SUBCHAPTER F. RATE REVIEW FOR HEALTH BENEFIT PLANS
28 TAC §§3.501 - 3.507

INTRODUCTION. The Commissioner of Insurance adopts new Subchapter F, concerning the rate review process for individual and small group major medical coverage, to be added to 28 TAC Chapter 3. Sections 3.501 - 3.503, 3.506, and 3.507 are adopted without changes to the proposed text published in the April 8, 2022, issue of the *Texas Register* (47 TexReg 1844). Section 3.504 and §3.505 were revised in response to public comments.

REASONED JUSTIFICATION. The new subchapter is necessary to implement Insurance Code Chapter 1698, as added by Senate Bill 1296, 87th Legislature, 2021. Insurance Code Chapter 1698 requires the Commissioner to establish a process under which the Texas Department of Insurance (TDI) will review health benefit plan rates and rate changes for compliance with state and federal law, including rules establishing geographic rating areas. Adopted Subchapter F establishes a process to review the rates for individual and small group major medical coverage as provided by Chapter 1698. The new subchapter includes §§3.501 - 3.507. These sections state the rule's purpose and applicability, identify the rating standards, establish geographic rating areas, and provide guidance to address certain additional factors and requirements related to the review process and public disclosure requirements.

Federal law requires that federal regulators review certain health insurance rate increases if states do not do so. Prior to the passage of SB 1296, federal regulators were reviewing these rates because Texas law has not provided a mechanism for state review

since 2013. Insurance Code Chapter 1698 returns the rate review process to the state, consistent with federal rate review rules in 45 CFR Part 154.

The adopted sections of the new subchapter are described in the following paragraphs.

Section 3.501. Section 3.501(a) describes the purpose of the subchapter, which is to implement Insurance Code Chapter 1698 and establish an effective rate review program consistent with 45 CFR §154.301, concerning CMS's Determinations of Effective Rate Review Programs.

Subsection (b) explains that the subchapter applies to plans subject to Insurance Code Chapter 1698, while subsection (c) clarifies that the subchapter does not apply to (1) short-term limited-duration insurance; (2) grandfathered health plan coverage; and (3) individual limited scope plans, including dental benefit plans and vision benefit plans. The plans listed under subsection (c) are not subject to the same federal rating standards and are reviewed instead for compliance with other existing state rating standards, including Insurance Code Chapter 560; Insurance Code Chapter 1501, Subchapter E; and 28 TAC §26.11.

Section 3.502. Section 3.502 defines the following terms for use in the subchapter: "actuarial value (AV)," "cost-sharing reductions (CSRs)," "essential health benefits (EHBs)," "federal medical loss ratio standard," "HHS," "issuer," "index rate," "plan," "product," "qualified actuary," "single risk pool," and "Unified Rate Review Template (URRT)."

Section 3.503. Section 3.503 requires that all rate filings under Subchapter F comply with all applicable state and federal requirements, including specified provisions from the Insurance Code, United States Code, and Code of Federal Regulations.

Section 3.504. Section 3.504 addresses how issuers may vary rates based on geographic rating area. Insurance Code Chapter 1698 grants the Commissioner the authority to implement rules establishing geographic rating areas to use when reviewing the rates in compliance with 42 USC §300gg.

Subsection (a) provides that issuers may vary the rates based on rating areas, which are determined using the policyholder's or contract holder's address.

Subsection (b) establishes 27 rating areas that issuers must use for rates, beginning in 2023. Each rating area consists of a certain number of Texas counties in compliance with 45 CFR §147.102(b)(3). Currently, Texas uses the federal default rating areas, composed of 25 Metropolitan Statistical Areas and one area that includes all rural areas. The adopted new rating areas place rural areas with nearby metropolitan areas and are based around health care districts and the regions defined by the Texas Health and Human Services Commission. The newly established rating areas could have a positive effect on rural communities by generating competition in areas where a limited variety of health plans is currently available.

In the proposal, King County was mistakenly listed in rating area 24 (Wichita Falls) instead of rating area 14 (Lubbock). That mistake is corrected in the section as adopted.

Section 3.505. Section 3.505(a) prohibits an issuer from using a rate with respect to a plan if the rate filing has not been filed with TDI for review, does not comply with applicable rating standards, or has been withdrawn.

Subsection (b) requires that issuers submit an annual rate filing no later than June 15 for any individual or small group market plan that is to be issued on or after January 1 in the following calendar year. Subsection (b) also prohibits an issuer from modifying an

annual rate filing later than October 1 prior to the calendar year for which the filing was submitted.

Subsection (c) applies only to small group issuers and allows them to submit a rate filing for a quarterly rate change as long as the filing is submitted at least 105 days before the effective date of the rate change.

