OFFICE of the
INSURANCE
COMMISSIONER
WASHINGTON STATE

Adjusting geographic rating areas to increase market stability (Rule 2017-11)

Concise Explanatory Statement;
Responsiveness Summary, Rule Development
Process and Implementation Plan

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Introduction

The Revised Code of Washington (RCW) 34.05.325(6) requires the Office of Insurance Commissioner (OIC) to prepare a Concise Explanatory Statement (CES) prior to filing a rule for permanent adoption. The CES must:

1. Identify the OIC's reasons for adopting the rule.
2. Describe the differences between the proposed rule and the final rule (other than editing changes) and the reasons for the difference.
3. Summarize and respond to all of the comments that the OIC received regarding the proposed rule during the official public comment period, indicating whether or not the comment resulted in a change to the final rule. If the OIC did not incorporate the change that the commenter requested, the response will include an explanation of why the agency did not incorporate the change.
4. Be distributed to all persons who commented on the rule during the official public comment period and to any person who requests it.

Background and reasons for the rulemaking

The current geographic rating area rules, WAC 284-43-6680 and 284-43-6700, were adopted in 2013. WAC 284-43-6700(2) provides that the Commissioner will review the geographic rating area designation not more frequently than every three years. This rulemaking undertakes that review and provides an opportunity for OIC to utilize more recent individual and small group market data and experience. Specifically, the OIC has made adjustments to the geographic rating area designations and premium ratio restrictions to more accurately reflect the individual and small group health insurance markets and to incentivize offering qualified health plans in the individual market. Qualified health plans are sold through the Washington State Health Benefit Exchange but also can be sold off-Exchange.

<u>Guiding principles for the rulemaking</u>

OIC identified the following principles to guide its review of the geographical rating area rules at WAC 284-43-6680 and WAC 284-43-6700:

1. The review will be data driven.
2. Rating areas are composed of at least three contiguous counties, with the exception of King County.
3. The rules will balance:
    a. Awareness of the potential impact on health plan rates for rural county residents.
    b. Reducing disincentives for issuers to offer health plans in rural counties.

<u>Applicable federal law</u>

The Affordable Care Act (ACA) defines the factors that can be considered in setting rates for individual and small group health plans. Issuers must pool the claims experience for their

entire individual or small group market health plans into single risk pools, respectively.[1] Once an index rate is established, based upon the experience of the single risk pool, the issuer can adjust rates for each health plan based upon the plan design, e.g., the plan's actuarial value.[2] To determine the rate that an individual enrollee will pay, there are a limited number of rating factors that can be used by an issuer: age, whether the coverage is for an individual or a family, tobacco use and geographic rating area.[3]

Federal regulations and guidance define the factors that states can take into consideration when establishing individual market and small group market geographic rating areas. In setting geographic rating areas, the OIC can consider the following factors:

- Provider reimbursement costs; and
- Practice pattern differences.

Federal law does not allow the OIC to take the health status of enrollees into consideration when setting geographic rating areas.[4] Rating areas can be defined by counties, three digit zip codes or metropolitan statistical areas and non-metropolitan statistical areas.[5] OIC's current five geographical rating areas are defined by counties.

<u>Methodology</u>

OIC began its work on this rule making with data analysis, using Washington State individual market and small group claims data from CY 2015 and CY 2016. OIC developed an underlying cost model using data derived from External Data Gathering Environment (EDGE) server files generated by issuers for the CMS (federal) risk adjustment program. Issuers offering

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[1] 42 CFR 156.80 https://www.ecfr.gov/cgi-bin/text-idx?rgn=div5;node=42%3A1.0.1.1.2
[2] Id
[3] 42 CFR 147.102 https://www.ecfr.gov/cgi-bin/text-idx?rgn=div5;node=42%3A1.0.1.1.2
[4] HHS/CMS <u>2018 Unified Rate Review Instructions</u> (April 6, 2017) at p. 11, accessed at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Unified-Rate-Review-URR-Reporting-Requirements-for-Single-Risk-Pool-Plans-OMB-0938-1141-Final-2018-URR-Instructions-Parts-I-II-and-III-.PDF .
[5] 42 CFR 147.102(b).

health plans in the individual and small group markets are required by federal law to submit data to the EDGE server including information for each enrollee's demographics, health risk factors, plan choice information, and annual costs incurred. The data was submitted to the OIC in 2017 through a data call authorized in ESHB 2222 (2017). Washington State Legislature. The OIC also required issuers to submit enrollee location data.

OIC staff developed a multivariate linear regression model that controlled for the above descriptive factors. The analysis identified differences in provider reimbursement costs, as allowed by federal law, to assess the impact of location on insured health spending. OIC combined this value with the issuer-reported enrollment information for March 2017 to create a weighted relative cost for each county relative to an index, King County.

These cost indexes were then compiled across proposed rating regions to form a regional cost factor relative to King County. The variation of these factors is the rating factor range, which OIC used to compare cost ranges for proposed ratings regions.

OIC then analyzed multiple combinations of counties as potential rating areas. In its analysis, OIC examined ranges in costs among and within proposed rating areas, whether the counties in the proposed rating areas were contiguous and whether the combinations of counties reflected cross-county medical referral patterns. OIC sought proposals from issuers related to changes in the composition of geographic rating areas. Several issuers submitted proposals and each was analyzed. OIC also analyzed the geographic purchasing regions used for the Medicaid program by the Washington State Health Care Authority/Department of Social and Health Services. After review of the results of the analysis, OIC proposed nine rating areas that are substantially similar, but not identical, to those adopted by the Health Care Authority/Department of Social and Health Services. See Appendix A for the maps.

OIC also engaged in analysis and stakeholder discussion related to potential modification of the 1:1.15 premium ratio under WAC 284-43-6680. Using the claims data analysis methodology described above, in the aggregate, across all individual and small group

issuers in Washington State, the cost ranges from the lowest cost to the highest cost geographic rating area did not vary by more than 15% for each of the geographic rating area options analyzed. As noted in the comments received below, several issuers proposed that OIC eliminate premium ratios. OIC did not accept this proposal because it is counter to two of our guiding principles: that the rule should be data driven and concern for the impact on premiums for consumers in rural counties or higher cost geographic rating areas.

