Filing for Plan Year 2026

Rates, Forms, and Provider Networks

OFFICE of the
INSURANCE
COMMISSIONER
WASHINGTON STATE

WELCOME TO PY26, THE 13TH PLAN YEAR!

Housekeeping:

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

Overview

Ned Gaines, Deputy Commissioner

AGENDA

- Overview
- Forms
- Provider Networks
- Rates
- SERFF Binders
- Upcoming Changes to OIC's Website
- Recap

IMPORTANT DATES

- **May 15, 2025** – Filing deadline
- **June 27, 2025** – PY26 Service Area Changes deadline
- **September 4, 2025** – On Exchange Individual Market approval due date
- **September 11, 2025** – WAHBE Board meeting to certify QHPs and QDPs
- **October 15, 2025** – CMS's approval deadline for all off-Exchange individual and small group health plans.

SIGN UP TO RECEIVE GOVDELIVERY EMAILS

How to sign up for GovDelivery emails

- Subscribe to OIC news through our GovDelivery system by entering your email address at the following location https://public.govdelivery.com/accounts/WAOIC/subscriber/new

- Under industry information choose topic “Health care filing information” to receive updates on webinars, changes related to our filing instructions, and general news related to PY26

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

THE DIFFERENCE BETWEEN GFIs AND STMs

General Filing Instructions (GFIs) are required.

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

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

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

Website link to Filing Instructions and Speed to Market (STM) Tools:
https://www.insurance.wa.gov/health-care-and-disability-filings

NO MPMS FOR WASHINGTON STATE

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

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

Forms

Heather Shimoji, Health Forms Manager

DEFINITIONS OF PRODUCT AND PLAN

Product:

- Discrete package of health coverage benefits that uses a particular provider network type (HMO, PPO, EPO, POS or indemnity) within a service area

- Differences in the scope of benefits = different products
  - i.e., limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the amount, scope or duration of treatment
- Differences in "cost-sharing structure" ≠ different products
  - i.e., deductibles, coinsurance, copayments, or similar charges
- A product can be modified in some ways yet remain the same product.
  - "Uniform Modification": 45 CFR §146.152(f), 45 CFR §147.106(e), or 45 CFR §148.122(g).

DEFINITIONS OF PRODUCT AND PLAN (cont'd)

Plan:

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

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

- Product and plan defined in 45 CFR § 144.103

PRODUCT, PLAN, AND FORMULARY

- As part of Federal requirements, a "discrete set of health coverage benefits" includes the formulary.
- In PY 2026, OIC will continue to enforce the federal requirement that all plans within a product share the same drug formulary.
- OIC formally asked CMS what are allowable formulary changes within one product for purposes of maintaining that product status
    - According to CMS, a product formulary must have same list of drugs and same drugs in each cost-sharing tier, though cost-sharing may differ between plans
- "Formulary ID" as used in the CMS QHP templates does **not** automatically indicate a different drug formulary for the purpose of defining separate products.
    - For plans within the same product, plans may have different formulary IDs if differences are only due to variations in cost-sharing.