Subsection (d) requires that rate filings include the index rate for the single risk pool and reflect every product and plan that is part of the single risk pool in the applicable market. Subsection (d) also advises that issuers are not required to enter CSR plan variations separately.

Subsection (e) requires issuers to submit rate filings under Subchapter F through the electronic system designated by TDI in accordance with any technical instructions provided for the electronic system. The electronic system currently in use is the System for Electronic Rate and Form Filings (SERFF); additional technical guidance on filing is contained in TDI rules in 28 TAC Chapter 3, Subchapter A, and in 28 TAC §11.301.

Subsection (f) requires that rate filings made under Subchapter F include the following: (1) the URRT; (2) written descriptions justifying rate increases of 15% or more in a 12-month period; (3) rating filing documentation, including an actuarial memorandum signed by a qualified actuary; (4) a rates table that identifies the applicable rate for each plan depending on an individual's rating area, tobacco use, and age; (5) an enrollment spreadsheet that contains the information specified in subparagraphs (A) through (C) of the paragraph; and (6) an actuarial value (AV) and cost-sharing factor spreadsheet.

The AV and cost-sharing factor spreadsheet included with each rate filing must include a certain induced-demand factor based on the plan type (e.g., bronze plans, silver

plans, gold plans, and platinum plans). The spreadsheet must also include a CSR adjustment factor of 1.35—applicable to individual silver plans on the exchange—that accounts for the average costs attributable to CSRs. In setting this factor, TDI considered the different CSR plan variations with respect to (1) the eligibility criteria for CSRs; (2) the potential distribution of enrollees; (3) the maximum AV that may be provided across all silver plans; and (4) variation in induced demand.

Subsection (g) states that TDI will publish templates on its website that issuers may use to submit the required data.

Subsection (h) requires that an issuer provide any additional information needed to evaluate the rate filing upon TDI's request.

Subsection (i) requires an issuer to submit current and prior year data on enrollment, premiums, and claims by June 15, when the issuer does not intend to issue a plan that would require a rate filing for the next calendar year but has enrollment in a plan that is subject to Subchapter F in the current or prior year. This data enables TDI to consider medical claims trends and understand the impact of a change to an issuer's market participation. In response to comment, the timeframe for which current year cumulative data must be reported was shortened from May 31 to March 31.

Section 3.506. Section 3.506(a) provides that TDI will evaluate whether the issuer has provided sufficient data and documentation upon receipt of a rate filing under Subchapter F and may request additional information as necessary to make a determination on the filing. The issuer must provide any additional information requested within 10 business days of the request. If TDI requests additional information but the issuer fails to provide the requested information or establish a plan to provide the

information that is acceptable to TDI, TDI will deem the filing withdrawn and notify the issuer of the withdrawal.

Subsections (b) and (c) explain the factors TDI will examine and consider, which include (1) the reasonableness of the assumptions used by the issuer to develop the rates and the validity of the historical data underlying the assumptions; (2) the issuer's data related to past projections and actual experience; (3) the reasonableness of assumptions used by the issuer to estimate the rate impact of the reinsurance and risk adjustment programs; (4) the issuer's data related to implementation and ongoing utilization of certain factors as required by 42 USC Subchapter XXV, Part A, concerning Individual and Group Market Reforms; (5) factors specified in the Insurance Code; (6) factors listed in 45 CFR §154.301(a)(4); and (7) whether the issuer complies with rating standards under §3.503.

Subsection (d) provides that TDI will also consider the factors from Insurance Code §1698.052(c) when reviewing rates for a qualified health plan. Those factors include:

- the purchasing power of consumers who are eligible for a premium subsidy under federal law;

- if the plan is in the silver level, whether the rate is appropriate in relation to the rates charged for qualified health plans offering different levels of coverage, accounting for any funding or lack of funding for CSRs and the covered benefits for each level of coverage; and

- whether the plan issuer used the induced-demand factors developed by the Centers for Medicare and Medicaid Services (CMS) for the level of coverage offered by the plan or any state-specific induced-demand factors established by TDI.

Subsection (e) provides that the standard for determining that a rate increase is unreasonable is whether the rate is excessive, unjustified, or unfairly discriminatory. Subsection (e)(1) explains that a rate filing is excessive if it causes the premium charged for the health insurance coverage to be unreasonably high in relation to the benefits provided under the coverage.

Subsection (e)(2) explains that a rate increase is unjustified if the issuer provides incomplete or inadequate information or otherwise does not provide a basis for TDI to determine the reasonableness of the rate increase.

Subsection (e)(3) explains that a rate increase is unfairly discriminatory on the basis of Insurance Code §560.002(c), which provides that a rate is unfairly discriminatory if it is not based on sound actuarial principles; does not bear a reasonable relationship to the expected loss and expense experience among risks; or is based wholly or partly on the race, creed, color, ethnicity, or national origin of the policyholder or insured.