OIC received information from some issuers indicating that their provider contracting experience may differ from statewide aggregate experience. This rulemaking occurred as part of OIC's individual market stability work and one of our guiding principles is that the rule reduce disincentives for issuers to offer coverage in rural counties. Given the information received regarding issuer experience and the principle of reducing disincentives to offer coverage in rural counties, OIC includes in this rule two incentives:

1. If an issuer offers qualified health plans in every county in six or more rating areas, the issuer can use a premium ratio of 1:1.22, from the lowest cost to the highest cost geographic rating area, if development of the rating factor is actuarially justified.
2. If an issuer offers qualified health plans in every county in every rating area, i.e., statewide, the issuer can use a premium ratio of 1:1.4 from the lowest cost to the highest cost geographic rating area if development of the rating factor is actuarially justified.

Rule development process

On Aug. 23, 2017, the OIC filed a preproposal statement of inquiry (CR-101) for a rule to update the agency's geographic rating areas rule. The CR-101 comment period was open until Oct. 6, 2017.

Seven stakeholders submitted comments to the OIC regarding the rule during the CR-101 comment period.

Between publication of the CR-101 in August 2017 and filing of the CR-102 in February 2018, OIC engaged in extensive stakeholder discussions with the Association of Washington Healthcare Plans, issuers, the Washington State Medical Association, the Washington State Hospital Association, Northwest Health Law Advocates and other consumer advocates. These discussions informed a stakeholder draft issued in December 2017, as well as the language of the proposed rule.

On Dec. 21, 2017, the OIC released a stakeholder draft.

On Jan. 5, 2018, the OIC held a stakeholder meeting. Comments on the stakeholder draft were due Jan. 5, 2018 and five stakeholders submitted comments.

On Feb. 7, 2018, the OIC filed a CR-102. The agency held a hearing on March 13, 2018. Comments on the CR-102 were due March 12, 2018, and five stakeholders submitted comments.

The OIC filed the CR-103P to adopt the rule on March 14, 2018 and the rule went into effect on April 14, 2018.

Differences between proposed and final rule

No changes were made to the proposed rule in the final rule for the reasons described in the responses to the comments below.

Responsiveness summary of comments

The OIC received 17 comments and suggestions regarding this rule. The following information contains a description of the comments, the OIC's assessment of the comments, and information about whether the OIC included or rejected the comments.

The OIC received comments from:

- Gretchen Gillis
- Jessica Fjerstad
- Merlene Converse
- Meg Jones
- Kate Kimball
- Adrianna Siomenlli
- Waltraut Lehmann
- Kathryn Kolan
- Chelene Whiteaker
- Andrew Busz
- Gary Holiday
- Leanne Gassaway

Comments

The following comments were received and considered in developing the rule:

Comments relating to the structure and number of regions	
Comments in response to the CR 101	
Comment: The new rating area designations should: reflect how people actually seek care in a region and provider availability; preclude setting rating areas that result in the subsidization of	**Response:** The new rating area designations take into account medical referral patterns and are smaller than the current five rating areas. By virtue of having multiple counties in each rating

rates for more expensive counties within the same rating area; and be smaller to better represent the counties in them, based on urban/rural mix. (AWHP)	area, some subsidization of rates for more expensive counties may occur. Isolating higher cost counties into separate rating areas could disincentivize issuers offering any health plans at all in those counties, which is not the intended result of this rule making.
Comment: We also ask that you model variations that include the different proposals that at least four carriers will submit to you; the OIC's use of total market data from the Edge Server files should give you an accurate picture of the total market to ensure that the rating area designations do not disadvantage one carrier vs another. We ask that you include the principle of equity in your final decision making for rule revision. (AWHP)	**Response:** The OIC modeled each of the proposals submitted by issuers. We agree that the use of total market data from the Edge Server files provided an accurate picture of the total market. The principle of equity is reflected in our consideration of the impact of a potential rule change on both issuers and consumers.
Comment: We propose breaking up geographic rating area two into the following two new rating areas. Area 2: Clallam, Cowlitz, Grays Harbor, Jefferson, Mason, Lewis, Kitsap, Pacific, Pierce, Thurston, and Wahkiakum counties. New Area: Snohomish, Island, San Juan, Skagit, and Whatcom counties. We propose breaking up geographic rating area five into the following two new rating areas. Area 5: Adams, Asotin, Columbia, Franklin, Garfield, Walla Walla, and Whitman counties. New Area: Benton, Chelan, Douglas, Grant, Kittitas, Okanogan, and Yakima counties. (Regence BlueShield)	**Response:** The updated geographic rating areas divide what are currently areas 2 and 5 each into three separate rating areas. The county composition varies somewhat from that proposed in this comment, due to the principles taken into account in establishing the rating areas.
Comment: We recognize that our proposed changes to the rating areas themselves would result in 10 areas total. Within the overall revised areas, we view current areas 2 and 5 as being of the greatest concern. Each of these two combines particularly disparate urban and rural counties, and needs to be broken up. Area 2 currently is made up of 16 counties; area 5 is made up of 14 counties. Both of them are too big to support the	**Response:** The Commissioner appreciates the comment. The rule expands the number of rating areas from 5 to 9 and breaks what are currently areas 2 and 5 into multiple rating areas.

notion that all providers in the area have the same unit cost. (Premera Blue Cross)	
Comment: Our members are generally supportive of the OIC's efforts to modify the current geographic rating areas to be more consistent with the patterns of how individuals seek care and the health system care costs in Washington state. We believe that this can be achieved by creating more geographic rating areas than the existing five without exceeding the federal threshold (MSA+1), so that an actuarial justification is not needed. (America's Health Insurance Plans)	**Response:** The Commissioner appreciates this comment.
Comment: Washington can [...] establish up to 14 rating areas without being required to provide an actuarial justification to the federal government. (America's Health Insurance Plans)	**Response:** The Commissioner appreciates this comment. By proposing 9 rating areas, OIC agrees that we are not required to provide actuarial justification to the federal government.
Comment: We understand some in the insurance industry are requesting that the number of geographic regions be expanded, so that regions more closely align with perceived regional differences in cost. We do not support this proposal as we believe broader regions better reflect the service delivery systems used within the region. For example, tertiary care is often provided within a broader region outside of a consumer's own county. While we understand insurers can opt out of specific counties in a region, it seems greater fragmentation of rating areas would make it easier for insurers to do so, or make it easier to require rates that may be unaffordable for consumers in the region. (WSHA)	**Response:** While increasing the number of rating areas, OIC factored in medical referral patterns in the composition of the rating areas. After discussions with WSHA, they endorsed the stakeholder draft sent on December 21, 2017, which proposed increasing to 9 rating areas.
Comment: Coordinated Care submitted a proposed revision to the geographic rating areas. Under the current WACs, there are five rating areas that each contain an average of 7.8 counties and 47,618 lives. Under the company's proposal, there	**Response:** Coordinated Care's proposed revision was one of the proposals analyzed by OIC. The analysis yielded an increase to 9 rating areas.