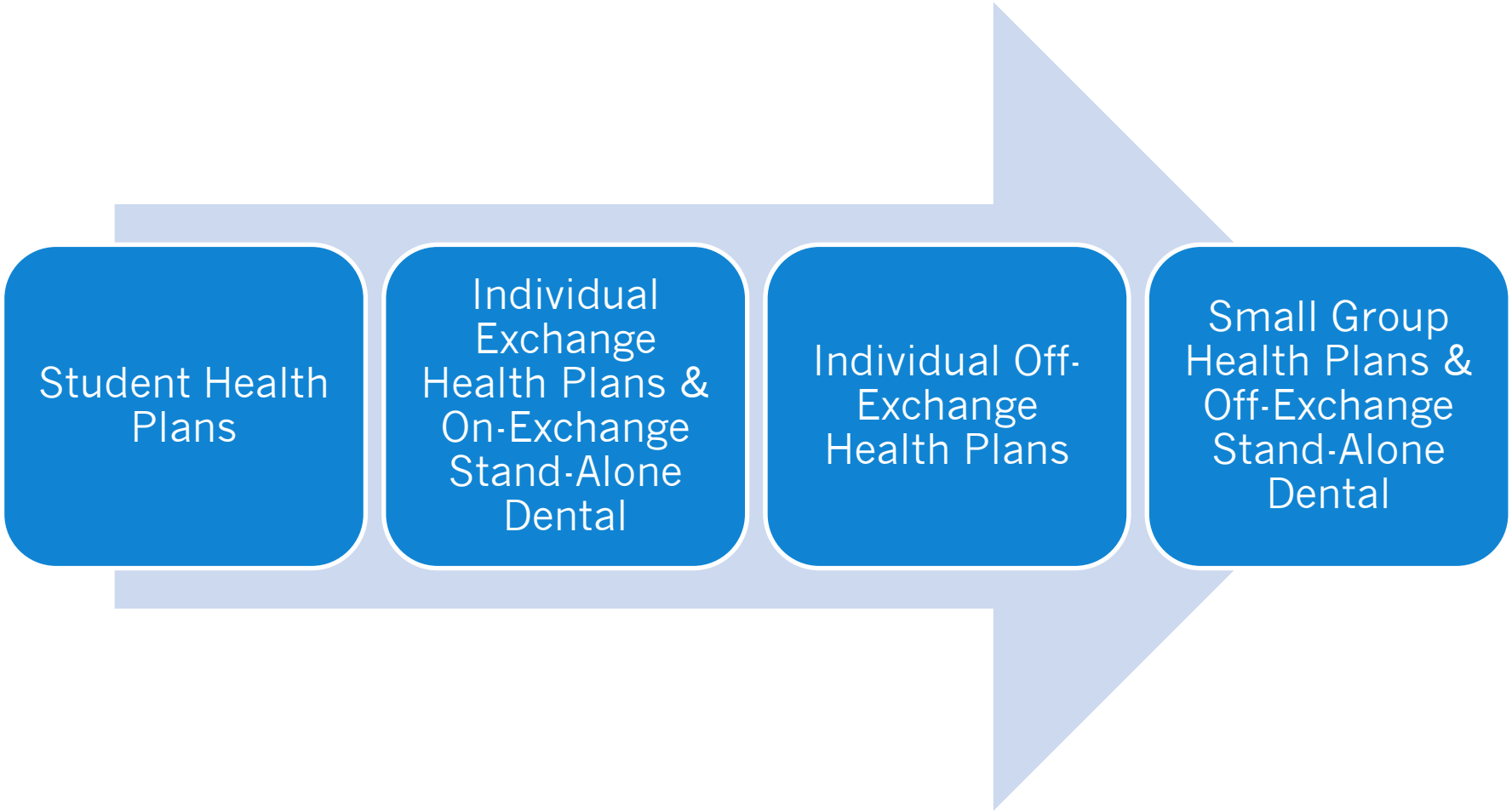
PRODUCT, PLAN AND FORMULARY (cont'd)

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

"PRIMARY PRODUCT"

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

PRIORITY OF FORMS REVIEW BY MARKET



PRELIMINARY FORMS REVIEW

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

Preliminary Review of ALL Filings:

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

PRELIMINARY FORMS REVIEW (cont'd)

