



Filing for Plan Year 2027

Rates, Forms, and Provider Networks



OFFICE of the
**INSURANCE
COMMISSIONER**
WASHINGTON STATE

Overview

*Todd Lovshin, Deputy Insurance Commissioner
Rates, Forms & Provider Networks*

WELCOME TO PY27, THE 14TH PLAN YEAR!

Housekeeping:

- This PowerPoint Deck will be posted on the OIC website after the presentation.
- A link will be sent out via a GovDelivery email
- Ask questions using the Q&A link on the Teams task bar.
 - We will post Questions and Answers as the webinar progresses.
- If we don't answer your question, email it to Rfhealthplan@oic.wa.gov

AGENDA

- Overview
- Forms
- Provider Networks
- Rates
- SERFF Binders
- Recap

IMPORTANT DATES

- **May 14, 2026** – Filing deadline
- **June 26, 2026** – PY27 Service Area Changes deadline
- **September 3, 2026** – On Exchange Individual Market approval due date
- **September 10, 2026** – WAHBE Board meeting to certify QHPs and QDPs
- **October 15, 2026** – CMS's approval deadline for all off-Exchange individual and small group health plans.

Items of Note

- **Notice of Benefit Payment Parameters** – not final yet and we will continue to monitor and provide guidance.
- **Artificial Intelligence Questions in SERFF** – New questions that are required for all filings 5/1/2026 and forward.
- **Draft General Filing Instructions and Speed to Market Tools** – we are reviewing comments.

SIGN UP TO RECEIVE GOVDELIVERY EMAILS

How to sign up for GovDelivery emails

- Subscribe to OIC news through our GovDelivery system by entering your email address at the following location
<https://public.govdelivery.com/accounts/WAOIC/subscriber/new>
- Under industry information choose topic “Health care filing information” to receive updates on webinars, changes related to our filing instructions, and general news related to PY27

And sign up for any other topics you want to receive information on, such as rulemaking.

THE DIFFERENCE BETWEEN GFIs AND STMs

General Filing Instructions (GFIs) are required.

- Compliance with GFIs is required to get your filing through the door in SERFF
- Following GFIs does not mean your filing will be approved

Speed To Market (STMs) tools, processes, documents are optional.

- STMs are not required to get your filings accepted in SERFF for review
- Using STMs helps get your filing to approval faster
- We will prioritize filings with completed STMs

Website link to Filing Instructions and Speed to Market (STM) Tools:

<https://www.insurance.wa.gov/health-care-and-disability-filings>

NO MPMS FOR WASHINGTON STATE

CMS/CCIIO has created a new HIOS Marketplace Plan Management System (MPMS) Module for states that use the federal platform.

This does not impact Washington state because we have a State-Based Exchange (Marketplace) that does not use the federal platform.

Forms

Heather Shimoji, Health Forms Manager

DEFINITIONS OF PRODUCT AND PLAN

Product:

- Discrete package of health coverage benefits that uses a particular provider network type (HMO, PPO, EPO, POS or indemnity) within a service area
- Differences in the scope of benefits = different products
 - i.e., limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the amount, scope or duration of treatment
- Differences in "cost-sharing structure" ≠ different products
 - i.e., deductibles, coinsurance, copayments, or similar charges
- A product can be modified in some ways yet remain the same product.
 - "Uniform Modification": 45 CFR §146.152(f), 45 CFR §147.106(e), or 45 CFR §148.122(g).

DEFINITIONS OF PRODUCT AND PLAN (cont'd)

Plan:

- Pairing of health insurance coverage benefits under the product with a particular cost-sharing structure, provider network, and service area
- All service areas of the plans offered within a product constitutes the service area of the product

Same Product with Different Plans			
	Plan A	Plan B	Plan C
Benefits Covered	Same benefit package as State EHB Benchmark	Same benefit package as State EHB Benchmark	Same benefit package as State EHB Benchmark
Network Type	PPO	PPO	PPO
Metal Level	Gold	Silver	Bronze

- Product and plan defined in 45 CFR § 144.103

PRODUCT, PLAN, AND FORMULARY

- As part of Federal requirements, a “discrete set of health coverage benefits” includes the formulary.
- In PY 2027, OIC will continue to enforce the federal requirement that all plans within a product share the same drug formulary.
- OIC formally asked CMS what are allowable formulary changes within one product for purposes of maintaining that product status
 - According to CMS, a product formulary must have same list of drugs and same drugs in each cost-sharing tier, though cost-sharing may differ between plans
- “Formulary ID” as used in the CMS QHP templates does **not** automatically indicate a different drug formulary for the purpose of defining separate products.
 - For plans within the same product, plans may have different formulary IDs if differences are only due to variations in cost-sharing.

