

WSR 26-06-090
PROPOSED RULES
OFFICE OF THE
INSURANCE COMMISSIONER

[Insurance Commissioner Matter R 2025-02—Filed March 4, 2026, 9:23 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 25-13-098.

Title of Rule and Other Identifying Information: Health carrier rate development components.

Hearing Location(s): On Tuesday, April 7, 2026, at 10:00 a.m. PT, virtual meeting via Zoom. Detailed information for attending this meeting is posted on the office of the insurance commissioner (OIC) website at <https://www.insurance.wa.gov/laws-rules/legislation-and-rulemaking/rulemaking/health-carrier-rate-development-components-r-2025-02>. Written comments are due to OIC by 11:59 p.m. PT on April 8, 2026. Written comments should be emailed to rulescoordinator@oic.wa.gov.

Date of Intended Adoption: April 9, 2026.

Submit Written Comments to: Rules Coordinator, P.O. Box 40255, Olympia, WA 98504-0255, email rulescoordinator@oic.wa.gov, fax 360-586-3109, TTY 360-586-0241, beginning March 4, 2026, at 12:00 a.m. PT, by April 8, 2026, at 11:59 p.m. PT.

Assistance for Persons with Disabilities: Contact rules coordinator, phone 360-725-7171, fax 360-586-3109/3535, TTY 360-586-0241, email rulescoordinator@oic.wa.gov, by April 6, 2026, at 5:00 p.m. PT.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The proposed rule would preserve health insurance affordability for certain consumers who buy qualified health plans (QHPs) through the health benefit exchange (HBE) in Washington state's individual health insurance market. The proposed rule intends to mitigate decreases in the state's uninsured rate that have begun, and are likely to continue, as the result of recent federal policy changes. The proposed rule ensures that health insurers and affected entities understand rate development requirements for plan years beginning in 2027.

The proposed rule achieves these aims by establishing uniform rate development standards that preserve a level playing field among issuers and foster transparency and healthy competition in the market. The policy contained in this proposed rule may also be referred to as "premium alignment" or "standardized silver loading."

OIC is amending chapter 284-43 WAC to implement these changes.

Reasons Supporting Proposal: On December 31, 2025, federally funded enhanced premium tax credits (ePTCs) expired. In plan year 2025, the ePTCs lowered health insurance costs for approximately 200,000 consumers who purchased QHPs through HBE. As the result of the ePTCs' expiration, starting January 1, 2026 these consumers face significantly higher health insurance costs because the tax credits they were previously receiving were either reduced or eliminated altogether. Approximately 20,000 fewer people are enrolled in QHPs this year than during the same period last year, according to HBE; HBE has cited the ePTC expiration as a contributor to this trend (<https://washingtonstatestandard.com/2026/02/06/insurance-coverage-drops-in-wa-open-enrollment-after-loss-of-tax-credits/> and https://www.wahbexchange.org/pr_012226/). More consumers may forego or "drop" coverage as 2026 continues due to these increased costs.

Consumers in Washington's individual health insurance market also face new barriers to getting and keeping health coverage in plan year 2026 and in future years as the result of H.R.1 (P.L. 119-21) (https://www.wahbexchange.org/content/dam/wahbe-assets/legislation/WAHBE_federal_impacts_080825.pdf).

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> and https://www.kff.org/uninsured/key-facts-about-the-uninsured-population/#:~:text=While%20there%20was%20no%20change,in%202023%20compared%20to%202019.)). Uninsured individuals 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. Being uninsured and thus seeking care later increases consumer medical debt and places increasing uncompensated care demands on hospitals and health care providers. A 2025 survey of 1,700 Washington consumers found that 35 percent of survey respondents reported experiencing at least one significant financial burden related to medical debt, such as using up all or most of their savings to pay off bills, being contacted [contacted] by a collection agency or being unable to pay for food, heat, or housing due to medical bills (<https://healthcarevaluehub.org/wp-content/uploads/WA-2025-CHESS-Healthcare-Affordability-Brief.pdf>). 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.

On March 10, 2025, OIC adopted an emergency rule (WSR 25-07-021) that set standards for health carrier rate development components for plan year 2026 (<https://www.insurance.wa.gov/sites/default/files/2025-03/cr-103e-to-r-2025-01.pdf>).

OIC extended this emergency rule on June 29, 2025 (WSR 25-14-070) and October 27, 2025 (WSR 25-22-021) to ensure that it remained in effect for the 2026 plan year (<https://www.insurance.wa.gov/sites/default/files/2025-07/cr103e-to-r2025-07.pdf> and <https://www.insurance.wa.gov/sites/default/files/2025-11/r2025-15-cr-103e.pdf>).

