WSR 25-07-021
EMERGENCY RULES
OFFICE OF THE
INSURANCE COMMISSIONER

[Insurance Commissioner Matter R 2025-01—Filed March 10, 2025, 10:28 a.m., effective March 10, 2025, 10:28 a.m.]

Effective Date of Rule: Immediately upon filing.

Purpose: The office of the insurance commissioner (OIC) must review and approve all individual health plan rates prior to their use. This emergency rule adjusts health insurer rate development components for plan year 2026 to preserve consumer affordability and stability in Washington state's individual health insurance market. It applies a uniform cost-sharing reduction silver load adjustment factor to rates for silver level qualified health plans (QHPs) sold on the Washington state health benefit exchange (HBE). This emergency rule is necessary for the preservation of the public health, safety, or general welfare by keeping health insurance affordable for up to 80,000 individuals who are at risk of losing health insurance when the enhanced advance premium tax credits (eAPTCs) expire on December 31, 2025.

Citation of Rules Affected by this Order: New WAC 284-43-6800, 284-43-6810, and 284-43-6820; and amending WAC 284-43-6520.

Statutory Authority for Adoption: RCW 48.02.060, 48.44.050, 48.46.200, and 48.43.733.

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.

Reasons for this Finding: The federal Affordable Care Act (ACA) (P.L. 111-148, as amended) and state law (chapter 43.71 RCW) allow eligible Washingtonians to enroll in QHPs through HBE. Federal advance premium tax credits (APTCs) and eAPTCs, as well as state premium assistance (Cascade Care Savings), work together to lower consumer premiums, thereby making health care affordable and accessible, especially for individuals with income under 250 percent of the federal poverty level (FPL). The APTCs, eAPTCs, and Cascade Care Savings are based on a consumer's income. HBE's 2025 open enrollment preview report (https://www.wahbexchange.org/content/dam/wahbe-assets/materials/communications/enrollment/2025/2025EnrollmentPreviewReport_20250203.pdf), which includes data as of January 17, 2025, found that:

- Seventy-seven percent of the 309,000 consumers who selected a QHP in the 2024 open enrollment period are receiving eAPTCs or Cascade Care Savings.
- The eAPTCs and Cascade Care Savings are reducing the average premium these consumers pay to $163 per member per month, compared to the average unsubsidized premium of $601 per member per month.
- The eAPTCs are essential for consumers to access and maintain health insurance coverage.

Under current federal law, eAPTCs will expire on December 31, 2025, absent congressional action, making them unavailable to consumers beginning on January 1, 2026, i.e., plan year 2026. The original APTCs are permanently authorized in federal law and would remain when eAPTCs expire; however, the original APTCs offer a lower level of pre-

mium subsidies than the eAPTCs. eAPTCs enhance affordability by lowering net premiums for households with income above 400 percent of FPL ($62,600 per year for an individual in 2025) and by increasing subsidy levels for people with income below 400 percent of FPL who were originally eligible for APTCs. The eAPTCs have particularly made health care more affordable for people ages 55 to 64 who face high health care costs but are not yet eligible for medicare. For this population, HBE estimates that the eAPTCs have decreased annual net premium costs by $1,900. Under current state law, Cascade Care Savings are also set to expire on June 30, 2025, absent state legislative action to fund them for state fiscal years 2026 and 2027 (ESSB 5950, chapter 376, Laws of 2024; RCW 43.71.110).

HBE has conducted an analysis estimating that up to 80,000 currently enrolled individuals will drop health insurance coverage due to expiration of the eAPTCs (https://www.wahbexchange.org/content/dam/wahbe-assets/materials/communications/policy/2025/FinalDraftPY2026CascadeCareSavingsPolicy.pdf; https://www.wahbexchange.org/content/dam/wahbe-assets/materials/communications/legislative/2025/IntroductionPresentationToHouseHealthCare_20250116.pdf). HBE expects these enrollees to not renew their coverage because their premiums will become unaffordable. Individuals without health insurance coverage can face devastating health and financial consequences (https://aspe.hhs.gov/sites/default/files/documents/9376755db2480ad7288aaa5ec38f3d8c/improving-access-to-coverage.pdf; https://www.kff.org/855449e/). They may delay seeking care when they are ill or injured, and they are more likely to be hospitalized for chronic conditions such as diabetes or hypertension. These individuals incur high medical debt when they do access care. They also are more likely to use costly and intensive hospital emergency room services due to exacerbations of current or new medical or behavioral health conditions. Consumers with more severe health conditions, who cannot afford timely or corrective care before their conditions become severe, will enter the health care system when they are sicker and at more advanced disease stages than people with health insurance. They will face increased risk of death and use more intensive and costly services than would have been needed had they sought care earlier. In addition, children without health insurance are less likely to get vaccinations, increasing their risk of contracting and spreading communicable diseases.

Being uninsured and thus seeking care later increases consumer medical debt and places increasing uncompensated care demands on hospitals and health care providers. Based upon a 2024 survey of consumers in Washington state, 31 percent of Washington residents already live in a household with medical debt (https://fairhealthprices.org/wp-content/uploads/2024/08/Report-2024-WA-Health-Care-Affordability-Survey.pdf). Losing health insurance coverage would exacerbate this problem.

Being uninsured has a significant economic impact in the form of lost earnings due to fewer years of healthy life and lower productivity while at work. These economic costs are substantial and represent a hidden cost of uninsurance, over and above the cost of the medical care used by people without health insurance.