Subsection (f) provides that a rate will be deemed compliant at the expiration of 60 days from the date the rate is filed, unless the filing is withdrawn or TDI has determined that the rate is noncompliant or granted an extension. If TDI has not finalized its determination before the 60th day, TDI may extend the period by up to 10 days, with notice to the issuer. The issuer may also extend the time frame for review or waive the right to deem the rate compliant.

Subsection (g) provides that TDI will identify deficiencies for any rate filing that does not comply with the applicable rating standards and ask for corrections. If the issuer fails to make the necessary corrections within 10 business days or establish a plan that is acceptable to TDI to address the identified deficiencies, the filing will be determined to be noncompliant and TDI will notify the issuer of the determination.

Subsection (h) explains that TDI will communicate objections to a rate increase and give the issuer an opportunity to provide additional information or modify the filing prior to TDI determining that the rate increase is unreasonable. Subsection (h) also describes what will happen when TDI determines that a rate increase is unreasonable but that the issuer is legally permitted to implement the rate increase. In this case, TDI will issue a final determination and brief explanation. After receipt of this, the issuer is required to submit a final justification for the rate increase and prominently post information concerning the rate increase on its website, consistent with 45 CFR §154.230, which requires that the issuer keep the posting on its website for at least three years.

Section 3.507. Section 3.507 addresses public disclosure and input related to rate increases, consistent with 45 CFR §154.301(b). Subsection (a) provides that information related to an adopted annual rate increase of 15% or more will be made publicly available on a website published by CMS.

Subsection (b) supplies the TDI email address to which public comments concerning adopted rate increases may be sent.

Subsection (c) states that final rate increases will be publicly available on a website published by CMS no later than the first day of the annual open enrollment period in the individual market for the applicable calendar year.

Subsection (d) provides that TDI will make information related to proposed or final rate filings publicly available in a manner consistent with federal law.

SUMMARY OF COMMENTS AND AGENCY RESPONSE.

Commenters: TDI received comments from six commenters on the proposed new sections. Commenters in support of the proposal were AARP, Every Texan, Texas 2036,

and the Texas Medical Association. Commenters in support of the proposal with changes were Superior HealthPlan and the Texas Association of Health Plans.

Comments generally

Comment. Several commenters state that they support the rule as proposed and encourage its adoption. Specifically, the commenters state they support the inclusion of uniform induced-demand factors and the reference to Insurance Code Chapter 1698 in §3.503.

Agency Response. TDI appreciates the support.

Comment on §3.504

Comment. One commenter notes an error in the list of rating areas. King County should be in rating area 14 (Lubbock) as noted on the CMS website, and not rating area 24 (Wichita Falls).

Agency Response. TDI agrees with the comment and has made the noted correction.

Comments on §3.505

Comment. A commenter asks whether TDI will be developing its own standards when considering rate increases of 15% or more or using the federal standards.

Agency Response. TDI intends to have similar review of increases as federal standards. Review standards are specified in §3.506. Carriers need to submit a final justification for rate increases more than 15%, as required by §3.506(h).

Comment. One commenter states a preference for a CSR load factor of 1.40 in §3.505(f). The commenter states that this number would align with the expected member migration in which enrollees receiving no CSRs, or minimal CSRs (in the 73% AV plan), would no longer purchase silver plans. Two other commenters expressly support the proposed CSR adjustment factor of 1.35.

Agency Response. TDI disagrees with the first commenter and declines to make the suggested change. The factor of 1.35 as proposed is based on the actual 2021 enrollment distribution across the silver plan variations. TDI believes it is more prudent to base the factor on data currently available rather than on future projections that could change based on a variety of factors. However, TDI plans to monitor the market to determine whether enrollment distribution changes warrant a change to the CSR adjustment factor in future years. If a change becomes necessary, this would occur through an amendment to the rules.

Comment. One commenter suggests a change to the proposed requirements in §3.505(i) that apply to issuers that do not intend to issue a plan in the subsequent calendar year. The proposed requirement includes submission of current year cumulative data on June 15, including data through May 31. The commenter requests that TDI change the current year cumulative data to be through March 31. The commenter states that this would align the provisions with the requirements of the enrollment spreadsheet to include the number of covered lives as of March 31 and provide adequate time for gathering the data.

Agency Response. TDI agrees and has made the change.

Comment on §3.507

Comment. A commenter requests clarification from TDI on whether the intent is to follow the CMS dates for publication of carrier-proposed rate filings.

Agency Response. CMS will publish carrier-proposed rate filings according to the schedule it determines. TDI will provide a link to the filings published by CMS on its website: tdi.texas.gov/health/ratereview.html.