OIC adopted this policy through its emergency rule-making authority because it was necessary for the preservation of the public health, safety, or general welfare to keep health insurance affordable for consumers. In compliance with the Administrative Procedure Act, OIC initiated notice-and-comment rule making corresponding to this proposed rule through release of a CR-101 on June 18, 2025, and release of a prepublication draft on January 16, 2026 (<https://www.insurance.wa.gov/laws-rules/legislation-and-rulemaking/rulemaking/health-carrier-rate-development-components-r-2025-02>).

HBE has publicly stated that "Early data from 2026 indicates [the OIC emergency rule] is improving affordability and helping customers stay covered" and that "The emergency rule is expected to cut estimated 2026 Exchange enrollment losses in half—mitigating increases to Washington's uninsurance rate" (<https://www.insurance.wa.gov/sites/default/files/2026-02/washington-health-benefit-exchange-r2025-02-first-prepublication-draft-comment.pdf>).

This proposed rule is based on OIC's 2025 emergency rules and applies to plan years beginning on or after January 1, 2027. The proposed rule aims to preserve health insurance affordability and health

insurance enrollment by adjusting insurers' rate development components in three ways:

- (1) Sets a uniform cost sharing reduction silver load adjustment for individual market on-exchange health plans.
- (2) Sets standardized induced demand factors for individual and small group market health plans.
- (3) Establishes restrictions on actuarial value pricing.

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.

Overall, OIC expects this proposed rule to result in more affordable premiums for many consumers buying QHPs through HBE and keeping more consumers enrolled in beneficial coverage. This in turn will result in better health outcomes, promote individual health insurance market stability, and reduce potential increased uncompensated care demands for health care facilities and providers.

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

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Patty Kuderer, insurance commissioner, governmental.

Name of Agency Personnel Responsible for Drafting: Nico Janssen, P.O. Box 40255, Olympia, WA 98504-0255, 360-725-7171; Implementation: Todd Lovshin, P.O. Box 40255, Olympia, WA 98504-0255, 360-725-7000; and Enforcement: Sofia Pasarow, P.O. Box 40255, Olympia, WA 98504-0255, 360-725-7000.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is required under RCW 34.05.328. A preliminary cost-benefit analysis may be obtained by contacting Rules Coordinator, P.O. Box 40255, Olympia, WA 98504-0255, phone 360-725-7171, fax 360-586-3109, email rulescoordinator@oic.wa.gov.

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 19.85.025(3) as the rules only correct typographical errors, make address or name changes, or clarify language of a rule without changing its effect.

Is exempt under RCW 19.85.025(4).

Explanation of exemptions: This rule proposal, or portions of the proposal, are exempt from requirements of the Regulatory Fairness Act under RCW 19.85.025(4), the businesses that must comply with the proposed rule are not small businesses, under chapter 19.85 RCW. OIC has found that none of the existing health insurance issuers may be considered small businesses under RCW 19.85.020(3).

The average number of employees per firm was determined below using 2024 annual average quarterly census of employment and wages (QCEW) data from the Washington state employment security department¹:

¹ <https://esd.wa.gov/jobs-and-training/labor-market-information/employment-and-wages/covered-employment-qcew>.

Average number of firms: 78

Average annual employment over 12 months: 7,444

Average number of employees per firm: 95

The average number of employees for a direct health and medical insurance carrier is 95 employees, above the small business threshold of 50 under RCW 19.85.020(3).

Scope of exemption for rule proposal:
Is fully exempt.

A copy of the statement may be obtained by contacting Rules Coordinator, P.O. Box 40255, Olympia, WA 98504-0255, phone 360-725-7171, fax 360-586-3109, email rulescoordinator@oic.wa.gov.

March 4, 2026
Patty Kuderer
Insurance Commissioner

RDS-7017.1

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))~~ has the same meaning as that contained in RCW 48.43.005.

(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 the United States Centers for Medicare and Medicaid Services.

(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.

(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.

(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 rate development, align rating methodology with the federal risk adjustment model and development of cost-sharing reduction silver load, and 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.

(3) Except to the extent provided otherwise in this subsection, to promote fair competition and ensure consumers can compare plans based on consistent metal level categories and pricing methodologies, the AV pricing value must be within $\pm 2\%$ 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 $\pm 3\%$, 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 each plan's AV metal value, AV pricing value, and the method used to develop AV pricing values.

(4) 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 health benefit exchange for plan years beginning on or after January 1, 2027.

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

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

(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 based on federal risk transfer formula factors published by the United States Centers for Medicare and Medicaid Services.

(d) Membership distribution and enrollment assumptions are based on the prior year experience provided by the health benefit exchange and include appropriate adjustments for health benefit exchange plan mapping procedures.

(3) The methodology and formula used by the commissioner to calculate the CSR silver loading factor 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 step (a) of this subsection.

(c) Divide the result of step (b) of this subsection by the product of the actuarial value and induced demand factor for the base silver plan (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 commission-

er may update the final cost-sharing reduction silver loading factor 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 31st 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.