would be nine rating areas that would each contain an average of 4.3 counties and 26,454 lives. (Coordinated Care)	
Comment: WAC 284-43-6700 - Geographic rating area designation. (1) The following geographic rating areas are designated for Washington state for nongrandfathered individual and small group plans: Area 1: Index geographic rating area: King County. Area 2: Clallam, Cowlitz, Grays Harbor, ~~Island,~~ Jefferson, Mason, Lewis, Kitsap, Pacific, ~~Pierce, San Juan, Skagit, Snohomish,~~ [Thurston,]* and Wahkiakum~~, and~~ ~~Whatcom~~ counties. Area 3: Clark, Klickitat, and Skamania counties. Area 4: Ferry, Lincoln, Pend Oreille, ~~Spokane,~~ and Stevens counties. Area 5: Adams, Asotin, ~~Benton,~~ ~~Chelan,~~ Columbia, ~~Douglas,~~ Franklin, Garfield, ~~Grant,~~ ~~Kittitas, Okanogan~~, Walla Walla, and Whitman~~, and~~ ~~Yakima~~ counties. New area: Island, San Juan, Skagit, and Whatcom counties. New area: Pierce County. *[as an alternative, combine Thurston with Pierce] New area: Spokane County. New area: Snohomish County. New area: Benton, Chelan, Douglas, Grant, Kittitas, Okanogan, and Yakima counties. (AWHP)	**Response:** This rule increases current geographic rating areas from 5 to 9 and splits current rating areas 2 and 5 into multiple geographic rating areas. King County is the only single county rating area. Additional single county rating areas would be inconsistent with medical referral patterns and also could result in rural or higher cost counties being isolated into smaller more volatile rating regions.

Comments in response to stakeholder draft	
Comment: Premera is in agreement with the revised rating areas generally. (Premera Blue Cross)	**Response:** The Commissioner appreciates the comment.
Comment: Although initially concerned about increasing the number of rating areas, OIC has taken care to preserve regional care patterns. (WSHA)	**Response:** The Commissioner appreciates the comment.
Comment: The association approves of increasing the number of regions. (AWHP)	**Response:** The Commissioner appreciates the comment.
Comments in response to CR-102	
We thank the OIC for your work to increase the number of geographic rating areas in Washington state. (Cambia Health Solutions)	The Commissioner appreciates the comment.
The increase and rearrangement of geographic rating areas is a positive change that we appreciate. (Kaiser Permanente)	The Commissioner appreciates the comment.
Support the geographic rating area groupings, and believe it allows for more accurate rating. Also support review of the rating area structure no more frequently than every three years. (Premera Blue Cross)	The Commissioner appreciates the comment
Comments relating to rating area ratios	
Comments in response to CR 101	
Comment: Current rating areas discourage entering counties due to rates. Current rating areas as well as the 15% delta in the current rule result in rating outcomes between areas where the rates in	**Response:** OIC's analysis does not justify eliminating the premium ratio. However, OIC does acknowledge that individual issuers may have somewhat different experience and has allowed use of premium ratios at higher levels

an area don't appropriately reflect the costs in that area because of how to shape that / demographics / provider availability and that drives decision making about who's going to offer in a county. Each carrier takes those things into account, and how much money they're prepared to lose in the individual market then becomes the underlying question. (AWHP)	for issuers who are willing to offer coverage in all counties in at least 6 rating areas or offer coverage statewide, as described on page 7.
Comment: As an alternative to the 30% spread for the rating factor, we would also support a factor of +/-15. (Premera Blue Cross)	**Response:** OIC's analysis does not justify eliminating the premium ratio. However, OIC does acknowledge that individual issuers may have somewhat different experience and has allowed use of premium ratios at higher levels for issuers who are willing to offer coverage in all counties in at least 6 rating areas or offer coverage statewide, as described on page 7.
Comment: We think the OIC should consider re-examining the +/-15% constraint on how carriers can vary the price of premiums between geographic rating areas. If carriers had more flexibility here, such as +/-30% margin to remain within, premium prices across the state could more accurately reflect the differences in geographical delivery costs of health care services. (Regence BlueShield)	**Response:** OIC's analysis does not justify eliminating the premium ratio. However, OIC does acknowledge that individual issuers may have somewhat different experience and has allowed use of premium ratios at higher levels for issuers who are willing to offer coverage in all counties in at least 6 rating areas or offer coverage statewide, as described on page 7.
Comment: We encourage the OIC to be cautious regarding changes to georating based on purported differences in provider rates. There are many factors that influence differences between regions, including the administrative costs for lower enrollment areas since an adequate provider network must be sustained even in those regions. In assessing differences in provider payment rates, the Office of the Insurance Commissioner (OIC) should consider differences in how care is	**Response:** OIC has been cautious in its updating of geographic rating areas, using extensive data analysis to inform this work. Under federal law, as described in the background information, OIC cannot take the medical status of enrollees into consideration in establishing geographical rating areas. Our analysis was based upon geographical cost differences related to provider payment rates and practice patterns.

provided in rural versus urban areas. The other factor that should be considered is that costs by county are more likely to be due to differences in medical status of enrollees than in differences in provider payment rates. (WSHA)	
Comments in response to the stakeholder draft	
Comment: OIC should not set a ratio cap, or at least increase the ratio to 1.50. As it stands, the cap will cause lower premiums in areas with higher costs, but higher premiums in those areas with lower cost. Even a 1.20 won't affect carriers dropping counties. Although statewide 1.15 may be accurate, it is too limited on a carrier by carrier basis considering the increase in rating areas. A carrier in more counties will have a larger variation of cost, and without the ability to rate without a cap lower-cost counties' rates will be raised to non-competitive levels. This will discourage more county participation because carriers would have to raise rates statewide. In 2014, with five rating areas, there was a 31% difference, and 2017 numbers look similar. (Premera Blue Cross)	**Response:** OIC's analysis does not justify either eliminating the premium ratio or increasing it to 1:1.5. However, OIC does acknowledge that individual issuers may have somewhat different experience and has allowed use of premium ratios at higher levels for issuers who are willing to offer coverage in all counties in at least 6 rating areas or offer coverage statewide, as described on page 7.
Comment: WSHA is supportive of the incentive for insurers and the increase in consumer options, so long as there are also adequate provider networks. (WSHA)	**Response:** The Commissioner appreciates this comment. OIC has strong network access rules and will continue to enforce them.
Comment: The ratio is not wide enough to price competitively in counties throughout the state. The association would like OIC to consider individual plans' requests for a larger range. (AWHP)	**Response:** OIC's analysis does not justify either eliminating the premium ratio or increasing it to 1:1.5. However, OIC does acknowledge that individual issuers may have somewhat different experience and has allowed use of premium ratios at higher levels for issuers who are willing to offer coverage in all counties in at least 6