In addition, OIC expects the eAPTC expiration to lead to risk to the stability of the individual health insurance market. If up to 80,000 people leave the individual market, it likely will result in adverse selection in the individual market. This occurs when individu-

als who are sicker and know they will need care need to retain their coverage and are willing to pay higher premiums. Younger and healthier individuals do not have a comparable incentive or reason to pay the higher costs for their coverage and are more likely to forgo it. This results in a higher risk and shrinking individual health insurance market risk pool, reducing health insurers' ability to distribute costs across both healthy individuals and those with chronic medical or behavioral health conditions. This older and less healthy individual market risk pool will likely lead to increased premiums, making affordability challenges even greater, and risking individual market stability. It also could lead to insurers reducing their service area, particularly in rural communities, which already have more limited plan choices than urban counties. These factors introduce uncertainty and financial risk, disadvantaging insurers and disrupting market competition.

OIC's mission to protect consumers and its role to ensure a healthy insurance market necessitates emergency rule making to mitigate these negative impacts before they occur in 2026. Under RCW 48.43.733, OIC must review and approve individual health plan design and rates prior to their use. This extensive review process requires that carriers submit their proposed plan designs and rates in May of the year prior to their health plans being offered, i.e., in May 2025 for health plans to be offered in 2026. As a result, OIC must give insurers rate development instructions sufficiently in advance of the May filing date. This emergency rule provides such instructions and thus must be filed as an emergency rule to protect consumers and the stability of the individual health insurance market in time for plan year 2026. The May 2025 deadline for carriers' proposed plan design and rate submissions is imminent; therefore, observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.

Under the ACA, APTCs and eAPTCs are calculated using the "benchmark" plan, which is the second lowest cost "silver" plan (https://www.kff.org/faqs/faqs-health-insurance-marketplace-and-the-aca/what-are-premium-tax-credits-and-how-do-they-work/). The ACA uses "metal levels" to define the richness of different plans; in silver plans, the insurer pays 70 percent of costs while the enrollee pays 30 percent of costs (https://www.healthcare.gov/choose-a-plan/plans-categories/).

The ACA also establishes that health plans must offer cost-sharing reduction (CSR) plan variations to individuals with income up to 250 percent of the federal poverty level. Since 2018, the federal government has ceased funding the CSRs directly, instead allowing insurers to compensate for this cost through on-exchange silver plan premium adjustments called CSR silver loading. For eAPTC-eligible individuals enrolled in a nonsilver plan, this "silver loading" practice has reduced net premiums and increased enrollment, while leaving the net premiums of silver plans unchanged (https://www.brookings.edu/articles/the-case-for-replacing-silver-loading/).

Current federal rules allow state insurance regulators to make rate development adjustments (Notice of Benefit and Payment Parameters 2026 Final Rule, CMS-9888-F, amending 45 C.F.R. Parts 153, 156, and 158, https://www.federalregister.gov/d/2025-00640). Multiple states have adopted similar rate development adjustments.

OIC is adjusting insurer rate development components in three ways:

(1) Uniform CSR Silver Load Adjustment: Sets a uniform CSR silver load adjustment for the individual on-exchange health plans.

(2) Standardized Induced Demand Factors (IDFs): Sets IDFs for individual and small group market health plans.

(3) Pricing Actuarial Value (AV) Guardrails: Establishes restrictions on AV pricing value to ±3 percent of the plan's federal AV metal value for individual and small group market health plans.

OIC expects these adjustments to lessen the negative impact of the eAPTC expiration. Overall, OIC expects these adjustments to result in a higher level of premium tax credits (APTCs), thereby reducing net premiums for HBE consumers enrolled in a silver plan and mitigating negative impacts on consumers who choose to enroll in nonsilver plans. HBE consumers enrolled in a nonsilver plan represent about half of all HBE enrollees, according to HBE data shared with OIC in 2024. OIC expects these changes to have the overall effect of keeping more enrollees covered by lessening the premium increases that consumers would otherwise experience in 2026. This in turn will result in better health outcomes for up to 80,000 Washingtonians, promote individual health insurance market stability, and reduce potential increased uncompensated care demands for health care facilities and providers.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 3, Amended 1, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 3, Amended 1, Repealed 0.

Date Adopted: March 10, 2025.

Patty Kuderer
Insurance Commissioner

RDS-6222.1

AMENDATORY SECTION (Amending WSR 16-03-018, filed 1/8/16, effective 1/8/16)

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" 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.

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 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 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 year 2026.

(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 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 Centers for Medicare and Medicaid Services (CMS).

(3) Except to the extent provided otherwise in this subsection, to promote fair competition by ensuring 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, 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) Each plan's AV metal value, AV pricing value, and the method used to develop AV pricing values.

(b) The methodology used to develop the AV pricing value be based on a standardized population. The carrier must identify all material changes in the AV pricing value development and 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 plan year 2026.

(2) The following assumptions are used in the cost-sharing reduction (CSR) silver load calculation:

(a) Actuarial values: Based on federal risk transfer formula factors published by 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: Based on federal risk transfer formula factors published by 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 WAHBE, and with the following adjustments for WAHBE plan mapping 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 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 induced demand factor.

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

(c) Divide the result 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.

(4) Based on the calculation in subsection (3) of this section and the assumptions in subsection (2) of this section, the final CSR silver loading factor for plan year 2026 is 1.435.