurances (TOIs). Refer to the NAIC Product Coding Matrix for TOI numbers.

* Accident Only: H02G, H02I
* Death and Dismemberment (AD&D): H03G, H03I
* Blanket Accident: H04
* Specified Disease: H07G, H07I
* Hospital Indemnity: H14G, H14I, Prescription Drug: H17G, H17I,
* Travel Insurance: H19
* Other Types: H05, H08G, H08I, H09G, H09I, H23G and H23I.

The guidance in this document **does NOT apply to the following TOIs** because there are separate Speed to Market Tool documents that address them.

* Medicare Supplement,
* Disability Income,
* Long Term Care,
* Stop Loss,
* Life Insurance,
* Health plans and Health Benefits,
* Conversion plans,
* Student Health,
* Short-Term Medical plans

# How to use this document

The “General Guidance Section” of this document applies to all TOIs listed in the scope of this document. Guidance that only applies to specific TOIs is provided in the sections after the General Guidance Section.

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# General Guidance

*The guidance under this section applies to all TOIs identified in the scope of this document.*

## General Rating: If you are submitting a rate filing for Washington State, the rate filing must be prepared for Washington State (WA) per RCW 48.18.110.

## The rate filing must be prepared by a qualified actuary and include an actuarial certification per WAC 284-58-033.

## Additional information needed for prepare a rate filing is provided in the SERFF Washington State Life, Health and Disability Rate Filing General Instructions (WAC 284-58-025) (aka general filing instructions or GFIs), which can be found in SERFF and on the Washington State Office of the Insurance Commissioner’s (OIC) website (<https://www.insurance.wa.gov/>).

## Make sure SERFF Rate/Rule Schedule tab reflect the appropriate information.

## For renewing plans, provide the information for the previous filing at the top of the Rate/Rule Schedule tab.

## Fill out the Company Rate Information unless the filing is for new plans. The data provided in the Company Rate Information should only be for Washington state experience and for the TOI and company name submitted.

## These rate filings are subject to RCW 48.19.010 (2), which requires that all rates, rules classifications, and modifications must be filed before use. Include all information needed to complete a premium calculation (RCW 48.18.170) on the Rate/Rule Schedule tab in SERFF. Include the following information:

## Provide a list of all the information that is needed to complete a premium calculation and where the information comes from (i.e., from the policy or the policyholder's information).

## Provide a rate manual with all content needed to complete a premium calculation (rating rules, definitions, references, tables, notes, adjustment factors, arithmetic, etc.). Ensure it includes a premium calculation algorithm and all internal references.

## Provide a comprehensive illustrative example of a premium calculation based on the rate manual. The example should be consistent with the rate manual and include all applicable policy variables, calculation steps and rate manual references.

## Can the final premium rates be determined from the rate manual?

**RCW 48.19.010(2) requires that your manual of classification, manual of rules and rates and any modification must be filed BEFORE use. To determine this, the filing must:**

## Exclude all ambiguous rating descriptions and ranges from the rate filing.

## Include all rates, factors, including modalization factors, and the rules and formulas for applying them, including rounding rules, in the rate manual.

## Note, rates must be filed before use per RCW 48.19.010(2). Therefore, the rate manual must account for every rating variation the company uses to calculate the premium charged. Any premium amount that cannot be duplicated exactly using only the rate manual is considered not filed and violates RCW 48.19.010(2).

## All form variability that affects benefits, limits, maximums, conditions, or exclusions must be accompanied by corresponding rate adjustments in the rate manual. In addition, the variability ranges, options, and increments must align so that every option in the forms is paired with exactly one rate or adjustment factor, after any rating formulas are applied (e.g., interpolation or multiplying by the number of units).

## If applicable, provide the interpolation formula (the general formula is only needed once) and an example in the rate manual, including how the rate or factor is rounded for each applicable table. Note: extrapolation and other open-ended rating formulas are not allowed.

## Is the rate filing subject to pooling requirements of WAC 284-60? How does this impact the rate filing requirements?

## Applicability of WAC 284-60:

## Specified Disease (H07G, H07I) products are always subject to WAC 284-60. Note that specified disease policies are also always subject to the minimum loss ratio requirements of Chapter 48.70 RCW.