	rating areas or offer coverage statewide, as described on page 7.
Comments in response to CR-102	
In proposed WAC 284-43-6681(2)(d)(iv), it is unclear whether the language applies to an issuer that is completely new to the Washington state market or is new to only the individual or small group market. (AWHP)	**Response:** The language applies in situations in which an issuer does not have individual or small group market enrollment experience, so would apply to both issuers who are new to Washington state and those who are new to only the individual or small group market. We believe the language is clear when reading the entirety of WAC 284-43-6681(2)(d). The Commissioner did not amend the proposed text based upon this comment.
An artificial cap on premium ratios is not needed. If a carrier can actuarially justify a premium ratio, it should not be artificially capped. We do not believe the incentivized ratios will have a meaningful impact on market participation. (Cambia Health Solutions)	**Response:** OIC's analysis does not justify eliminating the premium ratio. However, OIC does acknowledge that individual issuers may have somewhat different experience and has allowed use of premium ratios at higher levels for issuers who are willing to offer coverage in all counties in at least 6 rating areas or offer coverage statewide, as described on page 7. The Commissioner did not amend the proposed text based upon this comment.
Comment: Base premium ratio: Incentives to serve higher cost areas are best accomplished through use of independent rate methodology and regulatory review, independent of a premium ratio cap. The base premium ratio does not assist in the goal of stabilizing the individual market. (Kaiser Permanente)	**Response:** A guiding principle in this rulemaking is that OIC's review be data driven. OIC's data analysis does not justify eliminating the premium ratio. Use of the base premium ratio provides some stability in cost for Washington consumers. At the same time, the rule seeks stability by allowing issuers to utilize a higher premium ratio to increase participation in the individual market, as described on page 7. This is intended to provide greater certainty and choice of health plan options for consumers. The Commissioner did not amend the proposed text based upon this comment.

Comment: Potential offering of higher premium ratios: Permitting up to 1.22 and 1.40 premium ratios does not align with the philosophy of protecting consumers from unnecessary and actuarially unjustified rates. Potential offering of higher premium ratios disadvantages issuers without a statewide service area. Using different premium ratios could lead to considerably different premiums and unintended consequences, e.g. lower cost plans exiting higher-cost areas or higher cost plans exiting due to inability to compete. (Kaiser Permanente)	**Response:** OIC understands that allowing actuarially justified premium ratios linked to a commitment to cover additional counties could result in higher premiums for some individual market enrollees. In making this proposal, OIC balanced the opportunity to incentivize coverage in additional counties against the risk of higher premiums, knowing that enrollees with income below 400% FPL are shielded from premium increases through their ACA premium subsidies and that consumers are interested in having more health plan options to choose from. The Commissioner did not amend the proposed text based upon this comment.
We support the proposed approach of step increases in the ratio based on the carrier's geographic "footprint" in the state. (Premera Blue Cross)	**Response**: The Commissioner appreciates this comment.
Premera Blue Cross reads the proposed rules as the higher premium ratios not applying when coverage is offered in the same number of counties outside the Exchange, or in on-Exchange/off-Exchange combinations. Premera asks that OIC confirm or clarify this detail. (Premera Blue Cross)	**Response:** As a result of the federal guaranteed issue requirement, if an issuer offers a health plan on the Exchange, the issuer must allow an individual to apply for coverage and purchase the health plan off-Exchange. 45 CFR 147.104. The 2018 Unified Rate Review Instructions, cited at FN 3 above, provide as follows on page 11: "Geographic rating areas are specific to each state and all issuers in the state are required to follow them. Issuers may only set one rating factor per rating area, per state, per market and that factor must apply uniformly to all plans the issuer has in that rating area." Given this provision, if an issuer offers a qualified health plan on the Exchange consistent with WAC 284-43-6681(2)(b) or (c), then the higher premium ratio would apply to all of the health plans that the issuer offers, both on- and off-Exchange. An issuer who does not offer a QHP, i.e., only offers health plans off-Exchange, would not be able to use the expanded premium ratio, and the 1:1.15 ratio would apply uniformly to all of their individual market health plans. The federal

	law on this issue is clear and would preempt any state interpretation to the contrary. The Commissioner did not amend the proposed text based upon this comment.
Statewide incentive: Premera believes that more flexibility in how a carrier's presence in the market is structured would have better results and that there is flexibility under federal law to allow the statewide incentive to operate at the holding company, rather than the individual carrier, level. While it may be too late to modify the proposed rule for PY 2019 filings, Premera requests resumption of discussions in the near future regarding incentives for statewide coverage. (Premera Blue Cross)	**Response:** As noted in the Background section of this document, the ACA prescribes the means by which individual and small group health plan rates are determined. There are limited factors that can be applied in setting an enrollee's premium. One of those factors is the rating area that the policyholder resides in. The OIC has set outer boundaries on the extent to which premiums can vary between geographic rating areas by the use of premium ratios. The premium ratios are an integral component of the rating area factor. All references to rating areas in the federal regulations, guidance and 2018 Unified Rate Review Instructions refer to the rating area factor being applied at the issuer level. There are no references to applying rating factors at the holding company level. 45 CFR 147.102 and the CCIIO Market Rating Reforms provide: "The Market Rules and Rate Review Final Rule (45 CFR Part 147) provide that each state will have a set number of geographic rating areas that all issuers in the state must uniformly use as part of their rate setting." Market Rating Reforms - Centers for Medicare & Medicaid Services. OIC identified a single reference in which the ACA rules are applied at the holding company, or "controlled group" level, rather than the issuer level. 45 CFR 147.106(d)(3) addresses issuer discontinuation of health plans that leads to a 5 year bar on participation in the applicable market. Under the rule, an issuer will not be considered to have withdrawn from the market if the issuer or another member of its controlled group (i.e. holding company) offers the same product as the discontinued product. If HHS had intended to apply the rating rules referenced above at the holding company,

