R 2025-02 – Health carrier rate development components

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Note for interested organizations reading this document:

This prepublication draft's proposed changes are shown in highlighted track changes and strikethroughs.

OIC's emergency rule language (Plan Year 2026 rate development components) is incorporated in this document in either underlined black text (where it amends an existing section) or in black text (where it creates a new section).

Chapter 284-43 WAC

SUBCHAPTER J

HEALTH PLANS, STAND-ALONE DENTAL PLANS AND STAND-ALONE VISION PLANS – FILING REQUIREMENTS

AMENDATORY SECTION

WAC 284-43-6520 Definitions. For the purpose of this subchapter:

(1) "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.

(2) "Contract form" means the prototype of a "contract" and any associated riders and endorsements filed with the commissioner by a carrier.

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

(4) "Dependent" has the same meaning as that contained in RCW 48.43.005.

(5) "Health carrier" or "carrier" has the same meaning as that contained in RCW 48.43.005. ~~means an insurer that issues disability insurance regulated under chapter 48.20 or 48.21 RCW, a health care service contractor as defined in RCW 48.44.010, or a health maintenance organization as defined in RCW 48.46.020, and includes "issuers" as that term is used in the federal Patient Protection and Affordable Care Act (Public Law 111-148).~~

(6) "Individual market" has the same meaning as that contained in RCW 48.43.005.

(7) "Individual health plan" means a health plan issued in the individual market.

(8) "Large group contracts" or "large group plans" include group health benefit plans and stand-alone dental plans or stand-alone vision plans that are not small group plans and are not individual plans.

((~~(7)~~)) (9) "Limited health care service contractor" means a health care service contractor that offers one and only one limited health care service.

((~~(8)~~)) (10) "Negotiated contract" form means a health benefit plan or stand-alone dental plan or stand-alone vision plan where benefits and other terms and conditions, including the applicable rate schedules, are negotiated and agreed to by the carrier or limited health care service contractor and the policy or contract holder. The only plans that carriers can negotiate are large group plans. The negotiated policy form and associated rate schedule must otherwise comply with state and federal laws governing the content and schedule of rates for the negotiated plans.

((~~(9)~~)) (11) "Premium" means all sums charged, received, or deposited as consideration for a contract or the continuance of a contract. Any assessment, or any "membership," "policy," "survey," "inspection," "service," or similar fee or charge made by the carrier in consideration for a contract is part of the premium. Premium does not include amounts paid as enrollee point-of-service cost-sharing.

((~~(10)~~)) (12) "Rate" or "rates" means all classification manuals, rate manuals, rating schedules, class rates, and rating rules.

((~~(11)~~)) (13) "Rate schedule" means the schedule of rates that includes the description of methodology used to obtain the premium rate for a specific individual or group, if given the necessary information such as the demographic data and plan design of the individual or group. For a single negotiated contract form, the rate schedule also includes the premium for the employer.

((~~(12)~~)) (14) "Small employer" ((~~means an employer that fits within the definition of small employer as that term is used in the federal Patient Protection and Affordable Care Act (Public Law 111-148)~~)) has the same meaning as defined in 42 U.S.C. 18024.

((~~(13)~~)) (15) "Small group plans" means the class of "group contracts" issued to "small employers." For the purposes of this section, "small group contracts" and "small group plans" also apply to stand-alone dental plans or stand-alone vision plans.

((~~(14)~~)) (16) "Stand-alone dental plan" means coverage for a set of benefits limited to oral care including, but not necessarily limited to, pediatric oral care.

((~~(15)~~)) (17) "Stand-alone vision plan" means coverage for a set of benefits limited to vision care including, but not necessarily limited to, materials.

((~~(16)~~)) (18) "Subscriber" means a person on whose behalf a "contract" or "certificate" is issued.

[Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064, 48.46.066, and 2015 c 19. WSR 16-03-018 (Matter No. R 2015-04), § 284-43-6520, filed 1/8/16, effective 1/8/16.]

NEW SECTION

WAC 284-43-6800 Definitions. For the purpose of WAC 284-43-6810 and 284-43-6820:

(1) "Actuarial value metal value" or "AV metal value" means the actuarial value that results from use of the Federal Actuarial Value

Calculator, or a permissible alternative method prescribed in 45 C.F.R. § 156.135(b).

(2) "Actuarial value and cost-sharing design of the plan" has the same meaning as defined in 45 C.F.R. § 156.80(d) and as used in rate development for individual and small group health plans in the Unified Rate Review Template published by the United States Centers for Medicare and Medicaid Services ~~(CMS)~~.

(3) "Actuarial value pricing value" or "AV pricing value" means the rate development component of the "actuarial value and cost-sharing design of the plan" adjustment that estimates the expected paid-to-allowed claims ratio for essential health benefits of the plan but does not consider the morbidity or health status of members.

(4) "Cost sharing" has the same meaning as defined in 45 C.F.R. § 155.20.

(5) "Cost-sharing reductions" has the same meaning as defined in 45 C.F.R. § 155.20.

(6) "Cost-sharing reduction silver load" or "CSR silver load" means the rate development component of the "actuarial value and cost-sharing design of the plan" adjustment that accounts for the cost and

risk from unfunded cost-sharing reduction amounts provided to eligible enrollees as authorized by 45 C.F.R. § 156.80.

(7) "Cost-sharing reduction variants" or "CSR variants" are silver plan variations defined in 45 C.F.R. § 156.420 that have different actuarial values.

(8) "Essential health benefits" has the same meaning as defined in 45 C.F.R. § 156.110(a).

(9) "Grandfathered health plan" has the same meaning as defined in RCW 48.43.005.

(10) "Percentage of the total allowed costs of benefits" has the same meaning as defined in 45 C.F.R. § 156.20.