## Individual policies for the other TOIs listed in the scope of this document are always subject to WAC 284-60.

## Group policies for the other TOIs listed in the scope of this document are exempt from WAC 284-60 only when the policy is issued to an employer who employs 100 or more employees, and the employer pays more than 50% of the premium.

## If your rate filing is subject to WAC 284-60, remove all group specific experience rating references from the rate filing (rate manual and actuarial memorandum) per WAC 284-60-040(1).

## If the group is exempt from the requirements of WAC 284-60 per WAC 284-60-010(1)(d) and you want to rate the group using experience and/or non-standard rates and factors, you must submit a separate filing that is specific for this group. See the Group Specific Filing Section below for detailed requirements.

## Note that rate filings for TOIs in the scope of this document that qualify for the group exemption identified above must:

#### Provide the specific rate for the group, not just the experience formula.

#### Confirm, in the actuarial memorandum, that the group meets the required conditions for a single employer rate filing.

## Does the general rating manual meet the pooling requirements of WAC 284-60-040?

## Basing or adjusting a group’s rate on its own experience (i.e., group-specific experience) is not allowed and must be removed from the rating manual.

## If you already have policy forms filed with us or are filing a rate filing with multiple corresponding form filings for the same TOI, provide a table in the actuarial memorandum or separate PDF document that lists all the forms and the SERFF or State Tracking numbers of the corresponding form filings. In the same section as the table or in the PDF document:

## Please review WAC 284-60-040, which requires that similar policy forms be pooled, and identify which policy forms listed you do not consider similar policy forms to those you are currently filing and provide detailed explanation as to why they are not similar. Ensure you address all the characteristics referenced in WAC 284-60-040.

## For the similar policy forms, please demonstrate or explain how you have pooled the experience for rating purposes.

## Note that expenses, including commissions, must also be pooled.

## For rate change filings, you must base rate changes on pooled experience from the identified experience period.

## Your rate change development must show how you calculated an indicated rate change based on the pooled WA experience. It must consider the credibility of the experience and may consider nationwide experience or other information when WA experience is not fully credible.

## Do you wish to have attained age and issue age rates for the same plan?

## Only one rate filing should be filed, but you must file two forms, one for attained age and one for issue age rating.

## Both forms may be filed in the same filing, but it must be clear that the difference in these forms is due to how they are rated.

## The rate filing must show how you meet the pooling requirements of WAC 284-60-040.

## To demonstrate that you meet the pooling requirements, show how you determined the premiums using the same claim costs and demonstrate how over time the premiums are the same.

## Usually what works best is to provide the persistency and investment assumptions and demonstrate how the attained age rates and issue age rates are the same over time; or show how the issue age claim costs are calculated from the attained age claim costs. If Excel spreadsheets are included, see section below related to Excel spreadsheets.

## Note that if you use issue age rates, the forms (i.e., policy) must be guaranteed renewable.

## Do Excel copies of PDFs meet our standard submission requirements?

Excel files may be submitted in support of the rate filing if the following conditions are met:

## External file links must be broken.

## Internal file links and formulas must be maintained. Formulas should support all the calculated amounts.

## Password protection must not be used on the workbook or any of its content.

## A copy of the Excel file must also be submitted as a PDF file. The contents must match exactly between the two files. The PDF file must fully display the contents of the workbook, including all cells on all spreadsheets. You must unhide all rows, columns, and tabs (i.e., sheets).

## The PDF and Excel files must be named identically, except the name of the Excel file must end with “duplicate.xlsx”.

## The PDF file should be reviewed for completeness and readability. For example, column headings and row descriptions should be repeated on each page for continuation of large tables. There must not be any values that are cut off, displaying as “####”, or otherwise unreadable.

## Note: when a proprietary rate filing is submitted along with a for-public rate filing, unless the Excel file includes public information, the Excel files should only be included in the proprietary filing.

## Are you using group specific factors for an individual filing?

Individual filings (rate filings only applicable to plans sold to individuals) must not contain any group rating factors, such as those adjusting rates based on SIC code, percentage participation, or where the policy is purchased.

## Are all benefits and cost-sharing variability accounted for in the rate filing? Ensure that the rate manual accounts for the variability of the terms and conditions, rights, and privileges, and benefits payable as described in the form filing per **RCW 48.18.110 and RCW 48.18.480**.