	rather than exclusively the issuer level, it would have explicitly provided such in its regulations. There will be an opportunity to discuss this issue further when OIC engages in review of the rule in 2021. The Commissioner did not amend the proposed text based upon this comment.
Comments relating to treatment of individual vis a vis small group	
Comments in response to the stakeholder draft	
Comment: Concerned about the OIC's differentiation of the individual market and the small group market because it sets two standards, and the requirement conflicts with other sections. The individual and small group market should be treated the same. We also question whether the index county is King for both markets if carriers only provide coverage for one line of business in King, or if the index is based on the county with the largest enrollment? (Regence BlueShield)	**Response:** OIC identified issues unique to the individual market with respect to the risk of having counties where no individual health plan is offered. In order to incentivize issuers to offer coverage more broadly, the rule includes broader premium ratios for those issuers willing to offer qualified health plans in all counties in 6 or more rating regions or statewide. The rule identifies the county that will be the index county in situations in which: • King County is not in an issuer's service area, and • An issuer offers both individual and small group health plans and either the individual or small group health plans are not offered in King County. • If an issuer is new to the Washington state market. Revisions were made to the language of the rule prior to publication of the proposed rule to address this issue.
Comments relating to network adequacy	
Comments in response to the stakeholder draft	
Comment: OIC will need to continue to monitor the market for network adequacy, coverage access, provider access, and broader offerings.	**Response:** OIC appreciates this comment and will continue to enforce our provider network access regulations.

(WSMA)	
Comment: The rule should also address potential network adequacy issues that could disrupt services and rates. (WSHA)	**Response:** OIC has strong its network access rules and will continue to enforce them.
General / Miscellaneous Comments	
Comments in response to CR 101	
Comment: AWHP suggests that the assessment use allowed health care costs for its analysis of trend/spend, as that reflects the carrier's actual cost as well as the member contribution, resulting in a better picture of the total cost of care. (AWHP)	**Response:** The Commissioner appreciates this comment.
Comment: We also interpret the CMS guidance as permitting the state to amend its rating area designation by filing the amended rating area with them, per the process used to establish the initial set of rating areas. Under that process, a state can designate rating areas without actuarial justification as long as the proposal does not exceed the number of MSAs in the state plus 1. (CMS guidance 8/20/1) (AWHP)	**Response:** OIC agrees that the state does not need to seek review or approval of the rating areas included in the rule because they do not exceed the number of MSA's in the state.
Comment: We urge the OIC to leave out any provision that would require carriers to offer plans in all counties within a geographic rating area. (Regence BlueShield)	**Response:** The rules do not include a provision that would require issuers to offer plans in all counties in a geographic rating area.
Comment: Due to antitrust restrictions, it is difficult for individual carriers to discuss enrollment and pricing data through which a single proposal can be developed, rationalized, and presented to the OIC. We are interested in learning how the OIC will utilize the carrier data that they are currently collecting to evaluate	**Response:** OIC used the data analysis methodology described on pages 5-6 of this Concise Explanatory Statement to evaluate the geographic rating area proposals submitted by issuer in Washington state.

different proposals submitted by carriers in the state. (America's Health Insurance Plans)	
Comment: In considering revising the state's geographic rating areas and ratio restrictions, the desire for robust insurance offerings must be balanced against ensuring access to affordable coverage. To the extent the rule results in increased premiums, patients may be less able to avail themselves of coverage (particularly those patients who don't qualify for subsides). If the rule allows for premium increases in areas where health status lags, there could also be potential for adverse selection. Considered in concert with the OIC's broader market stabilization effort and other forces, our state's insurance landscape could change drastically over a short period of time. Any initiatives should be guarded against unintended consequences, and all public resources should be used efficiently. (WSMA)	**Response:** The Commissioner appreciates this comment.
Comments in response to the stakeholder draft	
Comment: Several of WSMA's set of principles align with the OIC's market stability goals. This stakeholder draft creates a balance between increasing insurance options and providing affordable options. (WSMA)	**Response:** The Commissioner appreciates this comment.
Comment: WSHA is supportive of the stakeholder draft. (WSHA)	**Response:** The Commissioner appreciates this comment.
Comments in response to CR-102	
Comment: This rule successfully balances robust insurance offerings with access to affordable coverage. We encourage continued monitoring of this rule, and beyond the context of this rulemaking we remain concerned about network	**Response:** The Commissioner appreciates this comment. OIC has strong network access rules and will continue to enforce them.

adequacy. We also urge close monitoring of the incentives offered to carriers in this rule, because although broader participation by carriers is beneficial, the plans offered must still be affordable to consumers. (WSMA)	

Implementation plan

Implementation and enforcement of the rule

The OIC intends to implement and enforce the rule through the Rates and Forms Division and Market Conduct Oversight Unit, which is part of the Company Supervision Division. Using existing resources, OIC staff will continue to work with issuers, providers, and interested parties in complying with the requirements of the rule.

How the agency will inform and educate affected persons about the rule

After the agency files the permanent rule and adopts it with the Office of the Code Reviser:

- Policy staff will distribute the final rule and the Concise Explanatory Statement (CES) to all interested parties by posting and sharing the documents through the OIC's standard rule making listserv and emailing the documents to stakeholder participants.
- The Rules Coordinator will post the CR-103 documents on the OIC's website.
- OIC staff will address questions as follows:

Type of Inquiry	Division
Consumer assistance	**Consumer Protection Division**
Rule content	**Rates and Forms**
Authority for rules	**Policy and Legislative Affairs**
Enforcement of rule	**Legal Division**
Market Compliance	**Company Supervision**

How the agency intends to promote and assist voluntary compliance for this rule

The steps listed under implementation will inform and educate affected persons on the changes and help promote voluntary compliance. The OIC's Rates and Forms Division has also added these requirements to its analyst checklists, which health issuers use to ensure that their plans comply with all applicable state and federal laws.

How the agency intends to evaluate whether the rule achieves the purpose for which it was adopted

The OIC will work closely with issuers, providers, and other interested parties to evaluate the effectiveness of the rule as well as to monitor consumer complaints and to monitor plans for non-compliance. The OIC will monitor which issuers, if any, exercise the option to use higher premium ratios as authorized in the rule.

WAC 284-43-6701 provides that the Commissioner will review the geographic rating area designation not more frequently than every three years, beginning Jan. 31, 2021.