STATUTORY AUTHORITY. The Commissioner adopts new 28 TAC §§3.501 - 3.507 under Insurance Code §§1698.051, 1698.052, 1701.060, and 36.001.

Insurance Code §1698.051 requires that the Commissioner by rule establish a process under which the Commissioner will review individual and small group health benefit plan rates and rate changes for compliance with Chapter 1698 and other applicable state and federal laws, including 42 USC §§300gg, 300gg-94, and 18032(c) and those sections implementing regulations, including rules establishing geographic rating areas.

Insurance Code §1698.052(b) - (d) authorize the Commissioner to adopt rules and provide guidance regarding requirements related to individual health benefit plan rates.

Insurance Code §1701.060 specifies that the Commissioner may adopt rules necessary to implement the purpose of Chapter 1701.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§3.501. Purpose and Applicability.

(a) The purpose of this subchapter is to implement Insurance Code Chapter 1698, concerning Rates for Certain Coverage, and to establish an effective rate review program in the individual and small group markets, consistent with 45 CFR §154.301, concerning CMS's Determinations of Effective Rate Review Programs.

(b) This subchapter applies to a plan that is subject to Insurance Code Chapter 1698.

(c) This subchapter does not apply to:

(1) "short-term limited-duration insurance" as defined in Insurance Code Chapter 1509, concerning Short-Term Limited-Duration Insurance;

(2) "grandfathered health plan coverage" as defined by 45 CFR §147.140, concerning Preservation of Right to Maintain Existing Coverage; or

(3) individual limited scope plans, including but not limited to dental benefit plans and vision benefit plans.

§3.502. Definitions.

For purposes of this subchapter, the following terms have the meanings indicated, except where the context clearly indicates otherwise:

(1) Actuarial value (AV)--As defined in 45 CFR §156.20, concerning Definitions.

(2) Cost-sharing reductions (CSRs)--As defined in 45 CFR §155.20, concerning Definitions.

(3) Essential health benefits (EHBs)--Health benefits contained in the applicable "essential health benefits package" as that term is defined in 45 CFR §156.20.

(4) Federal medical loss ratio standard--The applicable medical loss ratio standard for the market segment involved, determined under subpart B of 45 CFR part 158, concerning Issuer Use of Premium Revenue: Reporting and Rebate Requirements.

(5) HHS--The U.S. Department of Health and Human Services.

(6) Issuer--An insurance company or health maintenance organization that issues a plan that is subject to Insurance Code Chapter 1698, concerning Rates for Certain Coverage.

(7) Index rate--A rate based on the total combined claims costs for providing essential health benefits within the single risk pool of the applicable market.

(8) Plan--As defined in 45 CFR §144.103, concerning Definitions.

(9) Product--As defined in 45 CFR §154.102, concerning Definitions.

(10) Qualified actuary--An actuary who is certified by the American Academy of Actuaries to meet the U.S. Qualification Standards.

(11) Single risk pool--With respect to a particular issuer and for the purposes of considering claims experience and developing an index rate, the grouping of all members enrolled in individual market plans or small group market plans that are subject to this chapter, consistent with 45 CFR §156.80, concerning Single Risk Pool.

(12) Unified Rate Review Template (URRT)--A spreadsheet that comprises Part I of the rate filing justification, as described in 45 CFR §154.215, concerning Submission of Rate Filing Justification.

§3.503. Rating Standards.

A rate filing filed under this subchapter must comply with all applicable state and federal requirements, including:

(1) Insurance Code Chapter 560, concerning Prohibited Rates;

(2) Insurance Code §843.2071, concerning Notice of Increase in Charge for Coverage;

(3) Insurance Code §1201.109, concerning Notice of Rate Increase for Major Medical Expense Insurance Policy;

(4) Insurance Code Chapter 1271, Subchapter F, concerning Schedule of Charges;

(5) Insurance Code §1501.215, concerning Reporting Requirements, and §1501.216, concerning Premium Rates: Notice of Increase;

(6) Insurance Code Chapter 1698, concerning Rates for Certain Coverage;

(7) 42 USC §300gg, concerning Fair Health Insurance Premiums;

(8) 42 USC §300gg-94, concerning Ensuring That Consumers Get Value for Their Dollars;

(9) 42 USC §18032(c), concerning Consumer Choice;

(10) 45 CFR §147.102, concerning Fair Health Insurance Premiums;

(11) 45 CFR Part 154, concerning Health Insurance Issuer Rate Increases: Disclosure and Review Requirements; and

(12) 45 CFR §156.80, concerning Single Risk Pool.

§3.504. Geographic Rating Areas.