PRODUCT, PLAN AND FORMULARY (cont'd)

- If an issuer makes changes to its drug formulary upon renewal or mid-plan year, these changes must comply with the Uniform Product Modification Justification (UPMJ) criteria under 45 CFR §147.106(e)(3), including the allowable plan-adjusted rate index variation of +/- 2%.
 - For existing products, changes in the covered drug list may be considered a product discontinuation.
 - We will not expect a new UPMJ submission with a mid-year formulary change

"PRIMARY PRODUCT"

- ✓ Product with the most complex or "richest" benefit design in each market
- ✓ Designated in the analyst checklist and binder snapshot document
- ✓ If your individual market products include both standardized (Cascade or Cascade Select) and non-standardized plans, please designate your most complex non-standardized plan as primary

PRIORITY OF FORMS REVIEW BY MARKET



Student Health
Plans

Individual
Exchange
Health Plans &
On-Exchange
Stand-Alone
Dental

Individual Off-
Exchange
Health Plans

Small Group
Health Plans &
Off-Exchange
Stand-Alone
Dental

PRELIMINARY FORMS REVIEW

Purpose: Identify threshold issues that may prevent or delay substantive review of your filing

Preliminary Review of ALL Filings:

- ✓ Are “products” and “plans” correctly sorted and identified?
- ✓ Are HIOS IDs correct?
- ✓ Have you filed the same number of products and plans in your form, rate, and binder filings?

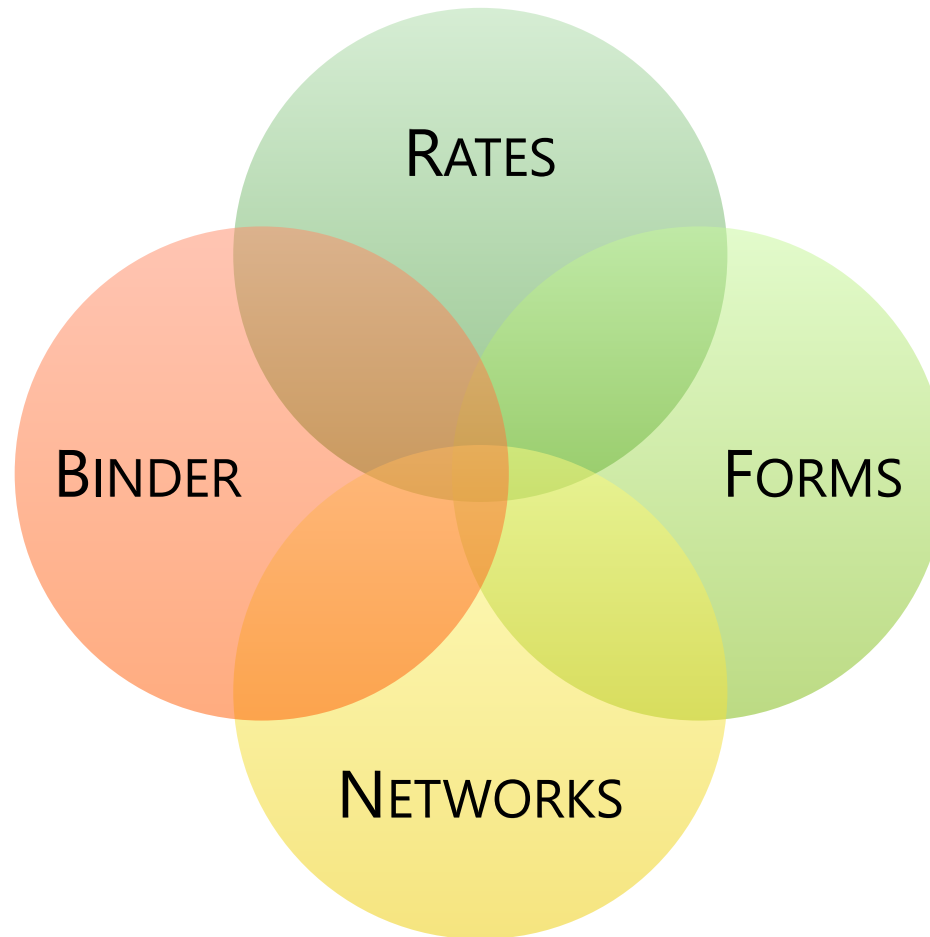
PRELIMINARY FORMS REVIEW (cont'd)