Appendix A – Hearing Summary

Summarizing Memorandum

To: **Mike Kreidler, Insurance Commissioner**

From: **Jane Beyer, presiding official for rule hearing**

Matter: **Rule 2017-11**

Topic: **Adjusting geographic rating areas to increase market stability**

This memorandum summarizes the hearing on the above-named rulemaking, which was held on March 13, 2018 at 12:00 p.m. in Olympia. I presided over this hearing in your place.

The hearing began at 12:06 p.m.

In attendance but did not testify:

- Kara Nester
- Christine Gibert
- Scott Barnes
- Dean Solis
- Paul Winder
- Simon Vismantas
- Jane Douthit

In attendance and testified:

- Merlene Converse

- Because Merlene Converse's testimony did not differ from the written comments that the OIC received in the comment letter from Kaiser Permanente, the applicable Commissioner's response for the written comments on the subject applies to the comments that Merlene Converse mentioned during the hearing.

- Waltraut Lehmann
  - Because Waltraut Lehmann's testimony did not differ from the written comments that the OIC received in the comment letter from Premera Blue Cross, the applicable Commissioner's response for the written comments on the subject applies to the comments that Waltraut Lehmann mentioned during the hearing.
- Meg Jones
  - Ms. Jones applauded the expansion of rating areas. She testified that maintaining the premium ratio could create an artificial barrier to issuer participation in the individual and small group markets. She suggested that language in WAC 284-43-6681(2)(d)(iv) be clarified. Her testimony is included in the comments to the proposed rule in this Concise Explanatory Statement, along with OIC's response to those comments.

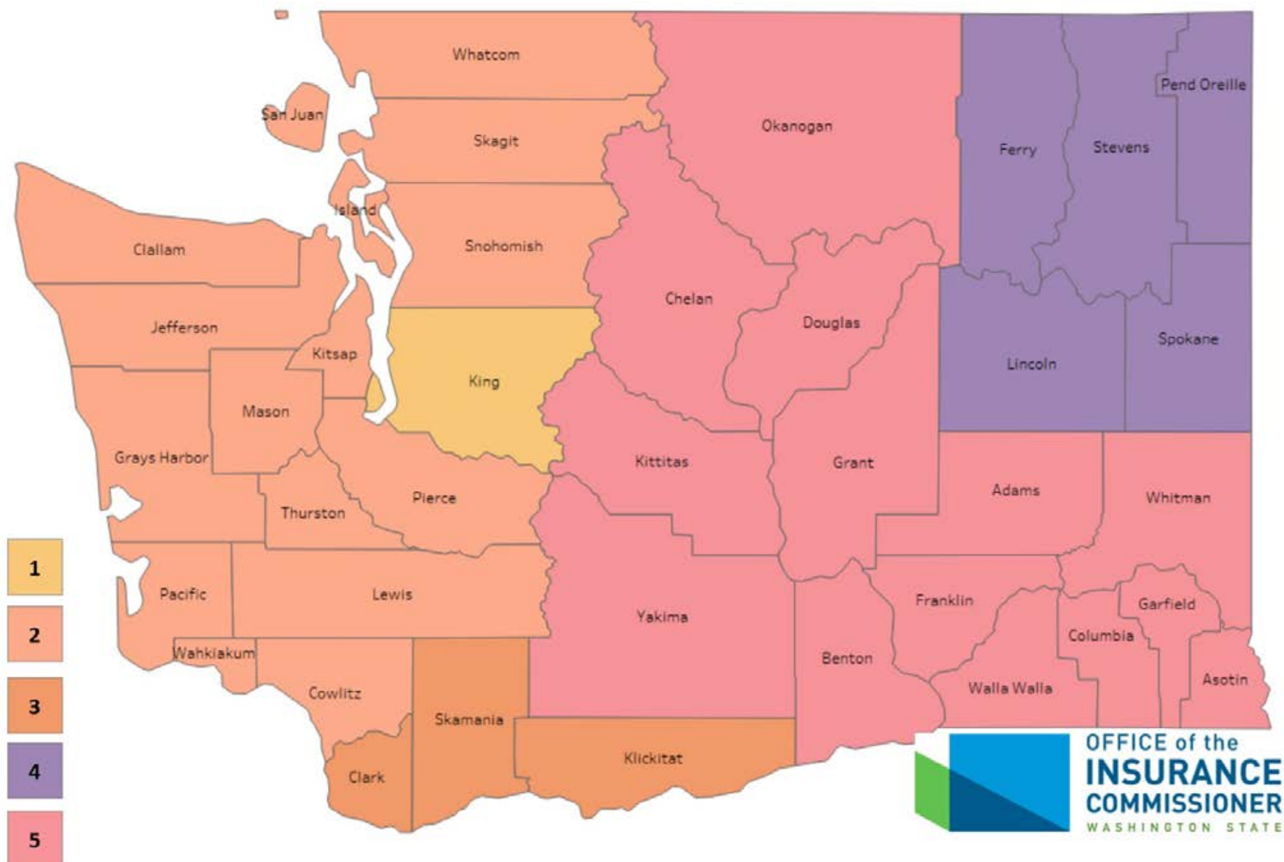
The hearing was adjourned.