## Do you meet the applicable loss ratios?

1. For Specified Disease TOIs H07I and H07G-RCW 48.70.030, the loss ratio is 75% for group and 60% for individual.
2. For non-Specified Disease TOIs listed at the beginning in the “Applicable TOIs” section, the individual loss ratio is 60% [WAC 284-60-050(1)], and the group loss ratios should follow [WAC 284-60-060(2)].

## Are you offering Portability, Conversion, or Continuation of Coverage in a group filing?

## Please note that you are not required to offer portability for this product, but if you do, the portability provisions must meet the pooling requirements of WAC 284-60-040 and not discriminate under RCW 48.18.480. For non-health care policies, there are no specific citations for portability, conversion, or continuation of coverage. Companies have used these terms interchangeably. There are only two allowable options. For the purpose of this document, we will use the terms “Portability” and “Continuation of Coverage” which are defined as:

#### Portability – The applicable member is ported to a new policy submitted in a separate rate and form filing.

#### Continuation of Coverage – The applicable member remains with the group where the benefits and rates are consistent with the active members in the group.

## Include a section in the actuarial memorandum, which clearly describes the offering and rating differences to the groups, if any. This description should be consistent with the form filing and include the following:

#### An explanation of whether the member continues coverage under the group policy or ports to a different policy.

##### If there is Continuation of Coverage under the group policy, then the member’s premium rating should be consistent with active group membership.

##### If there is Portability to a different policy, then include the most recent state and/or SERFF tracking number of the applicable rate and form filing under which the member will be porting.

#### If applicable, include justification of the Continuation of Coverage factor. Include the projected claim costs per continuing member per month and discuss how this differs from the projected PMPM claim cost for the membership for active employees and their dependents. Include a projection of the expected percent of continuation members in the pool of members which have the option available. Note: any additional impact on claim costs for Portability should be factored into the porting rate filing.

## Does the filing contain enough information for the reviewer to determine whether the methods and data used are appropriate, and the assumptions, estimates, and results are reasonable?

## Key Requirements (Note: this is a high-level list and not exhaustive).

## Loss ratios must be expected to meet the applicable minimum loss ratio requirements.

## Rates must be based on pooled experience when subject to WAC 284-60.

## Benefits provided therein are reasonable in relation to the premium charged per RCW 48.18.110(2)

#### Rates must be based on appropriate and credible data.

#### Rate development must consider characteristics of the Washington State target population.

#### Rate development must consider contracting and utilization management when applicable.

## Actuarial Memorandum: General Information

## Include a list of the affected policy and certificate form numbers.

#### If your rate filing is for a new Washington State pool and the company has Washington State experience for the TOI, you must identify this in the actuarial memo and justify why the new pool is appropriate per WAC 284-60-040.

## Identify the scope of the filing, including a definition of the target market and rating pool.

## Include a description of the data used in the development of your rates. The description should at least address the source, period, appropriateness, and how you assessed the credibility of the data.

## Provide any cost and utilization trends or adjustment factors applied to the data.

## Explain how the rates development meets the pooling requirements of WAC 284-60-040. Include information that defines the pool such as policy and population characteristics.

## Specify your calculating period (the time span over which the actuary expects the premium rates, whether level or increasing, to remain adequate in accordance with his or her best estimate of future experience and during which the actuary does not expect to request a rate increase [WAC 284-60-030(4)]).

## Identify how you assessed the reasonableness of the rates. Include a description of the validation process used, any material findings, and how you addressed the findings.

## Clearly indicate that rate changes will follow the current filed and effective rate manual.

## Do not use ambiguous language such as, “we may change premium rates” or “we reserve the right to change premium rates.” For example, even if there was a change in regulations that may cause a rate impact, you must first file a revised rate manual.

## Include a Premium Rate Change section in the actuarial memorandum for the following, if applicable. The section should address rate changes made prior to the policies rate renewal date or rate guarantee period. The premium rate change rules must be clear and consistent in their application and must not discriminate [RCW 48.18.480]. This is not meant to imply that you may not change rates when the insured selects different benefits or amounts of coverage. Revise any applicable sections of the form filing to match the information in the memorandum.