- ✓ Have you filed at least one renewal product?
- ✓ Have you submitted redline versions of all “revised” forms under the Supporting Documentation tab?
- ✓ Have you submitted electronic review tool results with your binder filing?
- ✓ Do Cascade Care plan names meet WAHBE naming conventions?

SUBSTANTIVE REVIEW

- ✓ Begins when preliminary objections are resolved
- ✓ Uses applicable analyst checklist
- ✓ Analyst may “group” filings for review based on similarity across products
- ✓ “Primary product” reviewed beginning to end

MATCHING INFORMATION ACROSS FILINGS



COMMON FORM "MATCHING" OBJECTIONS

Cost-share amounts

- ✓ Forms: Schedule of Benefits/Summary of Costs
- ✓ Binder: Plan & Benefits Template
- ✓ Binder: Prescription Drug Template

Network names

- ✓ Forms content
- ✓ Binder: Network Template
- ✓ Provider Networks: Filed networks

Service Area - Counties

- ✓ Forms content
- ✓ Binder: Service Area Template counties

TIMELINES FOR RESPONSE TO FORM OBJECTIONS

	Preliminary & Substantive Objection Letters		
	1st	2nd	Subsequent
# of Business Days	5	3	2

- All timelines subject to OIC and/or WAHBE deadlines for plan approval and certification
- You may request an extension of the “respond by” date
 - Reasonable requests will be granted
- Reminder: All communications that relate to the OIC’s review of a specific filing **must** occur in SERFF

"PRIMARY PRODUCT" OBJECTIONS

- ✓ All first-round substantive objections are made within primary product filing
- ✓ Objections to secondary product filings will be based on differences/variation from primary

AMENDING FORMS (“FLIPPING” PROCESS)

- ✓ When all objections are resolved within primary product filing, you will be asked to amend all other product filings in accordance with these changes
- ✓ 5-day turnaround time, subject to OIC and WAHBE deadlines
- ✓ Required certification of changes

WHAT'S NEW FOR PY2027?

- **New Filing Question on Artificial Intelligence (AI) Use**
 - Beginning May 1, 2026, all new SERFF form, network, and rate filings must indicate whether AI was used in the preparation or support of the filing
 - Filers will be required to identify the AI system used and provide a brief description
 - The purpose of this requirement is to better understand how carriers use AI technology in their filings and to determine whether machine learning leads to predictable filing errors
 - This requirement will not change existing rate or form review standards.
 - Filers may update or modify their responses in SERFF if corrections or clarifications are needed

WHAT'S NEW FOR PY2027? (cont'd)

- **HHS Notice of Benefit and Payment Parameters for 2027 Proposed Rule**
 - The rule proposes to adopt many changes including:
 - Prohibiting issuers from including routine non-pediatric dental services as an EHB
 - Cost defrayal of state-mandated benefits
 - QHP certification of non-network plans
 - It is unknown if the proposed rule will be finalized before the May 14th filing deadline
 - Carriers should not file any rates and forms based on the proposed rule
 - Once the final rule is published, the OIC will send out a GovDelivery communication with further instructions

WHAT'S NEW FOR PY2027? (cont'd)

