

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

INTRODUCTION. The Texas Department of Insurance (TDI) proposes new Subchapter F, consisting of §§3.501 - 3.507, concerning the rate review process for individual and small group major medical coverage, to be added to 28 TAC Chapter 3. This new subchapter implements Insurance Code Chapter 1698, as added by Senate Bill 1296, 87th Legislature, 2021.

EXPLANATION. Insurance Code Chapter 1698 requires the Commissioner to establish a process under which TDI will review health benefit plan rates and rate changes for compliance with state and federal law, including rules establishing geographic rating areas. Proposed 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 have been reviewing these rates because Texas law had 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.

TDI received five separate comments on an informal draft of this rule, which was posted on TDI's website on October 19, 2021. Multiple commenters requested that the proposed new subchapter be drafted to include a common cost-sharing reduction (CSR) adjustment to address the federal government's discontinuance of CSR reimbursements

in 2017. Regulators in 45 states directed issuers to make this type of adjustment, commonly known as "actuarial loading" or "silver loading," in response to the defunding of CSRs. TDI considered those comments when drafting this proposal.

The proposed 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 rates may vary based on geography. 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 proposed new rating areas 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.

Section 3.505. Section 3.505(a) prohibits an issuer from using a rate with respect to a plan if the rate has not been filed with TDI for review, does not comply with applicable rating standards, or where the rate filing 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 so 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 §111.301.

Subsection (f) requires that rate filings made under Subchapter F include the following: (1) the URRT (Part I); (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, which is applicable to individual silver plans on the exchange. 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 actuarial value that may be provided across all silver plans; and (4) variation in induced demand. Before adopting a final CSR adjustment factor, TDI will consider comments on the proposed factor and whether it should be modified.

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.

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 review, 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 under the Insurance Code; (6) factors listed under 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 based on 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 the public disclosure and comments information related to rate increases, consistent with 45 CFR §154.301(b). Subsection (a) provides that information related to a proposed 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 proposed 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.

FISCAL NOTE AND LOCAL EMPLOYMENT IMPACT STATEMENT. Rachel Bowden, director of Regulatory Initiatives in the Life and Health Division, has determined that during each year of the first five years the proposed new sections are in effect, there will be no measurable fiscal impact on state and local governments as a result of enforcing or administering the new sections, other than that imposed by the statute. Ms. Bowden made this determination because the proposed new sections do not add to or decrease state revenues or expenditures, and because local governments are not involved in enforcing or complying with the proposed new sections.

Ms. Bowden does not anticipate a measurable effect on local employment or the local economy as a result of this proposal.

PUBLIC BENEFIT AND COST NOTE. For each year of the first five years the proposed new sections are in effect, Ms. Bowden expects that enforcing and administering the proposed new sections will have the public benefit of ensuring that TDI's rules conform to Insurance Code Chapter 1698 and 45 CFR Part 154.

Ms. Bowden believes that the proposed new sections will have several additional public benefits. The proposed new sections will provide issuers with greater certainty regarding rating standards, which improves compliance and adds stability to the marketplace. The proposed new geographic rating areas will have the benefit of allowing issuers to more accurately price products to better reflect the costs in the local health care

markets where consumers are likely to seek care. This benefit could increase competition and consumer choice in rural areas.

In addition, the new sections increase consumer purchasing power by requiring issuers to apply a uniform CSR adjustment factor. As explained in the author's statement of intent, SB 1296 sought to remedy a misalignment in premiums across the different metal tiers of coverage that resulted from the discontinuance of federal payments for the CSRs that issuers must provide to eligible consumers. See Senate Research Center, Bill Analysis, SB 1296, 87th Legislature, 2021. To address the discontinuance of federal subsidies, silver-level plans should be priced to reflect the cost of providing coverage that has a higher actuarial value. However, issuers have not taken a uniform approach in adjusting premiums. By requiring issuers to use a uniform CSR adjustment factor, the rule (1) ensures that the federal tax credits will be based on appropriately priced silver-level plans, and (2) prevents consumers in other metal tiers from absorbing the expenses of the CSRs they do not benefit from. TDI expects that the uniformity will maximize the federal tax credits available to Texas consumers, increasing purchasing power and health coverage affordability. By increasing consumers' purchasing power, issuers will also benefit from increased enrollment in the Texas individual health insurance marketplace.

Ms. Bowden expects that the proposed new sections will likely not generate additional costs to health benefit plan issuers. Issuers are currently required to submit rating information to both TDI for state review and CMS for federal review. By establishing an effective rate review process, TDI will have the ability to review rates for compliance with state and federal requirements. The responsibility of performing this task will be transferred from CMS to TDI; issuers will have to file and interact with only one regulatory entity, presumably saving time and costs.