## Include a signed actuarial certification in accordance with WAC 284-58-033 and WAC 284-05, as applicable. The contents should include, but not be limited to, the following:

#### Reliance information,

#### The applicable ASOPs, including ASOP No. 23, Data Quality, and ASOP No. 41, Actuarial Communications,

#### Identification of the certifying actuary and a statement that he or she is a member of the American Academy of Actuaries, and

#### A Statement about the compliance with requirements of Washington State laws and regulations.

#### A Statement about the reasonableness of the rates.

#### Provide the date the actuary signed the certification.

## For rate change filings,

#### Provide a list that identifies all material changes to the form and rate filing. Additionally, identify the changes that are considered in the requested rate change development, identify where they are considered, and quantify the impact.

#### Describe how the requested rate change was developed, include pooling information (if applicable), and where quantitative support for the rate change can be found in the rate filing.

## Actuarial Memorandum: Assumptions

## Include, in the actuarial memorandum, a percentage breakdown of the premium retention loads, including premium tax [RCW 48.14.020 or 48.14.0201], commissions, regulatory surcharge [RCW 48.02.190], and margin/profit, that supports your expected loss ratio and any applicable minimum loss ratio requirements under WAC 284-60 or RCW 48.70 (TOI H07, specified disease). If applicable, submit an exhibit showing the calculation converting any dollar loads or variable expense loads to an average percent of premium.

## Identify the overall target loss ratio for the product.

#### If the target loss ratio varies by group size, identify the target loss ratio by group size and explain why.

#### Note that pooling requirements apply to both claims and expenses. If target loss ratio varies by group size, differences in target loss ratio should be the result of expense development by fixed and variable expense types. For this case, provide a breakdown of expenses by fixed and variable types that support differences in target loss ratio by group size.

## Identify the key assumptions in your rate development.

#### Describe the sensitivity test process you used to identify the key assumptions and how you addressed the sensitivity when setting your assumptions.

#### Explain how you assessed the reasonableness of the key assumptions. Identify the level of conservatism or margin included in your key assumptions. If you included margin or a provision for adverse deviation (PAD) in your estimates, you should identify the amount included and how it was selected.

## For closed blocks of business:

#### An analysis of your expected loss ratio is sufficient in lieu of a breakdown of your expected retention loads.

#### Generally, we only allow a flat percentage increase across the pool.

#### Multiple closed blocks with the same TOI, including trusts and associations, can be combined into a single pooled block.

#### As an alternative to a general rate manual, you may submit a list of all the remaining policies with enough information (such as: issue age, premium modalization, inflation, benefit choices, etc.), to calculate the current rates. Note: This option may not be feasible if policy holders have the option to reduce or otherwise change benefits.

## If you are including an additional amount for retaliatory taxes [RCW 48.14.040], submit a summary of your most recent tax submission form as justification and show how the information was used to calculate the retaliatory tax load.

## Actuarial Exhibits and Other Supporting Documents

## Exhibits may be included in an Excel spreadsheet (see the section related to Excel spreadsheets above).

## For rate filings for new products (new rate filings without prior Washington State experience):

#### The rate filing must include enough detail about the rate development for the reviewer to determine whether the methods, data, and assumptions are appropriate. [RCW 48.18.110(2) and RCW 48.18.480]

#### The rate filing must include enough detail about the rate development for the reviewer to determine the premium is reasonable in relation to the benefits provided. [RCW 48.18.110(2)]

#### The rate filing must include a narrative description of material components of rate development and quantitative support for the reasonableness of the proposed rates.

##### Provide a document outlining the rate buildup calculations, including claim costs and retention loads, to justify that “the benefits provided therein are reasonable in relation to the premium charged” [RCW 48.18.110(2)] and that they are developed using pooled claims [WAC 284-60-040]. Include a description and the time period of the underlying claim costs and any adjustments or trending applied to the claims data.

###### If applicable, include an exhibit, and example, outlining the development of the issue age rates from the attained age rates.

## For renewal rate filings, (rate filings for products or TOIs where the carrier has Washington State experience) include the following exhibits, as applicable [see WAC 284-60-050 or 284-60-060, and 284-60-080 for more details]:

#### The annual historical experience (active lives or other exposure metric, earned premium, incurred claims, actual and expected loss ratios, etc.) for Washington State.

#### The current policyholder distribution by attained age (or age category) for Washington State and nationwide members. Within the exhibit, provide the number of current policyholders in each age band and display these figures converted to percentages of total Washington enrollment. If rates are both on an issue age basis and attained age basis, show the distribution by issue age and by attained age.