- **Essential Health Benefits Benchmark Plan**

- Updated WACs
 - [WAC 284-43-5604](#) – Essential Health Benefits Package Benchmark Plan
 - [WAC 284-43-5624](#) – Plan Design
 - [WAC 284-43-5644](#) – Essential Health Benefit Categories
 - [WAC 284-43-5704](#) – Essential Health Benefit Category – Pediatric Oral Services
 - [WAC 284-43-5784](#) – Pediatric vision services
 - [WAC 284-43-5939](#) – Hearing instrument coverage
- Reminders
 - Student Health Plan carriers need to update their pediatric dental benefit section to comply with the updated benchmark plan
 - Plans that update their pediatric dental benefits to match the benchmark plan and WAC 284-43-5781 (4) exactly are the most accurate

WHAT'S NEW FOR PY2027? (cont'd)

Health Plan Maximum Out of Pocket*:

- \$12,000 for self only coverage
- \$24,000 for other than self only coverage

Pediatric Dental Annual Limit on Cost Sharing**:

- \$450 for one child
- \$900 for multiple children

*Source: PAPI Guidance for 2027 Benefit Year (1/29/2026)

**Source: 2027 DRAFT Letter to Issuers in the Federally-Facilitated Exchanges (2/25/2026)

WHAT'S NEW FOR PY2027? (cont'd)

ESSHB 1432 (2025)

- Improving access to appropriate mental health and substance use disorder services by updating Washington's mental health parity law and ensuring coverage of medically necessary care

SHB 1706 (2025)

- Aligning the implementation of application programming interfaces (APIs) for prior authorization with federal guidelines

E2SSB 5395

- Making improvements to transparency and accountability in the prior authorization determination process

WHAT'S NEW FOR PY2027? (cont'd)

ESHB 2242

- Preserving access to preventive services by clarifying state authority and definitions
 - The Department of Health (DOH) is currently creating a dedicated webpage for pediatric and adult immunization recommendations.
 - Target launch date: mid-April
 - The DOH and the OIC will send out a joint GovDelivery message when the webpage goes live

SSB 6183

- Coverage for HIV antiviral drugs

ADDITIONAL RESOURCES

Washington State Department of Health Immunizations Guidance (HB 2242)

- *To be announced in mid-April*

U.S. Preventive Services Task Force A & B Recommendations

- <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations?SORT=D&DESC=1>

Women's Preventive Services Guidelines (HRSA)

- <https://www.hrsa.gov/womens-guidelines/index.html>

Bright Futures/American Academy of Pediatrics Recommendations

- <https://www.aap.org/en/practice-management/bright-futures/bright-futures-materials-and-tools/bright-futures-guidelines-and-pocket-guide/>

TIPS FOR SUCCESS: HELP US HELP YOU!

- ✓ REVIEW YOUR FILINGS FOR CONSISTENCY AND MATCHING INFORMATION
 - ✓ Highly recommend submitting STM checklist with form filing
- ✓ BE PROACTIVE
- ✓ COMMUNICATE WITH YOUR ANALYST
 - ✓ All communications that relate to the OIC's review of a specific filing **must** occur in SERFF



Provider Networks

Jennifer Kreidler, Provider Network Oversight Program Manager

DOES YOUR NETWORK MATCH?

PNOP will review the following:

- Network name(s) listed in approved provider contracts
- Registered network maintenance information:
 - Name,
 - Type of network (single or tiered),
 - Market (outside, Exchange or both)
 - Line of Business
 - HCBM licensure and subnetwork names
- Service Area template
- ECP and Network Adequacy Template
- Network ID Template
- **Access Plan and GeoNetwork Report – *SPNRR open 4/23/2026***
- Provider Network Form A report

Non-network plan

- Draft 2027 Payment Notice proposes to rescind requirements that all plans use a network of providers to obtain QHP certification.
- Non-network plans must ensure access to a range of providers.
 - Essential Community Provider (ECP) thresholds.
 - Master list of providers.
- Who can offer in Washington?
- Thinking about filing a non-network plan for PY2027 approval? **Contact us today.**

ESSENTIAL COMMUNITY PROVIDER (ECP)

Proposed Notice Benefit Payment Parameter (NBPP) rule FFE, SBE-FP *and non-network plans*