(a) An issuer may vary rates based on rating area, which is determined:

(1) in the individual market, using the primary policyholder's or contract holder's address; and

(2) in the small group market, using the group policyholder's or contract holder's principal business address.

(b) For the purposes of this subchapter, rating areas for plan or policy years beginning on or after January 1, 2023, are established as follows.

(1) Rating area 1 (Abilene) consists of the following Texas counties:

(A) Brown;

(B) Callahan;

(C) Coleman;

(D) Comanche;

(E) Eastland;

(F) Fisher;

(G) Haskell;

(H) Jones;

(I) Kent;

(J) Mitchell;

(K) Nolan;

(L) Runnels;

(M) Scurry;

(N) Shackelford;

(O) Stephens;

(P) Stonewall;

(Q) Taylor; and

(R) Throckmorton.

(2) Rating area 2 (Amarillo) consists of the following Texas counties:

(A) Armstrong;

(B) Briscoe;

(C) Carson;

(D) Castro;

(E) Childress;

(F) Collingsworth;

(G) Dallam;

(H) Deaf Smith;

(I) Donley;

(J) Gray;

(K) Hall;

(L) Hansford;

(M) Hartley;

(N) Hemphill;

(O) Hutchinson;

(P) Lipscomb;

(Q) Moore;

(R) Ochiltree;

(S) Oldham;

(T) Parmer;

(U) Potter;

(V) Randall;

(W) Roberts;

(X) Sherman;

(Y) Swisher; and

(Z) Wheeler.

(3) Rating area 3 (Austin) consists of the following Texas counties:

(A) Bastrop;

(B) Blanco;

(C) Burnet;

(D) Caldwell;

(E) Fayette;

(F) Hays;

(G) Lee;

(H) Llano;

(I) Travis; and

(J) Williamson.

(4) Rating area 4 (Beaumont) consists of the following Texas counties:

(A) Angelina;

(B) Hardin;

(C) Houston;

(D) Jasper;

(E) Jefferson;

(F) Nacogdoches;

(G) Newton;

(H) Orange;

(I) Polk;

(J) Sabine;

(K) San Augustine;

(L) San Jacinto;

(M) Shelby;

(N) Trinity; and

(O) Tyler.

(5) Rating area 5 (Brownsville) consists of the following Texas counties:

(A) Cameron;

(B) Kenedy; and

(C) Willacy.

(6) Rating area 6 (College Station) consists of the following Texas counties:

(A) Brazos;

(B) Burleson;

(C) Grimes;

(D) Leon;

(E) Madison;

(F) Milam;

(G) Robertson; and

(H) Washington.

(7) Rating area 7 (Corpus Christi) consists of the following Texas counties:

(A) Aransas;

(B) Bee;

(C) Jim Wells;

(D) Kleberg;

(E) Live Oak;

(F) Nueces;

(G) Refugio; and

(H) San Patricio.

(8) Rating area 8 (Dallas) consists of the following Texas counties:

(A) Collin;

(B) Dallas;

(C) Ellis;

(D) Hunt;

(E) Kaufman;

(F) Navarro; and

(G) Rockwall.

(9) Rating area 9 (El Paso) consists of the following Texas counties:

(A) Brewster;

(B) Culberson;

(C) El Paso;

(D) Hudspeth;

(E) Jeff Davis; and

(F) Presidio.

(10) Rating area 10 (Houston) consists of the following Texas counties:

(A) Galveston; and

(B) Harris.

(11) Rating area 11 (Killeen/Temple) consists of the following Texas counties:

(A) Bell;

(B) Coryell;

(C) Hamilton;

(D) Lampasas;

(E) Mills; and

(F) San Saba.

(12) Rating area 12 (Laredo) consists of the following Texas counties:

(A) Duval;

(B) Jim Hogg;

(C) McMullen;

(D) Webb; and

(E) Zapata.

(13) Rating area 13 (Longview) consists of the following Texas counties:

(A) Gregg;

(B) Harrison;

(C) Marion;

(D) Panola;

(E) Rusk; and

(F) Upshur.

(14) Rating area 14 (Lubbock) consists of the following Texas counties:

(A) Bailey;

(B) Cochran;

(C) Crosby;

(D) Dickens;

(E) Floyd;

(F) Garza;

(G) Hale;

(H) Hockley;

(I) King;

(J) Lamb;

(K) Lubbock;

(L) Lynn;

(M) Motley;

(N) Terry; and

(O) Yoakum.

(15) Rating area 15 (McAllen) consists of the following Texas counties:

(A) Brooks;

(B) Hidalgo; and

(C) Starr.