#### Address the credibility of the Washington State experience.

##### Identify the credibility procedure used to assess WA experience credibility and the resulting estimate consistent with Actuarial Standard of Practice (ASOP) No. 25.

#### If the Washington State experience is not 100% credible, also show the historical nationwide experience or other experience used in the rate development and provide justification for any adjustments made to the data to align the experience with the Washington State market Lifetime projections of earned premiums and incurred claims based on the filed proposed premium rate schedule.

#### Provide detailed data showing nationwide past implemented and proposed rate increases by state, average premiums by state, and explain any wide variations in average Washington State premium from nationwide premium.

#### Provide detailed development of an indicated rate change based on the credible experience. The indicated rate change should be the best estimate of overall required premium based on pooled experience and material internal and external forces impacting the projection. Generally, the development should include:

##### Completed claims estimate for the experience period based on credible data.

##### If non-WA data is used to supplement credibility, show how it was combined with WA data.

##### Adjustments for material changes in form and rate structures.

##### Projection of claims to the projection period.

##### Retention Loading

##### The indicated premium required.

##### The current premium and indicated require rate change percentage.

##### Identify how the indicated rate change is applied to the base rates in the rate filing.

## Is the proprietary filing complete?

## If you wish to withhold information from public inspection pursuant to RCW 48.02.120(3), you must file separate public and not-for-public (aka proprietary) filings as instructed in the Washington State SERFF Life, Health and Disability Rate Filing General Instructions.

## The proprietary filing should be a complete filing.

## Include a separate document in both the public and proprietary filings, listing all the data withheld. This list needs to identify each piece of information withheld by description and location in the filing.

## If one single page includes both public information and proprietary information, only the proprietary information in that page can be displayed as redacted.

## Cite the statutory exemption under which you are seeking an exemption and explain how that exemption applies to each piece of information.

# Group-Specific Rate Filing

## Are you filing for an association, trust, or out-of-state group?

## Provide the specific rates for the group on the Rate/Rule Schedule tab. Note: this includes out-of-state associations and trusts [RCW 48.19.010(2)].

## Have the actuary certify that the rates are reasonable in relationship to premium [RCW 48.18.110(2)].

## Provide the experience used to determine the rates.

## State in the actuarial memorandum how you meet the pooling requirements of WAC 284-60-040 or how the benefits for the association, trust, or out-of-state group differ from other benefits filed under the same TOI.

## Provide rate development documentation on the Supporting Documents tab in SERFF showing how the proposed rates are tied to the provided experience and other material changes.

## Are you filing for an employer whose filing is exempt from the requirements of Chapter 284-60 WAC?

## Provide the specific rates for the employer on the Rate/Rule Schedule tab.

## Have the actuary certify that the group rates are reasonable in relationship to premium [RCW 48.18.110(2)] and that they are exempt from Chapter 284-60 WAC.

## Provide the experience used to determine the rates.

## Provide rate development documentation on the Supporting Documents tab in SERFF showing how the proposed rates are tied to the provided experience and other material changes.

## Are you filing for a discretionary group?

## You must follow the discretionary group filing instructions. See Washington State SERFF Life, Health and Disability Rate Filing General Instructions.

## Provide the expected implementation date in the Implementation Date Requested field.

## Prior Approval

#### Please note that filings for discretionary groups must be approved by the commissioner before use [RCW 48.21.010(2)].

#### Identify if this filing is the result of a member moving to Washington State from another state.

##### In this case, provide information about where the filing was originally approved and when.

## Discretionary Group Filing Criteria

#### Applicable Products

##### Only disability income, accident only, dental only, vision only, and CHAMPVA products are applicable to discretionary groups.

#### Discretionary Group Support

##### Address the three requirements from RCW 48.21.010(2)(a) in the actuarial memo.

##### Provide quantitative support for each of the three requirements if possible.

## Rating Development Information

#### Include enough detail in your documentation to determine whether the date, assumptions, and methods used are appropriate, and whether the results are reasonable.