ECP Requirements	General ECP Standard	Alternate ECP Standard
Contract with at least 20% of available ECPs	X	X (within HPSA or low-income zip codes)
Contract with 20% Family Planning Providers	X (not applicable to SADPs)	X (within HPSA or low-income zip codes) (not applicable to SADPs)
Contract with 20% Federally Qualified Health Centers	X (not applicable to SADPs)	X (within HPSA or low-income zip codes)
Indian health care provider requirement – offer benefit amount as payment in full to all IHCP in plan service area	X	
Meet ECP Category per county requirement – offer benefit amount as payment in full to at least 1 ECP in each of the eight (8) categories per county in the service area.	X	

ESSENTIAL COMMUNITY PROVIDER (ECP)

Traditional Network Plans WAC 284-170-310(3)

ECP Requirements	General ECP Standard	Alternate ECP Standard
Contract with at least 30% of available ECPs	X	Does not apply
		Does not apply
Contract with at least 50% of Rural Health Clinics		
		Does not apply
Pediatric oral services - contract with at least 30% of available ECPs	X	

Carriers are required to meet the highest participation standard.

ECP/NA TEMPLATE

Provider reporting requirements by location:

- Washington state network access standards
 - The Provider Network Form A report should include **all** contracted in-network providers
 - Meeting network access standards may include access to providers in nearby states
- ECP standards
 - The ECP template may only include providers located in the state corresponding to the carrier's service area for the respective plan ID and network ID combination
 - ECPs reported outside Washington state will not count towards meeting threshold requirements

ECP/NA TEMPLATE (cont'd)

- Washington state uses the alternate access delivery request (AADR) process to report
 - Carrier issues meeting the ECP threshold standards
 - Network access issues:
 - SADPs [WAC 284-170-200(14)] or
 - Health benefit plans [WAC 284-170-200(15)]
- *New Alternate Access Delivery Request Form C* available
- Washington state **does not** use federal network adequacy justification forms.

Alternate Access Delivery Request

- Traditional network plans must be maintained to assure in-network access to contracted providers.
- AADR's are permitted to address short term situations in which the carrier has demonstrated a reasonable basis for not meeting network access standards.
- The OIC will not approve an AADR unless the carrier submits:
 - Substantial evidence of good faith efforts on its part to contract with providers or facilities; **and**
 - Demonstrate there is no available provider or facility available to contract.

Alternate Access Delivery Request (cont'd)

What is evidence of good faith efforts to contract?

- Contact logs demonstrating current and active negotiations. This includes supporting documentation of these activities.
- Letter of Intent to contract executed between the parties.
- Red-line/strike out contract documents between the parties.

Alternate Access Delivery Request (cont'd)

What is **not** evidence of good faith efforts to contract?

- Contact logs identifying limited outreach attempts.
- Only standard operational outreach request.
 - A phone call, mailer, etc.
- Logs with no supporting documentation.
- Long delays between outreach attempts.

TIERED NETWORK

- Tiered network means a network that identifies and groups providers and facilities into specific groups to:
 - Reimburse providers differently, or
 - Establish different enrollee cost-sharing levels, or
 - Establish provider access requirements, or
 - Any combination thereof, apply as a means to manage cost, utilization, quality, or to otherwise incentivize enrollee or provider behavior.
- Only tier one providers will be counted to determine essential community provider threshold standards.
- **CAUTION:** Benefit design changes may change your network structure and require development of a new network.

WHAT'S NEW FOR PY2027?

RCW 48.43.732 and WAC 284-170-421(4) – Prohibiting health carriers, facilities, and providers from making any public statements of any potential or planned contract terminations unless it satisfies a legal obligation. January 1, 2027, each provider contracts must contain notice requirements.

Senate Bill 5845 – Modernizing and clarifying timely payment requirements for health carriers.

Rates

Ben Driver, Actuary

Key Changes Impacting ACA Rate Filings

- Proposed changes to the URRT (CSR experience and projection reporting)
- Premium alignment rulemaking (Health carrier rate development components)
- Currently not expecting a need for two sets of rates due to CSR funding
- Updates to Speed to Market Tools

Proposed Federal Rule – Rate Filing Process

- The federal rules are not yet final, but it will affect PY27 filings.
- If the rule is not finalized before the filing deadline, carriers should file under current regulations.
- Based on the proposed rule, we do not expect the timing of the final PY27 NBPP to result in material filing differences, except for the adjudication requirement for CSR reporting experience in the URRT.
- If the rule is finalized after the filing deadline, carriers may revise only those filing components that are not compliant with the final rule, if needed.