(16) Rating area 16 (Midland/Odessa) consists of the following Texas counties:

(A) Andrews;

(B) Borden;

(C) Crane;

(D) Dawson;

(E) Ector;

(F) Gaines;

(G) Glasscock;

(H) Howard;

(I) Loving;

(J) Martin;

(K) Midland;

(L) Pecos;

(M) Reeves;

(N) Terrell;

(O) Upton;

(P) Ward; and

(Q) Winkler.

(17) Rating area 17 (San Angelo) consists of the following Texas counties:

(A) Coke;

(B) Concho;

(C) Crockett;

(D) Irion;

(E) Kimble;

(F) Mason;

(G) McCulloch;

(H) Menard;

(I) Reagan;

(J) Schleicher;

(K) Sterling;

(L) Sutton; and

(M) Tom Green.

(18) Rating area 18 (San Antonio) consists of the following Texas counties:

(A) Atascosa;

(B) Bandera;

(C) Bexar;

(D) Comal;

(E) Dimmit;

(F) Edwards;

(G) Frio;

(H) Gillespie;

(I) Gonzales;

(J) Guadalupe;

(K) Kendall;

(L) Kerr;

(M) Kinney;

(N) La Salle;

(O) Maverick;

(P) Medina;

(Q) Real;

(R) Uvalde;

(S) Val Verde;

(T) Wilson; and

(U) Zavala.

(19) Rating area 19 (Sherman/Dennison) consists of the following Texas counties:

(A) Cooke;

(B) Fannin; and

(C) Grayson.

(20) Rating area 20 (Texarkana) consists of the following Texas counties:

(A) Bowie;

(B) Camp;

(C) Cass;

(D) Delta;

(E) Franklin;

(F) Hopkins;

(G) Lamar;

(H) Morris;

(I) Red River; and

(J) Titus.

(21) Rating area 21 (Tyler) consists of the following Texas counties:

(A) Anderson;

(B) Cherokee;

(C) Henderson;

(D) Rains;

(E) Smith;

(F) Van Zandt; and

(G) Wood.

(22) Rating area 22 (Victoria) consists of the following Texas counties:

(A) Calhoun;

(B) DeWitt;

(C) Goliad;

(D) Jackson;

(E) Karnes;

(F) Lavaca; and

(G) Victoria.

(23) Rating area 23 (Waco) consists of the following Texas counties:

(A) Bosque;

(B) Falls;

(C) Freestone;

(D) Hill;

(E) Limestone; and

(F) McLennan.

(24) Rating area 24 (Wichita Falls) consists of the following Texas counties:

(A) Archer;

(B) Baylor;

(C) Clay;

(D) Cottle;

(E) Foard;

(F) Hardeman;

(G) Jack;

(H) Knox;

(I) Montague;

(J) Wichita;

(K) Wilbarger; and

(L) Young.

(25) Rating area 25 (Fort Worth) consists of the following Texas counties:

(A) Denton;

(B) Erath;

(C) Hood;

(D) Johnson;

(E) Palo Pinto;

(F) Parker;

(G) Somervell;

(H) Tarrant; and

(I) Wise.

(26) Rating area 26 (Houston SW) consists of the following Texas counties:

(A) Austin;

(B) Brazoria;

(C) Colorado;

(D) Fort Bend;

(E) Matagorda;

(F) Waller; and

(G) Wharton.

(27) Rating area 27 (Houston NE) consists of the following Texas counties:

(A) Chambers;

(B) Liberty;

(C) Montgomery; and

(D) Walker.

§3.505. Required Rate Filings.

(a) An issuer may not use a rate with respect to a plan if:

(1) the issuer has not filed the rate with TDI for review;

(2) the rate filing does not comply with the standards in §3.503 of this title (relating to Rating Standards); or

(3) the rate filing has been withdrawn.

(b) Each issuer must submit an annual rate filing no later than June 15 for any individual or small group market plan that will be issued effective on or after January 1 in the following calendar year. A small group issuer may include scheduled quarterly trend increases within the annual rate filing. An issuer may have only one active annual single risk pool rate filing in each market. An issuer may not modify an annual rate filing later than October 1 prior to the calendar year for which the filing was submitted.

(c) A small group issuer may submit a rate filing for a quarterly rate change that takes effect on April 1, July 1, or October 1. A small group issuer may have only one active quarterly single risk pool rate filing at a given time. Notwithstanding §26.11 of this title (relating to Restrictions Relating to Premium Rates), a small group issuer must submit a quarterly rate filing at least 105 days before the effective date of the rate change.

(d) A rate filing must include the index rate for the single risk pool and reflect every product and plan that is part of the single risk pool in the applicable market. Issuers are not required to enter CSR plan variations separately.

(e) Rate filings made under this subchapter must be submitted through the electronic system designated by TDI, according to any technical instructions provided for the electronic system and consistent with the rules and procedures in Chapter 3, Subchapter A, of this title (relating to Submission Requirements for Filings and

Departmental Actions Related to Such Filings) and §11.301 of this title (relating to Filing Requirements).