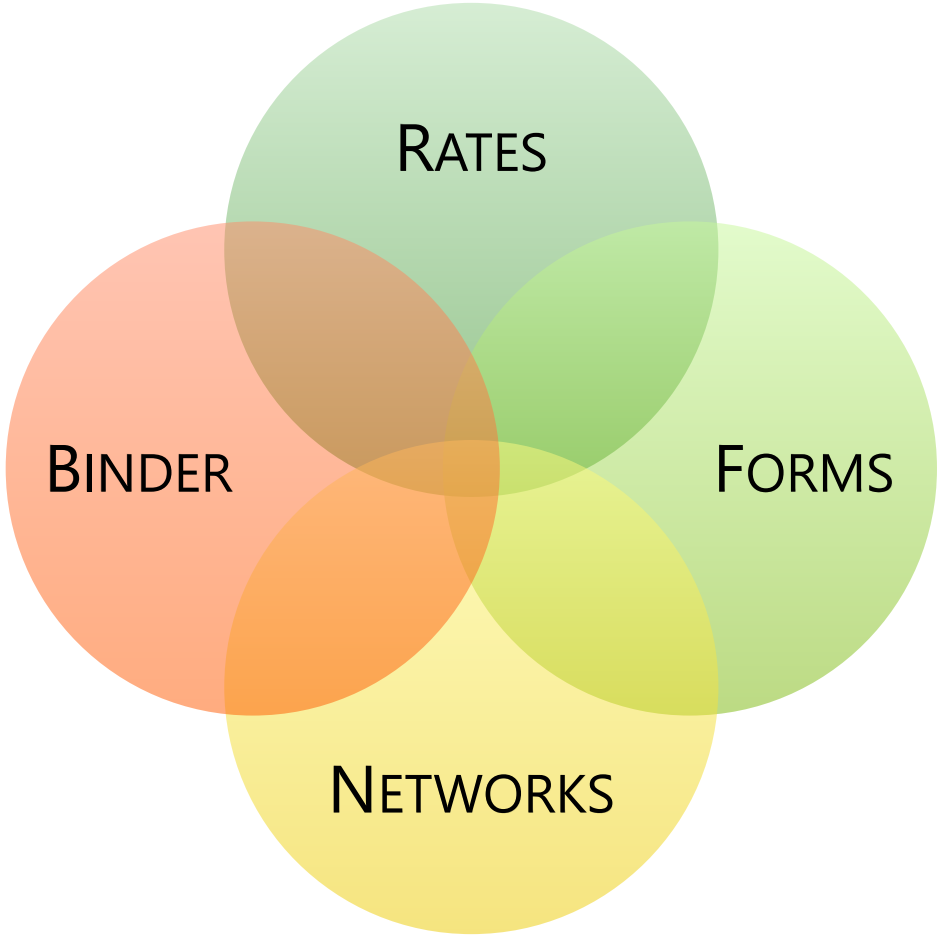
- ✓ Have you filed at least one renewal product?
- ✓ Have you submitted redline versions of all "revised" forms under the Supporting Documentation tab?
- ✓ Have you submitted electronic review tool results with your binder filing?
- ✓ Do Cascade Care plan names meet WAHBE naming conventions?

  (*Note: new plan naming conventions for Cascade Gold plans for PY2026)*

SUBSTANTIVE REVIEW

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

MATCHING INFORMATION ACROSS FILINGS



COMMON FORM "MATCHING" OBJECTIONS

Cost-share amounts

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

Network names

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

Service Area - Counties

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

TIMELINES FOR RESPONSE TO FORM OBJECTIONS

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

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

"PRIMARY PRODUCT" OBJECTIONS

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

AMENDING FORMS ("FLIPPING" PROCESS)

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

WHAT'S NEW FOR PY2026?

- **Essential Health Benefits Benchmark Plan**
  - Includes new benefits:
    - Donor human milk (per RCW 48.43.815)
    - Hearing instruments and associated services (per RCW 48.43.135)
    - Artificial insemination
  - More information, including the benchmark plan, can be found on the OIC's website:
    - Currently and after new website release
- **Breast Exams**
  - IRS Notice 2024-75 expanded the list of preventative care benefits to be provided by a HDHP without a deductible
  - When considering both IRS Notice 2024-75 and RCW 48.43.076 in conjunction, the OIC will require fully insured non-grandfathered health plans **issued or renewed on or after January 1, 2025**, to cover diagnostic and supplemental breast examinations - including ultrasounds, MRIs, and similar screenings – without cost-sharing on qualified HDHPs

WHAT'S NEW FOR PY2026? (cont'd)

- **2025 Marketplace Integrity and Affordability Proposed Rule**
  - The rule proposes to adopt many changes including:
    - Prohibiting issuers from providing coverage of sex-trait modifications as an essential health benefit
    - Revise actuarial value standards for health plans
    - Revise automatic reenrollment hierarchy
    - Revise the premium adjustment percentage methodology
  - It is unknown if the proposed rule will be finalized before the May 15th filing deadline
    - Carriers should not file any rates and forms based on the proposed rule
    - Once the final rule is published, the OIC will send out a GovDelivery communication with further instructions

WHAT'S NEW FOR PY2026? (cont'd)

Health Plan Maximum Out of Pocket*:

- $10,150 for self only coverage
- $20,300 for other than self only coverage

Pediatric Dental Annual Limit on Cost Sharing:**

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

* Source: PAPI Guidance for 2026 Benefit Year (*10/8/2024*)

** Source: 2026 Final Letter to Issuers in the Federally-Facilitated Exchanges (*1/15/2025*)

WHAT'S NEW FOR PY2026? (cont'd)

HB 1090/ SB 5498

- Concerning Contraceptive Coverage

ESHB 1291

- Cost sharing for maternity services

SHB 1669 / ESSB 5629

- Coverage requirements for prosthetic limbs and custom orthotic braces.