#### Provide the group’s experience if applicable.

#### For each item of the claims, trend, and expense rating components (include other components as needed):

##### Identify the data used.

##### Address its source, credibility, and appropriateness.

##### Describe the rating methodology used and address its appropriateness.

##### Identify material rating assumptions and adjustments to the experience used in the development.

# Type of Insurance (TOI) Specific Guidance

*The guidance under this section applies to the TOIs identified in the scope of the subsection below.*

# Blanket Insurance (TOI H04)

## Specify, in the scope and purpose section of the actuarial memorandum, the type of policy covered in this filing corresponding to:

## RCW 48.21.040(1)(a) – common carrier passengers; or

## RCW 48.21.040(1)(b) – volunteer fire department, first aid or ambulance squad or volunteer police organization; or

## RCW 48.21.040(1)(c) – any established organization whether incorporated or not, having community recognition and operated for the welfare of the community and its members and not for profit; or

## RCW 48.21.040(1)(d) – an employer covering any group of employees defined by reference to exceptional hazards incident to such employment; or

## RCW 48.21.040(1)(e) – students or employees issued to a college, school, or other institution of learning or to the head or principal thereof. (Note: for ACA higher education student health plans, see separate guidance.)

## Only group types under RCW 48.21.040(1)(a), (d), and (e) can file under sub-TOIs with sickness and include sickness benefits in the blanket policy.

## Note that blanket policies are not health plans under RCW 48.43.005(31). Therefore, coverages must align with the excepted benefits under RCW 48.43.005(31).

## Benefits must be linked to accident or sickness.

## Sickness benefits must be fixed indemnity payments and non-coordinated.

## Hospital benefits must be fixed indemnity payments and non-coordinated.

## If applicable, submit justification for pooling [WAC 284-60-040] multiple types of group coverages, listed above. The types of blanket coverages appear distinct such that no two categories would have similar factors, such as claims experience, expenses, or types of benefits.

## If applicable, specify how the group rates are determined when multiple activities are available through the group, in a manner consistent with the pooling requirements. Members within the group may or may not be involved in all the activities and the timing of activities may overlap.

## If applicable, specify the method of determining the daily exposure time for the group hazard concentration, in a manner consistent with the pooling requirements. Remove general language, such as “a rule of thumb” or “on an actuarially consistent basis,” and all unspecified adjustment ranges. The rate manual must include the deterministic method or calculation for selecting all rates and factors.

## If applicable, review every risk classification and remove all which do not qualify as “having community recognition and operated for the welfare of the community and its members and not for profit” for RCW 48.21.040(1)(c). Even if a group is not for profit, does it have community recognition, and is it operated for the welfare of the community?

# Specified Disease

## Are you filing for Specified Disease under TOI H07?

## RCW 48.70.020 (1) defines specified disease policy as “any insurance policy or contract which provides benefits to a policyholder only in the event that the policyholder contracts the disease or diseases specifically named in the policy.”

#### Individual specified disease products may not be combined with other types of insurance [RCW 48.20.460 and WAC 284-58-030(4)].

#### Benefits or rates must not vary based on the severity of the disease.

## Specified disease policies are always subject to the minimum loss ratio requirements of RCW 48.70.030:

## 75% for groups filings

## 60% for individual filings

## All groups filed under TOI H07G must meet the requirements of Chapter 284-60 WAC, per WAC 284-60-010(1)(d)(i).

* + 1. If you are required to submit a group specific rate filing per RCW, WAC, or Washington State SERFF Life, Health and Disability Rate Filing General Instructions, explain in the actuarial memorandum how you meet the pooling requirements of WAC 284-60-040 or explain how the benefits are not similar to other benefits the company offers.

# Hospital Indemnity

## Hospital indemnity insurance is type of insurance that can be offered to individuals or groups. Per RCW 48.21.010(2), it cannot be offered to discretionary groups.

## Hospital indemnity insurance must provide benefits for hospitalizations due to covered accidents or sicknesses.

## Per RCW 48.43.005(31), benefits must be fixed, independent, and noncoordinated.

* + 1. Fixed means that benefits do not vary based on the actual costs of the services. Benefits should be fixed dollar amounts (e.g., $100 per day), rather than reimbursements for actual costs (e.g., 80% of the provider’s charge). The benefit amount should not change even if the benefit exceeds the actual loss experienced by the insured.
		2. Benefits need to be listed in the policy and cannot be linked to external documents or schedules. For example, basing benefits on a percentage of Medicare reimbursement rates is not allowable.
		3. Independent and noncoordinated mean that the benefits should be paid regardless of other coverages the insured may have. For example, policies may not limit benefits to or base benefits on amounts not covered by, for example, the insured’s major medical coverage.
		4. This means that “gap coverage” (i.e., coverages meant to pay copays and deductibles of major medical plans) is not allowed. Of course, insureds may buy hospital indemnity insurance as a supplement to their major medical plan, but the hospital indemnity coverage cannot be explicitly built around the major medical plan.
		5. If benefits other than the primary hospital confinement benefit are included, they must be excepted benefits so as not to make the product qualify as a health plan under RCW 48.43.005(31).