(f) Rate filings made under this subchapter must include the following:

(1) the URRT (Part I);

(2) for a rate increase that is 15% or more within a 12-month period that begins on January 1, as determined by 45 CFR §154.200(b) and (c), concerning Rate Increases Subject to Review, a written description justifying the rate increase (Part II) that complies with 45 CFR §154.215(e), concerning Submission of Rate Filing Justification;

(3) rating filing documentation (Part III) that complies with 45 CFR §154.215(f) and that includes an unredacted actuarial memorandum signed by a qualified actuary;

(4) a rates table that identifies the applicable rate for each plan, depending on an individual's rating area, tobacco use, and age;

(5) an enrollment spreadsheet that contains, with respect to each county:

(A) the number of covered lives, as of March 31 of the current year, that are enrolled in each of the following plan types, separated on the basis of whether the enrollment is through the federal exchange or off-exchange:

(i) catastrophic plans;

(ii) bronze plans;

(iii) silver plans, separated as follows:

(I) silver plans with an AV of 70%;

(II) silver plans with an AV of 73%;

(III) silver plans with an AV of 87%;

(IV) silver plans with an AV of 94%; and

(V) silver plans with an AV of 100%;

(iv) gold plans; and

(v) platinum plans;

(B) whether the plan is available in the county in the current calendar year; and

(C) whether the plan will be available in the county in the next calendar year; and

(6) an AV and cost-sharing factor spreadsheet that contains:

(A) the plan ID specified in the URRT; and

(B) the component factors of an AV and cost-sharing design of plan field in the URRT, which should not include adjustments that account for the morbidity of the population expected to enroll in the plan, including:

(i) the AV of the plan, calculated consistent with 45 CFR §156.135, concerning AV Calculation for Determining Level of Coverage;

(ii) the induced-demand factor of 1.00 for bronze plans, 1.03 for silver plans, 1.08 for gold plans, and 1.15 for platinum plans; and

(iii) for individual silver plans on the exchange, a CSR adjustment factor of 1.35, that accounts for the average costs attributable to CSRs, to the extent that issuers are not otherwise being reimbursed for those costs. If issuers are being reimbursed for those costs by HHS, consistent with 42 USC §18071, concerning Reduced Cost-Sharing for Individuals Enrolling in Qualified Health Plans, then the CSR adjustment factor would not apply.

(g) Issuers may submit data using the templates available on TDI's website at www.tdi.texas.gov/health/ratereview.html.

(h) On request from TDI, an issuer must provide any additional information needed to evaluate the rate filing.

(i) An issuer that does not intend to issue a plan that would require a rate filing for the next calendar year, but that has enrollment in a plan that is subject to this subchapter in the current year or the prior year, must submit the data for such plan under paragraphs (1) and (2) of this subsection, as applicable, to TDI no later than June 15. For example, in June of 2022, an issuer must submit data under paragraph (1) of this subsection for the 2021 calendar year, and data under paragraph (2) of this subsection for the first five months of calendar year 2022. An issuer that does not have data to submit under paragraph (2) of this subsection is still required to submit data under paragraph (1) of this subsection.

(1) For prior year cumulative data, an issuer must submit:

(A) allowed claim costs, defined as total payments made under the plan to health care providers on behalf of covered members and including payments made by the issuer, member cost-sharing, cost-sharing paid by HHS on behalf of low-income members, and net payments from any federal or state reinsurance arrangement or program;

(B) incurred claim costs, defined as allowed claim costs as specified in subparagraph (A) of this paragraph, less member cost-sharing, cost-sharing paid by HHS on behalf of low-income members, and any net payments from a federal or state reinsurance arrangement;

(C) earned premium; and

(D) member months.

(2) For current year cumulative data through March 31, an issuer must submit:

(A) earned premium;

(B) member months; and

(C) the enrollment spreadsheet required under subsection (f)(5) of this section.

§3.506. Review of Rate Filings.

(a) Upon receipt of a rate filing under this subchapter, TDI will evaluate whether the issuer has provided sufficient data and documentation for TDI to make the determinations specified in this section. If the level of detail provided by the issuer under §3.505 of this title (relating to Required Rate Filings) does not provide a sufficient basis for TDI to make a determination, TDI will request additional information as necessary. The issuer must provide the requested information within 10 business days of the request. If the issuer fails to provide the requested information or establish a plan that is acceptable to TDI to provide the information, TDI will deem the filing withdrawn and notify the issuer of the withdrawal.