  (Note: only applies to small and large group plans)

WHAT'S NEW FOR PY2026? (cont'd)

ESHB 1971

- Increasing access to prescription hormone therapy

ESSB 5594

- Concerning biosimilar medicines and interchangeable biological products

ADDITIONAL RESOURCES

Women's Preventive Services Guidelines (HRSA)

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

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

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

TIPS FOR SUCCESS: HELP US HELP YOU!

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

Provider Networks

Jennifer Kreitler, Provider Network Oversight Program Manager

Network Adequacy Exception

For plan year 2026 HHS has granted Washington state an exception to the requirements of 45 CFR 155.1050(a)(2)(i) because the state applies and enforces alternate quantitative network adequacy standards [45 CFR 155.1050(a)(2)(ii)]

- Washington state **will not** be imposing quantitative time and distance standards.
  - Do not file justification documents
  .
- Washington state **will not** be imposing appointment wait time standards.

- Washington state **will be** collecting information about access to Telehealth services.
  - Information will be collected in the Provider Network Form A report.

DOES YOUR NETWORK MATCH?

PNOP will review the following:

- Network name(s) listed in approved provider contracts
- Registered network maintenance information:
  - Name,
  - Type of network (single or tiered),
  - Market (outside, Exchange or both)
  - Line of Business
  - HCBM licensure and subnetwork names
- Service Area template
- ECP and Network Adequacy Template
- Network ID Template
- **Access Plan and GeoNetwork Report – *SPNRR open 4/18/2025***
- Provider Network Form A report

ESSENTIAL COMMUNITY PROVIDER (ECP)

The approach for review will remain the same for PY2026 as PY2025.

- Overall participation threshold is **35%** of available ECPs in the plan's service area
- Washington state rule currently requires carriers to meet a 30% standard
- Carriers will be required to meet highest participation standard

ECP/NA Template

- Washington state **does not** use the network adequacy data side on the ECP/NA Template
  - Provider Network Form A report is used to collect network access data

ECP/NA TEMPLATE (cont'd)

Provider reporting requirements by location:

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

ECP/NA TEMPLATE (cont'd)

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

TIERED NETWORK

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

WHAT'S NEW FOR PY2026?

Substitute Senate Bill 5579 – Prohibiting health carriers, facilities, and providers from making any public statements of any potential or planned contract terminations unless it satisfies a legal obligation.

Rates

Rocky Patterson, Actuary

Key Changes Impacting ACA Rate Filings

- **New proposed federal rule** (Marketplace Integrity and Affordability Rule)
- Requirement for **two sets of rates** due to potential expiration of expanded Advance Premium Tax Credits (e-APTCs)
- Introduction of the **CSR Silver Loading Emergency Rule**
- Updates to **Speed to Market Tools**

Proposed Federal Rule – Rate Filing Process

- The federal rule is **not final**, but it impacts PY26 filings.

- If **not finalized before the deadline**, carriers must file based on current regulations.
- If finalized **after the deadline**, carriers will be allowed to update only components of their filings that violate the new rule.
- **Market fairness policy**: No additional updates permitted based on final rule provisions.

Two Sets of PY2026 Individual Health Plan Rates (Part 1)

Why Two Sets?

- Due to uncertainty regarding the continuation of **ARPA subsidies (e-APTCs)**
- Without congressional action, e-APTCs will **expire**, leading to potential market disruption.

How to File:

- **Primary rate filing:** Assume **e-APTCs are NOT extended**.
- **Secondary rate set:** Load a version in the **Supporting Documents tab (SERFF)** assuming **e-APTCs are extended**.

Two Sets of PY2026 Individual Health Plan Rates (Part 2)

Key Process Guidelines:

- **Do NOT update** the secondary rate set unless an objection explicitly requests it.
- **Do NOT modify** Company Rate Information or Rate Review Detail unless requested.
- If e-APTCs are extended **during review**, OIC will instruct carriers to replace the default rate documents.
- **Final filings must contain only one rate set**—OIC will issue instructions before disposition.