Premium Alignment Rulemaking

- Rulemaking is underway to permanently adopt changes to WAC 284-43-6800 through 284-43-6820.
- Pricing methodologies will align with PY2026.
- Speed-to-Market guidance remains largely unchanged, but clarifies treatment of model normalization in AV and cost-sharing design.
- Plan mapping rules for renewing members remain unchanged from last year.
- The checklist includes preliminary guidance.
- Additional guidance will be issued, if needed, after the PY27 NBPP and rulemaking are final.

Two Sets of PY2027 Individual Health Plan Rates

- Do not submit a second set of rates in your PY27 rate filing.
- We do not anticipate a need for a second set of rates like PY26 rate filings.

Draft Rate Filing Speed to Market Tools

- All Speed to Market Tools were posted for public comment.
- Notice was sent via GovDelivery on 3/20/2026
- Feedback deadline to ensure consideration in final version was 03/27/2026.
- Feedback is welcome outside of this window.

Rate Filing Speed to Market Tool Changes

- Applies to ACA non-grandfathered individual and small group health plan rate filings.
- Key updates to Washington standardized filing exhibits include:
 - Claims trend information by affiliate status.
 - Reconciliation of risk adjustment and URRT projections.
 - Rate impact transparency exhibit.
 - MLR rebate exhibit.
 - Miscellaneous updates based on feedback and review experience.
 - Tool- and sheet-specific instructions have been moved to a companion guide.
- New Alternative Access Delivery Request (AADR) rate support checklist.
- New Claims Data Support Template and companion guide.

Rate Filing Review Process Highlights

- Preliminary reviews of all rate filings within the first couple of weeks.
- Rate filing review priority (after preliminary reviews):
 - On-exchange rate filings first
 - Off-exchange rate filings second

How to Expedite the Review Process

- Include complete and accurate final versions of all STMs in the rate filing submission.
- Submit complete and accurate responses to all rate filing objections.
- Do not make changes to the rate filing unless requested in an objection or approved by the reviewer.
- If an objection is unclear, contact the reviewer for clarification before responding.

PY2027 Individual Supplemental Checklist for 1332 Waiver Reporting

- Although the Section 1332 waiver program remains active, it no longer has any enrolled members. Accordingly, the checklist must still be completed, and the scenarios with and without the 1332 waiver are identical.
- Checklist required by Washington Health Benefit Exchange (HBE) for 1332 Waiver Reporting.
- Applies to all individual carriers, on-Exchange and off-Exchange.
- OIC will review this checklist as part of rate filing.

PY2027 User Fees

- PY27 Exchange User Fees:
 - QHPs \$5.11 PMPM
 - QDPs \$0.94 PMPM
 - Pediatric Dental Plans \$0.67 PMPM
- PY27 Risk Adjustment User Fee: \$0.20 PMPM.

URRT/SERFF Procedure

Once the state determination is entered in the URRT tab (SERFF) and the final action is submitted,

- Rate filings are permanently locked.
- The state cannot reopen filings (same as previous years).

Please do not expect to make changes after the applicable deadlines.

SERFF Binders

Ray Odi, Actuarial Analyst

BINDER REVIEW PROCESS (HIGH LEVEL)

Step 1

Preliminary Review:

- Basic consistency and compliance checks:
 - Correct documents included?
 - HIOS IDs, plan names, etc., are consistent across documents?
 - Data Integrity Tool results?
 - Service area requirements are met?

Step 2

Substantive Review:

- Detailed checks are performed.
- Analysts compare the binder, form, network, and rate filings for consistency.
- Generally, this is step represents the majority of review and results in the majority of objections.

Notes:

- The process is not always linear. Preliminary checks are rerun throughout the process.
- Cleaner filings receive fewer objections and permit later review stages to begin earlier.

CONNECTING THE RATE, FORM, AND BINDER FILINGS

Use the same entries across documents:

- Plan names.
- HIOS IDs.
- Metal actuarial values (Metal AVs).
- Metal levels.
- Exchange marketing intentions.
- New or Existing Plan.