The proposed rules require issuers to (1) use the updated geographic rating areas, (2) file annually with TDI rates that include documentation demonstrating compliance with

applicable rating standards, (3) include data on enrollment and medical claim trends in annual filings, (4) report data on enrollment in silver-plan variations, and (5) use a uniform CSR adjustment factor. The use of updated geographic rating areas ensures that factors align with the health care market where rural enrollees are likely to seek care. Implementing the proposed geographic rating areas is not expected to create a cost for issuers. The documentation within annual filings and the collection of data are necessary for TDI to fully assess the appropriateness of the rates and consider all factors identified in Insurance Code §1698.052(c) and (d). Specifically, the information required to be submitted under §3.505(f)(1) - (5) is already required to be submitted under law or other regulations. The information required to be submitted under §3.505(f)(6) is not currently required, but it is necessary so that TDI can fully consider the factors referenced in Insurance Code §1698.052(c). Issuers already have this information, so there should be no cost to produce and submit it with the rate filing. Since issuers are already filing rates with TDI to review compliance with state requirements, the proposal does not require more rate filings or additional fees that issuers are expected to pay.

Section 3.505(f)(6)(B)(iii) also requires issuers to use a CSR adjustment factor of 1.35 for silver plans on the exchange. Requiring issuers to use this uniform factor will ensure that federal tax credits will be based on appropriately priced silver-level plans and will also prevent consumers in other metal tiers from absorbing the expenses of the CSRs they do not benefit from. TDI believes that most issuers already use a CSR adjustment factor, and requiring a uniform factor is not expected to increase the workload involved in formulating compliant rates. TDI does not have information on the adjustment factors currently being used by many issuers, so TDI cannot determine the precise impact to issuers for changing to the proposed uniform CSR adjustment factor, but TDI does not anticipate a cost increase. Even if there is a cost increase, TDI anticipates that it will be offset by the cost savings based on issuers no longer having to interact with two

regulatory entities under the rule and the benefits to consumers that will no longer have to absorb the costs of CSRs.

TDI also estimates that there are no measurable additional costs in the actual submission of the electronic form over the internet.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS. TDI has determined that the proposed new sections will not have an adverse economic effect on small or micro businesses, or on rural communities. Rural communities might benefit from the proposed new geographic rating areas because such communities were previously placed into a single rating area, which resulted in the rates not always being reflective of the market for each community. As a result, and in accordance with Government Code §2006.002(c), TDI is not required to prepare a regulatory flexibility analysis.

EXAMINATION OF COSTS UNDER GOVERNMENT CODE §2001.0045. TDI has determined that this proposal likely does not impose a cost on regulated persons. Therefore, no additional rule amendments are required under Government Code §2001.0045. Even if there were some costs attributable to the rulemaking, the proposal is necessary to implement SB 1296 and to receive a source of federal funds.

GOVERNMENT GROWTH IMPACT STATEMENT. TDI has determined that for each year of the first five years that the proposed new sections are in effect, the proposed rules:

- will not create or eliminate a government program;
- will not require the creation of new employee positions or the elimination of existing employee positions;
- will not require an increase or decrease in future legislative appropriations to the agency;

- will not require an increase or decrease in fees paid to the agency;
- will create a new regulation;
- will not expand, limit, or repeal an existing regulation;
- will increase the number of individuals subject to the rules' applicability; and
- will not positively or adversely affect the Texas economy.

TAKINGS IMPACT ASSESSMENT. TDI has determined that no private real property interests are affected by this proposal and that this proposal does not restrict or limit an owner's right to property that would otherwise exist in the absence of government action. As a result, this proposal does not constitute a taking or require a takings impact assessment under Government Code §2007.043.

REQUEST FOR PUBLIC COMMENT. TDI will consider any written comments on the proposal that are received by TDI no later than 5:00 p.m., central time, on May 9, 2022. Send your comments to ChiefClerk@tdi.texas.gov or to the Office of the Chief Clerk, MC-GC-CCO, Texas Department of Insurance, P.O. Box 12030, Austin, Texas 78711-2030.

The Commissioner will also consider written and oral comments on the proposal in a public hearing under Docket No. 2833 at 2:00 p.m., central time, on Monday, April 18, 2022, in Room 100 of the William P. Hobby Jr. State Office Building, 333 Guadalupe Street, Austin, Texas.

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STATUTORY AUTHORITY. TDI proposes §§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.

CROSS-REFERENCE TO STATUTE. Sections 3.501 - 3.507 implement Insurance Code Chapter 1698.

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) Lamb;

(J) Lubbock;

(K) Lynn;

(L) Motley;

(M) Terry; and

(N) 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) King;

(I) Knox;

(J) Montague;

(K) Wichita;

(L) Wilbarger; and

(M) 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 May 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 proposal and found it to be within the agency's authority to adopt.

Issued in Austin, Texas, on March 28, 2022.

DocuSigned by:

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James Person, General Counsel
Texas Department of Insurance