*More details available in **updated Speed to Market Tools** on the OIC website.*

CSR Silver Loading Emergency Rule

Expiration of e-APTCs expected to drive:

- Enrollment decline
- Increased morbidity
- Rising net premiums

New emergency rule implemented to mitigate these risks.

- **Rate filings must comply** with the rule.
- Assumptions on **membership and morbidity must reflect its impact**.

Find the emergency rule and additional guidance in the rate filing checklist on our website.

Draft Rate Filing Speed to Market Tools

- All Speed to Market Tools available in draft on the OIC website.
- Feedback Deadline: 03/28/2025
- Comments will inform final revisions.

Rate Filing Speed to Market Tool Changes

Most changes only impact ACA rate filings

Enhancements:

- Two sets of rates reflected in Individual Health Plan Tools
- Revised Individual & Small Group Checklists (emergency rule & redundant info removed)
- New filing exhibit template for standardized reporting

Rate Filing Review Process Highlights

- Preliminary reviews of all rate filings within the first couple of weeks.

- Rate filing review priority (after preliminary reviews):
  - On-exchange rate filings first
  - Off-exchange rate filings second

How to Expedite the Review Process

- Submit the final STMs in the rate filing
- Submit complete responses to rate filing objections.
- If you need clarification of an objection, contact the reviewer before you respond.

PY2026 INDIVIDUAL SUPPLEMENTAL CHECKLIST FOR 1332 WAIVER REPORTING

- Checklist required by Washington Health Benefit Exchange (HBE) for 1332 Waiver Reporting.
- Applies to all individual carriers, on-Exchange and off-Exchange.
- OIC will review this checklist as part of rate filing.
- Detailed instructions available in the supplemental checklist.

PY2026 USER FEES

- PY26 Exchange User Fees:
  - QHPs $5.11 PMPM
  - QDPs $0.94 PMPM
  - Pediatric Dental Plans $0.67 PMPM

- PY26 Risk Adjustment User Fee: $0.20 PMPM.

URRT/SERFF PROCEDURE

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

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

SERFF Binders

Ben Driver, Actuary

BINDER REVIEW PROCESS (HIGH LEVEL)

Step 1

Preliminary Review:

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

Step 2

Substantive Review:

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

Step 3

Cleanup:

- Check consistency with final versions of rate and form documents.
- Prepare filing for final disposition and reporting.

Notes:

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

CONNECTING THE RATE, FORM, AND BINDER FILINGS

Use the same entries across documents:

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

Ensure consistency between documents:

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

PLANS AND BENEFITS TEMPLATE – EXCHANGE STATUS

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

- Page 2E-6 of the "Qualified Health Plan Issuer Application Instructions: Plan Year 2025"

QHP/Non-QHP*	Indicate whether the plan will be offered only on the Exchange, only off the Exchange, or both on and off the Exchange. Choose from the following: ◆ **On the Exchange**—if the plan will be offered only on the Exchange. Under the guaranteed availability requirements in 45 CFR 147.104, a plan offered on the Exchange generally must be available to individuals and employers (as applicable) in the state who apply for the plan off the Exchange. If you offer a plan on the Exchange, select **Both** unless an exception to guaranteed availability applies. ◆ **Off the Exchange**—if the plan will be offered only off the Exchange. This includes non-QHPs and plans that are substantially the same as a QHP offered on the Exchange as part of the risk corridor program (see 45 CFR 153.500 for more details). ◆ **Both**—if the plan will be offered both on and off the Exchange. Such plans must have the same premium, provider network, cost sharing structure, service area, and benefits, regardless of where they are offered. Selecting this option creates two separate plan variations when the Cost Share Variances worksheet is created: one on-Exchange plan and one off-Exchange plan.

- Enter "Both" for plans (other than catastrophic plans) that are offered on the exchange.
- Enter "On the Exchange" for catastrophic plans.
- Enter "Off the Exchange" for plans not offered on the exchange.

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

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

REMINDERS, UPDATES, and NEWS

Binder Filing General Instructions and Templates

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

Service Area Template and Network ID Template

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

REMINDERS, UPDATES, and NEWS (cont.)

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

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

CMS's Standardized Plans Add-In File

- If CMS's add-in file is updated to match Washington's benchmark plan, please take advantage of this tool.
- Otherwise, please use Exhibits B and C to update the benefit information tables in your PBTs.
- Stay tuned. We will address the revised add-in file when we release our revised filing instructions and templates.