(b) In reviewing rates filed under this subchapter, TDI will examine:

(1) the reasonableness of the assumptions used by the issuer to develop the rates and the validity of the historical data underlying the assumptions;

(2) the issuer's data related to past projections and actual experience;

(3) the reasonableness of assumptions used by the issuer to estimate the rate impact of the reinsurance and risk adjustment programs under 42 USC §18061,

concerning Transitional Reinsurance Program for Individual Market in Each State, and 42 USC §18063, concerning Risk Adjustment; and

(4) the issuer's data related to implementation and ongoing utilization of a market-wide single risk pool, essential health benefits, actuarial values, and other market reform rules as required by 42 USC Subchapter XXV, Part A, concerning Individual and Group Market Reforms.

(c) In reviewing rates filed under this subchapter, TDI will consider the following factors to the extent applicable to the filing under review:

(1) the factors specified in Insurance Code §1698.052(b) and (d), concerning Additional Rules and Guidance Related to Individual Health Plan Rates;

(2) the factors listed in 45 CFR §154.301(a)(4), concerning CMS's Determinations of Effective Rate Review Programs; and

(3) whether the issuer complies with the rating standards provided under §3.503 of this title (relating to Rating Standards).

(d) In reviewing rates for a qualified health plan, TDI will also consider the factors specified in Insurance Code §1698.052(c).

(e) A rate increase is unreasonable if, based on the criteria identified in this subsection, the rate is excessive, unjustified, or unfairly discriminatory.

(1) A rate increase is excessive if it causes the premium charged for the health insurance coverage to be unreasonably high in relation to the benefits provided under the coverage. In determining whether the rate increase causes the premium charged to be unreasonably high in relationship to the benefits provided, TDI will consider:

(A) whether the rate increase results in a projected medical loss ratio below the federal medical loss ratio standard in the applicable market to which the rate increase applies, after accounting for any adjustments allowable under federal law;

(B) whether one or more of the assumptions on which the rate increase is based is not supported by substantial evidence; and

(C) whether the choice of assumptions or combination of assumptions on which the rate increase is based is unreasonable.

(2) A rate increase is unjustified if the issuer provides data or documentation that is incomplete, inadequate, or otherwise does not provide a basis upon which the reasonableness of an increase may be determined.

(3) A rate increase is unfairly discriminatory as described by Insurance Code §560.002(c), concerning Use of Certain Rates Prohibited; Rate Requirements.

(f) A rate will be deemed compliant at the expiration of 60 days from the filing of the rate, unless the filing is withdrawn or TDI has determined that the rate is noncompliant or granted an extension as described below. If TDI has not finalized a determination before the 60th day, TDI may extend the 60-day period by not more than 10 days if TDI provides notice of the extension to the issuer. Notwithstanding anything else in this subsection, the issuer may extend the time frame for TDI's review or waive the right to deem the rate compliant.

(g) If a rate filing fails to comply with the rating standards provided under §3.503 of this title, TDI will identify the deficiency and ask for corrections. If within 10 business days the issuer fails to either make the necessary corrections or establish a plan that is acceptable to TDI to address the identified deficiencies, TDI will deem the filing to be noncompliant and notify the issuer of the determination.

(h) Before making a determination that a rate increase is unreasonable, TDI will communicate its objections to the issuer and provide an opportunity for the issuer to provide additional information or to make modifications. If TDI determines that a rate increase is unreasonable but that the issuer is legally permitted to implement the rate increase, TDI will issue a final determination and a brief explanation. After receiving a final determination that a rate increase is unreasonable, the issuer must submit a final justification for the rate increase and prominently post information concerning the rate increase, consistent with 45 CFR §154.230, concerning Submission and Posting of Final Justifications for Unreasonable Rate Increases.

§3.507. Public Disclosure and Input.

(a) Information related to proposed annual rate increases of 15% or more will be publicly available on the website published by the Centers for Medicare and Medicaid Services (CMS). A link to the CMS website will be posted on TDI's website: www.tdi.texas.gov/health/ratereview.html.

(b) Public comments concerning proposed rate increases can be sent to RateReview@tdi.texas.gov.

(c) Final rate increases will be publicly available on the website published by CMS no later than the first day of the annual open enrollment period in the individual market for the applicable calendar year.

(d) TDI will make information related to proposed or final rate filings available to the public in a manner consistent with 45 CFR §154.301(b), concerning CMS's Determinations of Effective Rate Review Programs.

CERTIFICATION. This agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas, on May 27, 2022.

DocuSigned by:
Allison Eberhart
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Allison Eberhart, Deputy General Counsel
Texas Department of Insurance

The Commissioner adopts new 28 TAC §§3.501 - 3.507.

DocuSigned by:
C Brown
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Cassie Brown
Commissioner of Insurance

Commissioner's Order No. 2022- 7332