SIGNED the 13 of March 2018

Jane Beyer, Presiding Official

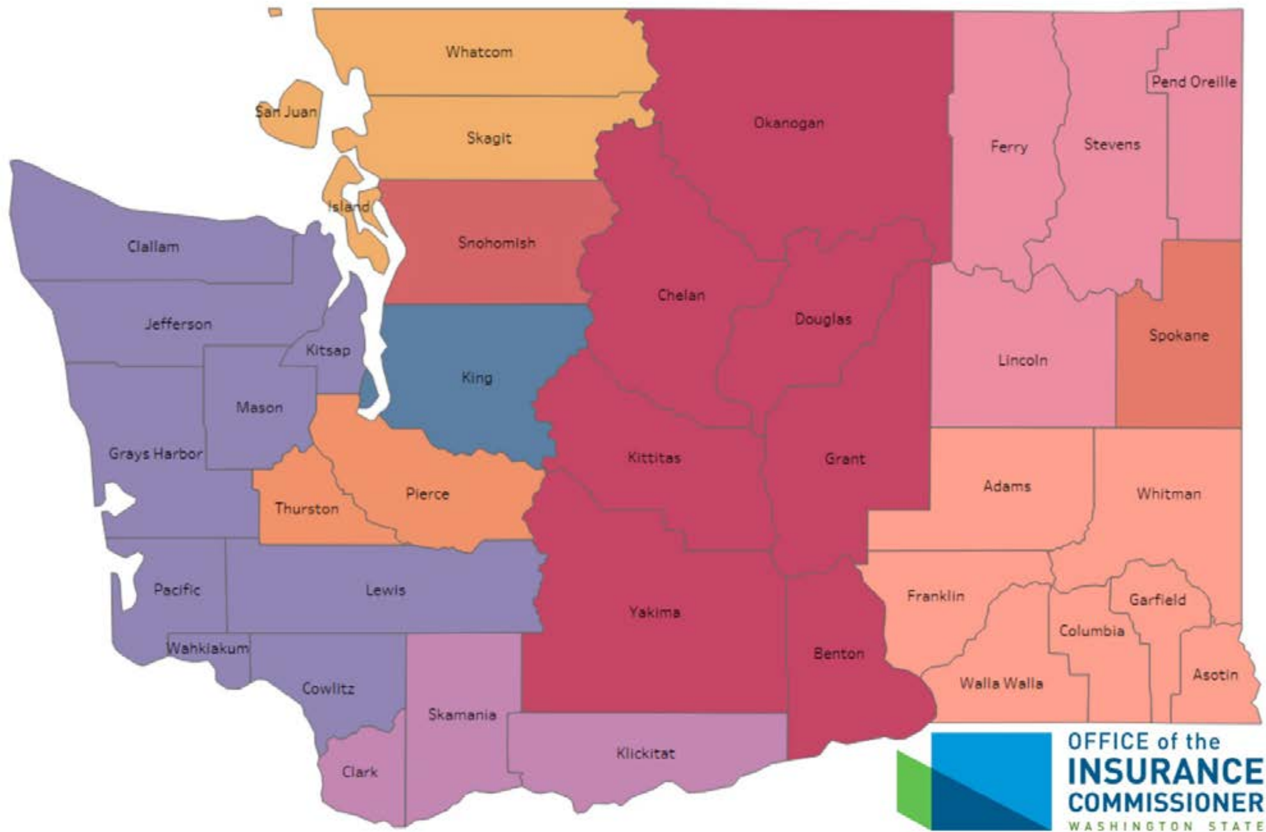
Appendix A

Geographic rating regions – Pre-stakeholder meeting maps



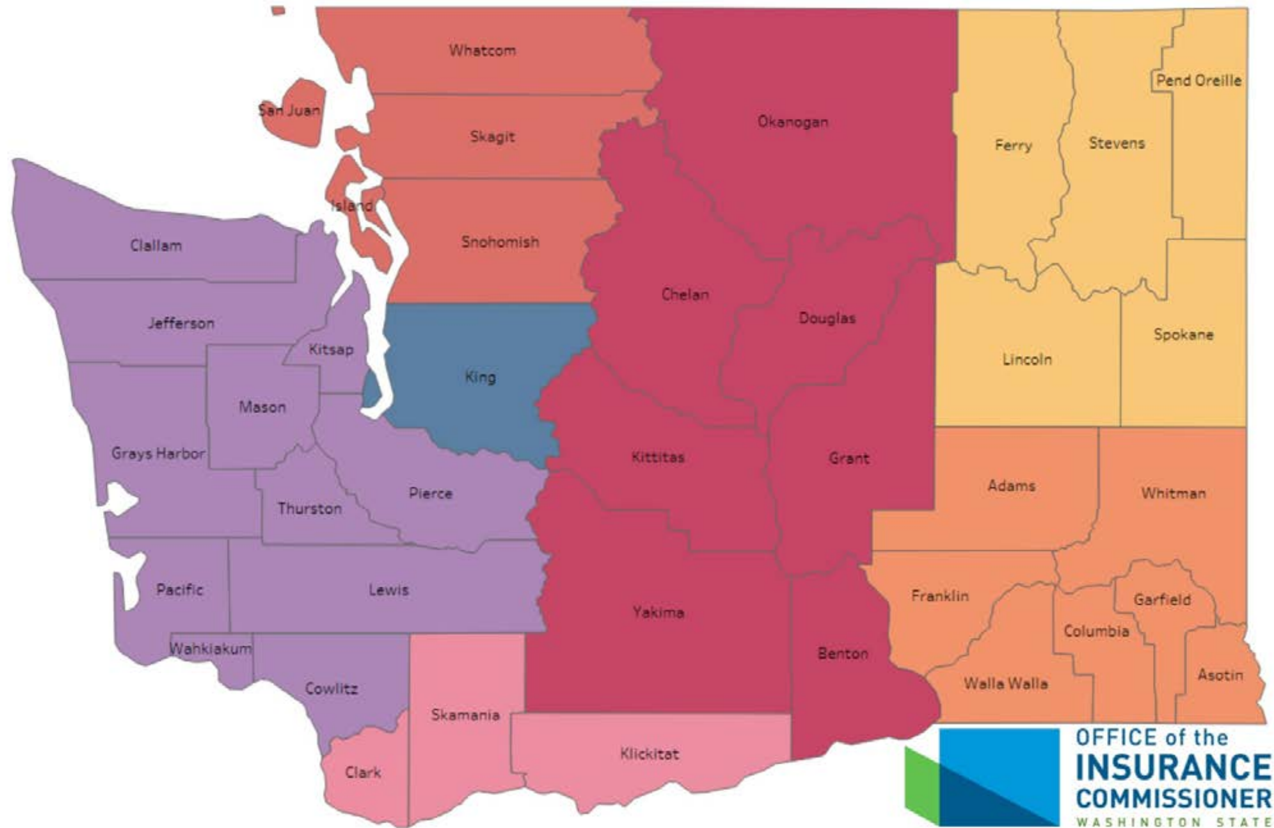
Issuer proposal 1

Ratio—1:1.15



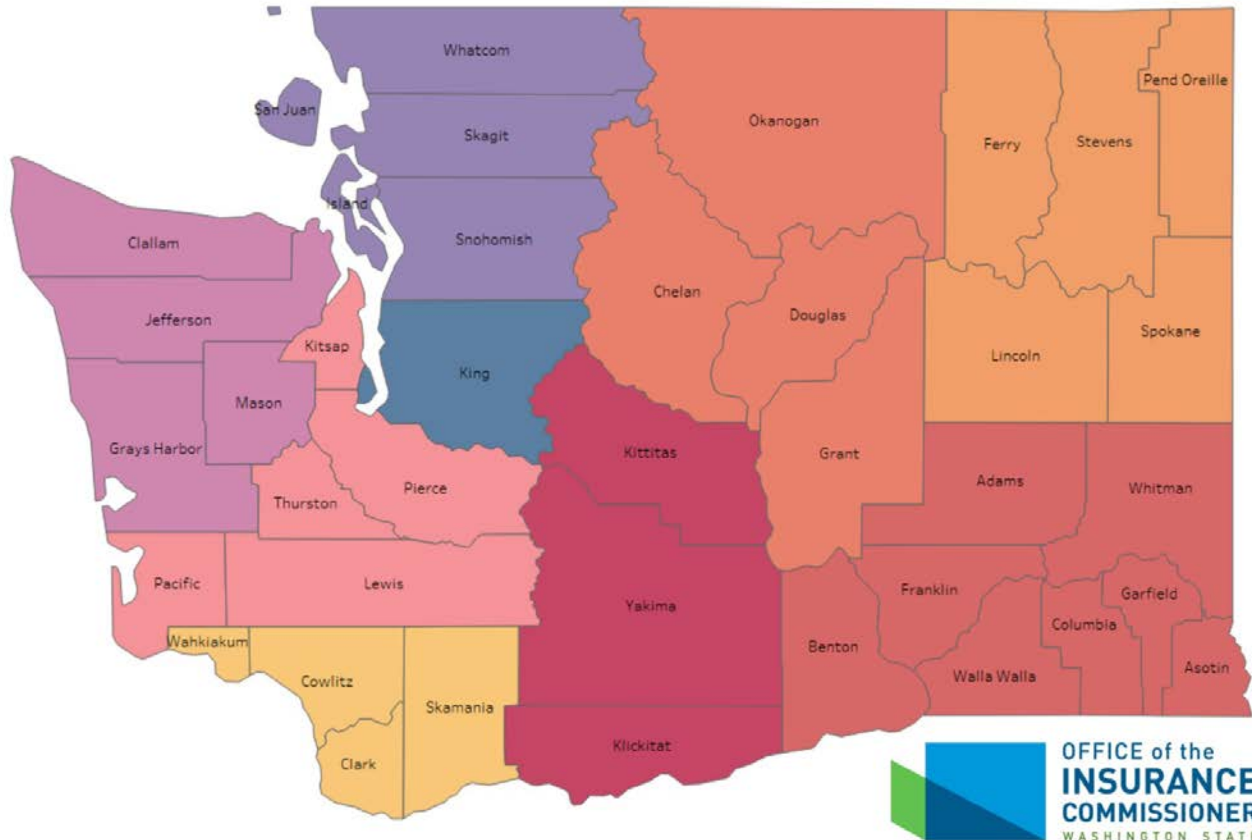
Issuer proposal 2

Ratio—1:1.15