REMINDERS, UPDATES, and NEWS (cont.)

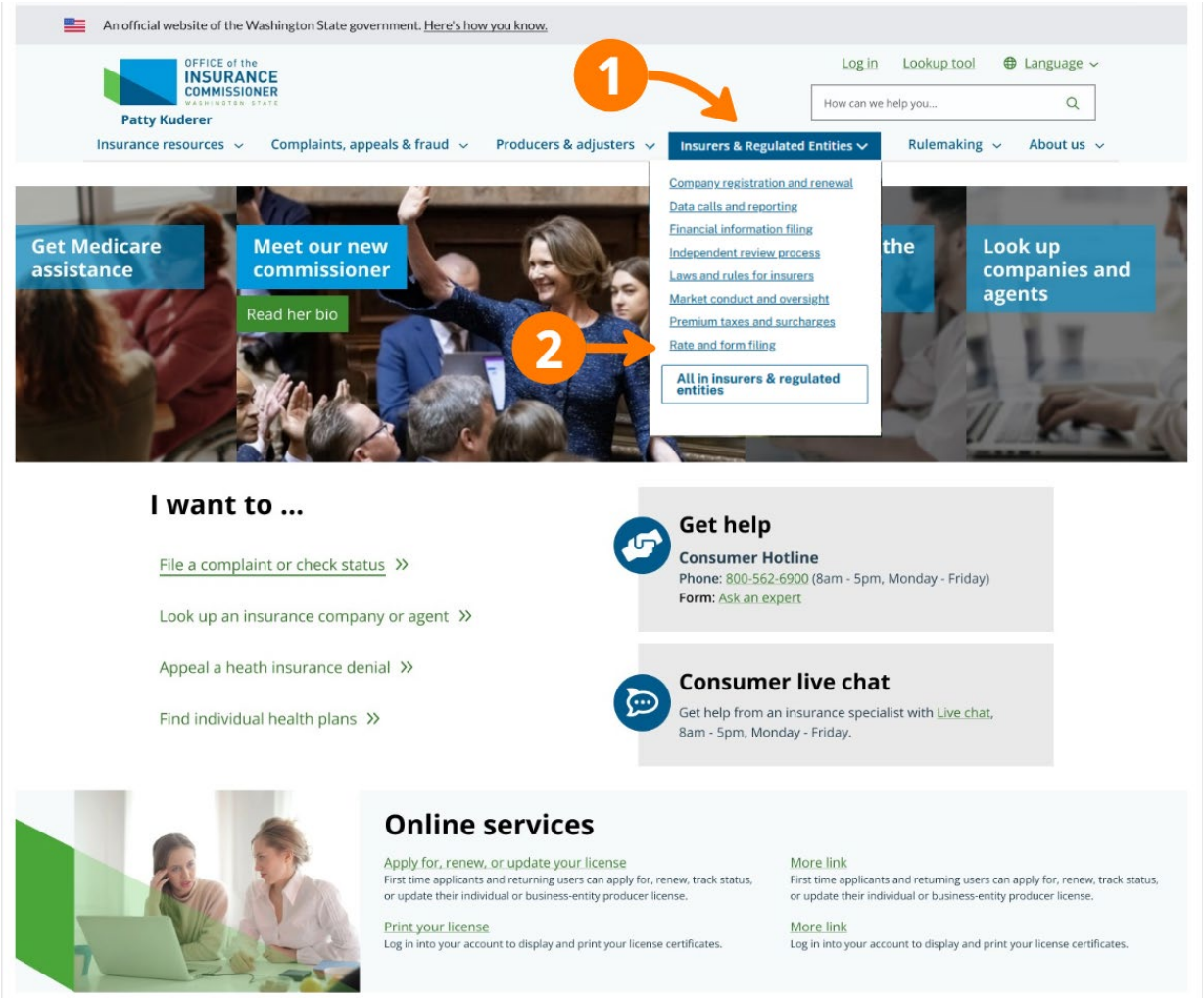
2025 Marketplace Integrity and Affordability Proposed Rule

- Proposed maximum out of pocket (MOOP) and AV de minimis range changes.
- Filings must be compliant with current rules (not proposed rules) at the time of filing.
- If proposed rules are later adopted, updates may be required to achieve compliance.