# Travel Insurance (For Disability Rate Filing)

## Travel insurance in disability rate filings must be submitted in SERFF under TOI H19.

## Travel insurance is not a health plan.

* + 1. Travel insurance is an excepted benefit (not a health plan) under RCW 48.43.005(31)(l) because it has ***a short-term limited purpose and duration.***
		2. Travel insurance is also not a health plan under the federal definition, which is the definition that applies in Washington State.

#### Travel insurance is defined by 45 CFR § 144.103: “Travel insurance means **insurance coverage for personal risks incidental to planned travel**, which may include, but is not limited to, interruption or cancellation of trip or event, loss of baggage or personal effects, damages to accommodations or rental vehicles, and **sickness, accident, disability, or death occurring during travel, provided that the health benefits are not offered on a stand-alone basis and are incidental to other coverage**. For this purpose, **the term travel insurance does not include major medical plans that provide comprehensive medical protection for travelers with trips lasting 6 months or longer**, including, for example, those working overseas as an expatriate or military personnel being deployed.”

## Travel insurance submitted under H19 must meet the following fundamental coverage and filing requirements.

## The disability policy MUST only include health benefits as referenced 45 CFR § 144.103 (sickness, accident, disability, or death occurring during travel).

#### The disability rate filing cannot include any property and casualty (P&C) benefits (loss baggage, trip delay, etc.) or the rates associated with those benefits.

#### The health benefits cannot be offered on a stand-alone basis and must be accompanied by other coverage (e.g., P&C portion of coverage) per 45 CFR § 144.103, which must be filed in a corresponding P&C filing.

## A corresponding set of P&C filings, for P&C benefits, MUST be submitted in SERFF concurrently with the disability filings.

#### See the federal definition of travel insurance for examples of P&C benefits.

## If the disability policy’s travel includes coverage for less than 90 days the benefits in the benefits policy should be for non-emergencies to differentiate between coverage in the P&C filing subject to inland marine laws.

## The travel insurance coverage MUST be for “planned travel” as stated in 45 CFR § 144.103 and to meet the limited purpose requirement of RCW 48.43.005(31)(l).

## The coverage period MUST be less than 6-months as stated in 45 CFR § 144.103 and to meet the limited duration requirement of RCW 48.43.005(31)(l).

#### Travel policies with durations longer than 6-months are not allowed under H19 per the federal definition of Travel Insurance.

## Planned travel must be at least 100-mile radius outside the US borders (if international travel) or at least 100-mile radius outside the insured’s residence (if domestic travel) per the definition of H19.

## In the actuarial memo, in addition to those items identified in the General Guidance Section of this document, include a section near the beginning of the document that addresses each of the requirements identified above.

## Travel Insurance Rating:

* + 1. All the information in the General Guidelines Section apply to Travel Insurance except where guidance differs in this section of the document.
		2. Travel insurance rates may not vary based on how you purchased your insurance except companies may vary the rate based on whether the insurance was purchased at the time the travel was booked or if it was purchased separately.

# Additional Information After a Filing is Submitted

## Are you responding to a SERFF Objection Letter?

* + 1. Responses and attachments should never be sent as a Note to Reviewer in SERFF.
		2. Unless instructed otherwise, all attachments to Responses must be in PDF format.
		3. Respond completely and in a timely manner [WAC 284-58-047].
		4. Amend the filing to respond to an objection. You must answer each objection individually. Depending on the objection, also separately file the appropriate revised form.
		5. Revise a Schedule Item to make changes to a document already submitted.
		6. Add a Schedule Item for additional documents not previously submitted.

# Contact Us

### For filing related questions, contact the Rates, Forms, and Provider Networks (RFPN) Help Desk:

### (360) 725-7111

### rfhelpdesk@oic.wa.gov

### For feedback or suggestions, email us:

### RFHealthplan@oic.wa.gov