Ensure consistency between documents:

- Schedule of Benefits (form filing) vs. Plans and Benefits Template (binder filing).
- Benefit Components Template (rate filing) vs. Plans and Benefits Template (binder filing).
- Rate Schedules (rate filing) vs. Rate Data Template (binder filing).
- Rate Schedules (rate filing) vs. Service Area Template (binder filing).
- Unified Rate Review Template (rate filing) vs. Rate Data Template (binder filing).

PLANS AND BENEFITS TEMPLATE – EXCHANGE STATUS

QHP/Non-QHP Field in the PBT (Benefits Package worksheets)

- Page 2E-6 of the “Qualified Health Plan Issuer Application Instructions: Plan Year 2026”

QHP/Non-QHP*	<p>Indicate whether the plan will be offered only on the Exchange, only off the Exchange, or both on and off the Exchange. Choose from the following:</p> <ul style="list-style-type: none">◆ On the Exchange—if the plan will be offered only on the Exchange. Under the guaranteed availability requirements in 45 CFR 147.104, a plan offered on the Exchange generally must be available to individuals and employers (as applicable) in the state who apply for the plan off the Exchange. If you offer a plan on the Exchange, select Both unless an exception to guaranteed availability applies.◆ Off the Exchange—if the plan will be offered only off the Exchange. This includes non-QHPs and plans that are substantially the same as a QHP offered on the Exchange as part of the risk corridor program (see 45 CFR 153.500 for more details).◆ Both—if the plan will be offered both on and off the Exchange. Such plans must have the same premium, provider network, cost sharing structure, service area, and benefits, regardless of where they are offered. Selecting this option creates two separate plan variations when the Cost Share Variances worksheet is created: one on-Exchange plan and one off-Exchange plan.
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- Enter “Both” for plans (other than catastrophic plans) that are offered on the exchange.
- Enter “On the Exchange” for catastrophic plans.
- Enter “Off the Exchange” for plans not offered on the exchange.

OIC Templates (including Benefit Components, Snapshot, and Rate Schedules)

- Enter based on **marketing intentions** instead.

REMINDERS, UPDATES, and NEWS

Binder Filing General Instructions and Templates

- Final filing instructions and templates are pending release of CMS's final QHP documents.

Service Area Template and Network ID Template

- Submit the same Service Area and Network ID Template across both coverage types (medical and dental) and both markets (individual and small group).
- Do NOT reuse service area IDs or network IDs across coverage types (medical and dental) or markets (individual and small group).

REMINDERS, UPDATES, and NEWS (cont.)

Plans and Benefits Template (PBT) Add-In File & Benefits Package Worksheets

- Use “Not Applicable” for the Design Type data entry field in the Plans and Benefits Template.
- The Benefit Information tables in your PBT Benefits Package worksheets should match Exhibit C, except where deviations are allowed (see Exhibits B and C for details).
- EHB Variance Reason: Do NOT use “Substituted,” “Substantially Equal,” or “Using Alternate Benchmark.” See Exhibit B and C for allowable reasons.

REMINDERS, UPDATES, and NEWS (cont.)

2025 Marketplace Integrity and Affordability Final Rule

- The final rule, which included changes to the AV de minimis range, were stayed by the court in *City of Columbus et. al. v. Kennedy et. al.*
- Filings must be compliant with current rules at the time of filing.

Recap

Todd Lovshin, Deputy Insurance Commissioner

NEXT STEPS

We are still waiting on:

- PBT instructions to finalize Binder GFIs

We will update GFIs/STMs as we finalize them & communicate via Gov Delivery when they are ready.

COMMUNICATION

If you have a question, contact us.

- Start with the OIC analyst assigned to your filing in SERFF.
- If you get the same objection a second time and you don't understand why, contact us.
- Remember that there is one OIC and many carriers.
- Please organize your questions.

If you asked a question today that we didn't answer, email it to RFHealthplan@oic.wa.gov

FILING DEADLINE

The filing deadline is **May 14, 2026**.

Please do not wait until the last minute to submit your filings.

Thank you for attending our PY27
filing webinar!

Any questions?

Questions?

Todd Lovshin

Deputy Insurance Commissioner

Todd.Lovshin@oic.wa.gov

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