Upcoming Changes to OIC's Website

Laura Walker, Web Services Manager

New OIC website launching April 21, 2025
What's changing?



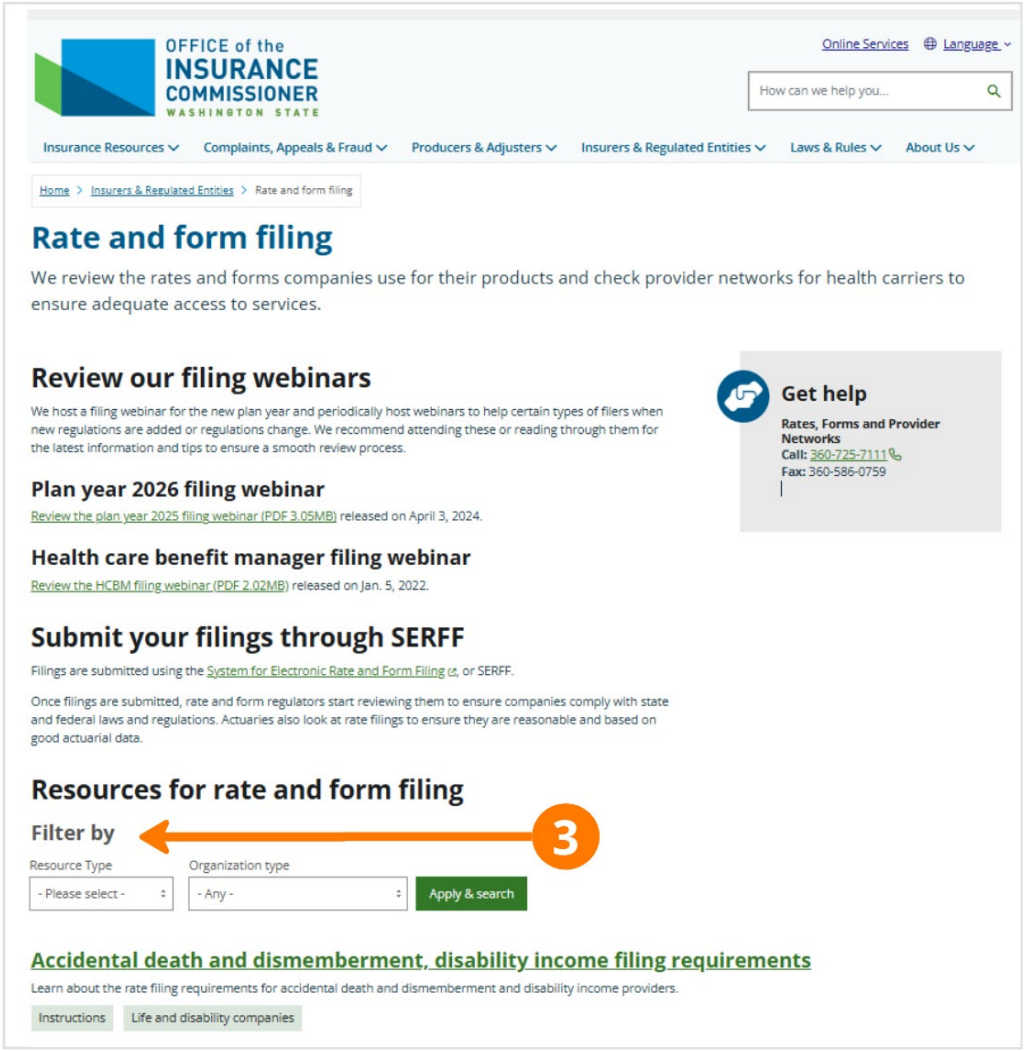
1. Begin by clicking on the dropdown menu labeled **"Insurers & Regulated Entities"** located at the top of the page.

   This will open a list of options related to various insurance providers and regulated organizations.

2. From the displayed menu, select the option titled **"Rates and Form Filing."**

   This section will provide you with access to information regarding the rates charged by insurers as well as the forms required for filing.