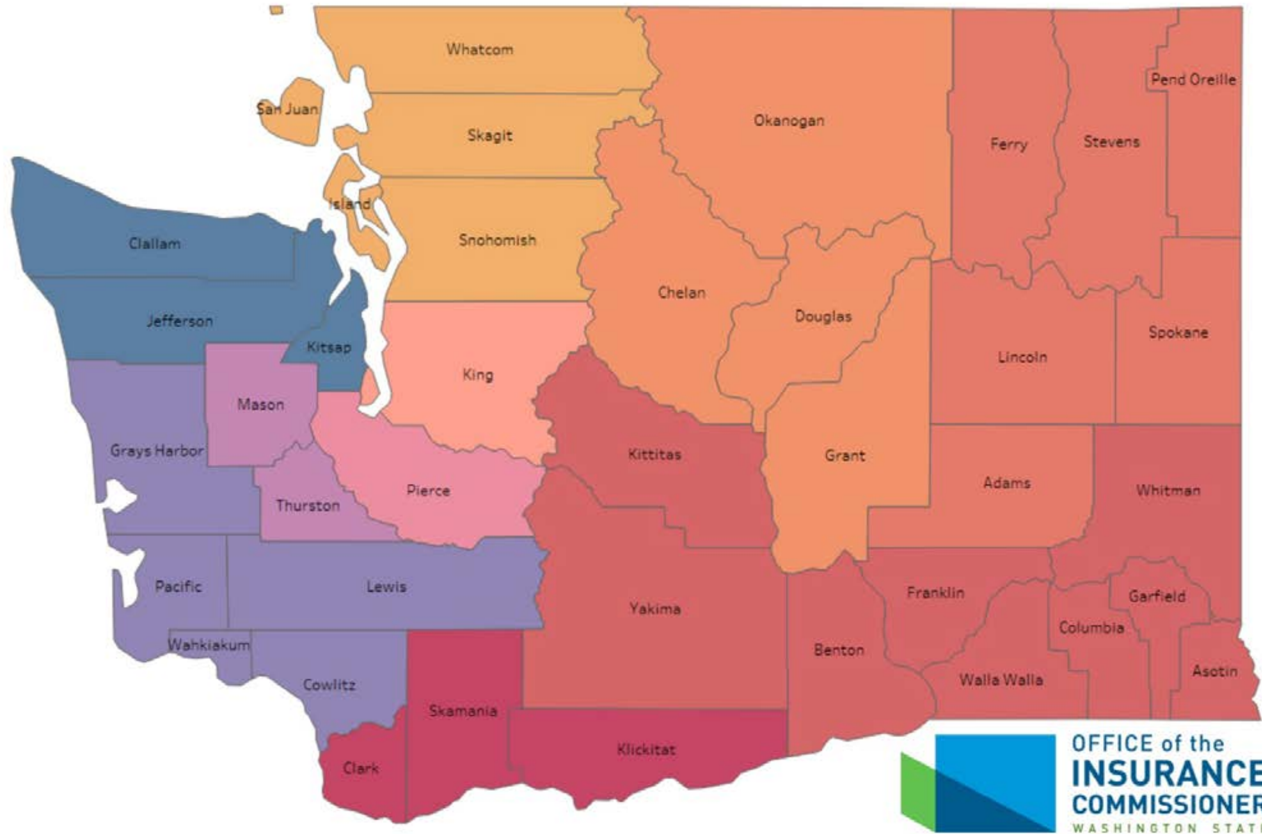
Issuer proposal 3

Ratio—1:1.15



DSHS/HCA purchasing regions

Ratio—1:1.15



Geographic rating regions – Draft of OIC proposal

Color Key	Region	Relative Cost
	West	0.70%
	South Sound	-1.41%
	South Central	-6.19%
	King	0.00%
	North West	-1.69%
	North Central	2.23%
	North East	-9.50%
	South East	-1.43%
	South	0.82%