(11) "Level of coverage" means one of four standardized actuarial value levels as defined in 42 U.S.C. 18022.

(12) "Induced demand factor" means the rate development component of the "actuarial value and cost-sharing design of the plan" adjustment that reflects the anticipated induced demand associated with the plan's cost-sharing level but does not reflect differences in the plan members' morbidity or health status, as referenced in the federal risk adjustment transfer formula for the individual and small

group markets and Unified Rate Review Template Instructions published by the United States Centers for Medicare and Medicaid Services (CMS).

(13) "Qualified health plan" has the same meaning as defined in 45 C.F.R. § 155.20.

(14) "Unified Rate Review Template (URRT)" means a spreadsheet that comprises Part I of the rate filing justification, as described in 45 C.F.R. § 154.215, concerning submission of rate filing justification.

NEW SECTION

WAC 284-43-6810 Standardized induced demand factors and AV pricing value guardrails. This section applies to all nongrandfathered individual and small group health plans for plan years beginning on or after January 1, 2027~~6~~.

(1) The allowed underlying rate development components of the "actuarial value and cost-sharing design of the plan" adjustment are:

(a) AV pricing value;

(b) Induced demand factor;

(c) Cost-sharing reduction silver load (if applicable); and

(d) Exclusion of funds for abortion services per 45 C.F.R. § 156.280(e) (if applicable).

(2) To ensure consistency in ~~the~~ rate development, align ~~the~~ rating methodology with the federal risk adjustment model and development of cost-sharing reduction ~~CSR~~ silver load, and ~~to~~ promote fair competition, the induced demand factors used in the individual and small group health plan rate filings may vary by plan design but must be consistent with the federal risk transfer formula published by the United States Centers for Medicare and Medicaid Services ~~(CMS)~~.

(3) Except to the extent provided otherwise in this subsection, to promote fair competition and ~~by~~ ensure~~ing~~ consumers can compare plans based on consistent metal level categories and pricing methodologies, the AV pricing value must be within ±2% of a plan's designated AV metal value. The allowable range of AV pricing value may be increased or decreased by 1% and must not result in a total adjustment exceeding ±3%, if the plan has significant features that are not considered in the AV metal value calculation. Applicable plan features may include, but are not limited to, an embedded pediatric dental benefit, an aggregate family deductible, or significant out-of-network utilization. The actuarial memorandum in the rate filing must

include ~~the following information related to AV metal value and AV pricing value:~~

~~(a) E~~each plan's AV metal value, AV pricing value, and the method used to develop AV pricing values.

(4~~b~~) The methodology used to develop the AV pricing value must be based on a standardized population. The carrier must identify all material changes in the AV pricing value development from the prior year's rate filing and quantify their impacts.

NEW SECTION

WAC 284-43-6820 Uniform cost-sharing reduction silver load adjustment factor. (1) This section applies to all individual silver level plans offered on the ~~Washington~~ health benefit exchange ~~(WAHBE) during~~ for plan years beginning on or after January 1, ~~plan year~~ 2027~~6~~.

(2) The following assumptions will be ~~are~~ used by the commissioner in the cost-sharing reduction (CSR) silver load calculation:

(a) Actuarial values are ~~: B~~based on federal risk transfer formula factors published by the United States Centers for Medicare and Medicaid Services ~~(CMS)~~.

(b) The actuarial value for limited cost-share silver variant is 70 percent based on qualified health plan application instructions.

(c) Induced demand factors are b~~: B~~ased on federal risk transfer formula factors published by the United States Centers for Medicare and Medicaid Services~~CMS~~.

(d) Membership distribution and enrollment assumptions~~: For plan year 2026 CSR silver load adjustment factor, the membership distribution and enrollment assumptions~~ are based on the prior year experience~~,~~ provided by the health benefit exchange~~WAHBE~~, and ~~with~~ include appropriate adjustments for ~~the following adjustments for~~ health benefit exchange ~~WAHBE~~ plan mapping ~~assumptions and~~ procedures.

~~(i) Members ineligible for CSR subsidies will not enroll in silver plans. These members will be mapped to a lower-cost gold plan with a higher AV metal value.~~

~~(ii) Members eligible for the silver 73 percent CSR variant subsidies will not enroll in silver plans. These members will be mapped to a lower-cost gold plan with a higher AV metal value.~~

(3) The methodology and formula used by the commissioner to calculate the CSR silver loading factor ~~for plan year 2026~~ is as follows:

(a) For each exchange silver plan variant, compute the enrollment-weighted product of the plan's actuarial value and the induced demand factor.

(b) Sum the results of ~~from the~~ step ~~in~~ (a) of this subsection.

(c) Divide the result of ~~from the~~ step ~~in~~ (b) of this subsection by the product of the actuarial value and induced demand factor for the base silver plan (i.e., values for the 70 percent AV metal level plan).

(d) The result in step (c) of this subsection is the final CSR silver load factor for the plan, which applies only to exchange silver plans. The result must be incorporated into premium rate development as a component of the "actuarial value and cost-sharing design of the plan" adjustment, provided the issuer does not otherwise receive reimbursement for cost-sharing reduction amounts.

(4) Based on the calculation in subsection (3) of this section and the assumptions in subsection (2) of this section, the commissioner may update the final cost-sharing reduction ~~CSR~~ silver

loading factor ~~for plan year 2026 is 1.435~~ annually, as the commissioner determines appropriate.

(5) The commissioner will provide the final cost-sharing reduction silver loading factor and plan-mapping assumptions used in the commissioner's calculation to issuers by March 31 of each year.

(6) For any plan year during which all issuers receive reimbursement for cost-sharing reduction expenses from the federal government, the commissioner will forego calculating a silver loading factor.