Rate and form filing

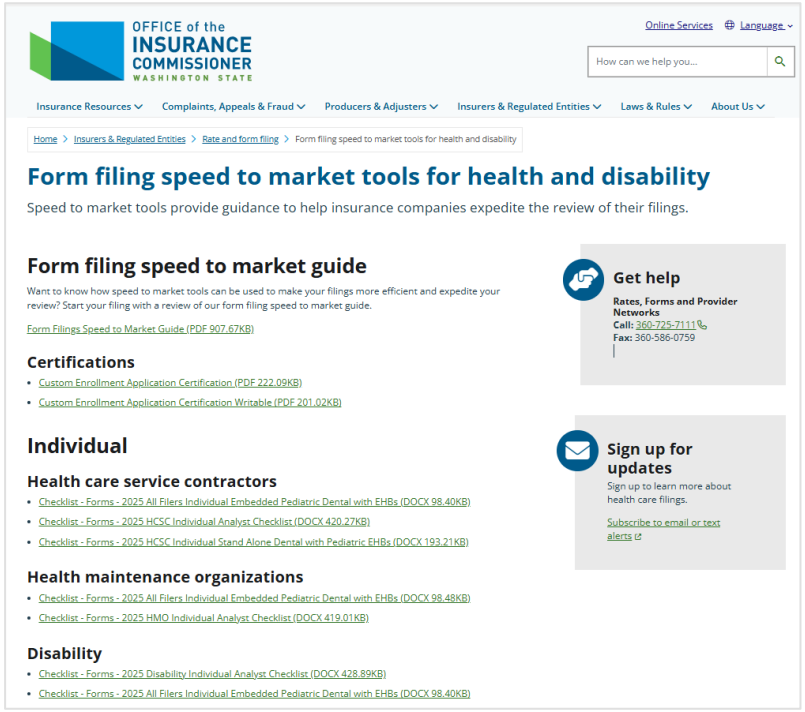


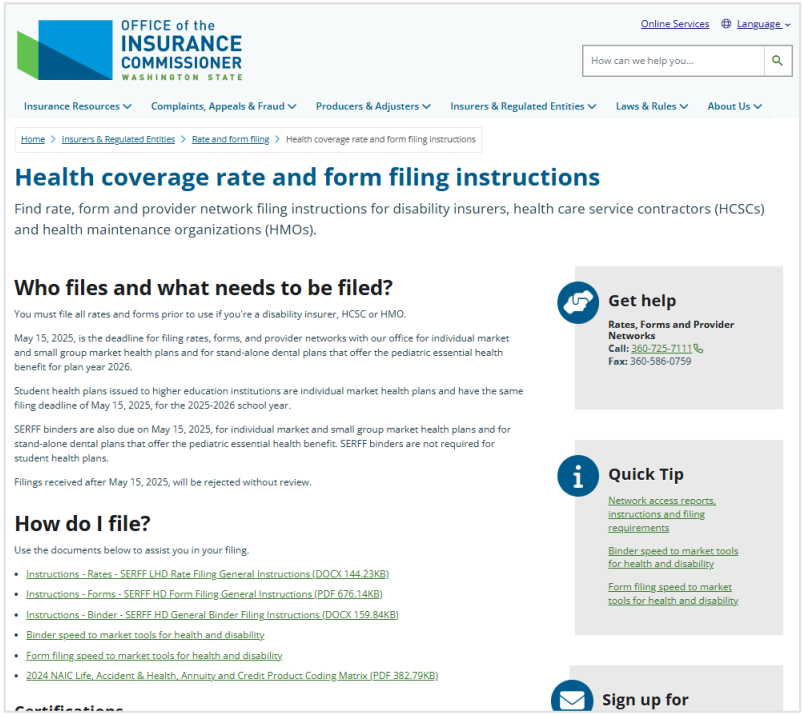
3. Filter by **"Resource Type"** and **"Organization Type"**

   Click the **"Apply & Search"** bottom

   Find Speed to Market (STM) tools, SERFF guidelines and filing instructions.

STM tools and filing instructions





Preview our demo website and let us know your thoughts—send us a message!

Recap

Ned Gaines, Deputy Commissioner

NEXT STEPS

We are still waiting on:

- PBT instructions to finalize Binder GFIs

We will update GFIs/STMs as necessary.

COMMUNICATION

If you have a question, contact us.

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

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

FILING DEADLINE

The filing deadline is May 15, 2025.

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

Thank you for attending our PY26 filing webinar!

Any questions?

Questions?

Kim Tocco

Acting Deputy Commissioner (effective April 7, 2025)

Kim.Tocco@oic.wa.gov

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