Adopted rules include new rules, amendments to existing rules, and repeals of existing rules. A rule adopted by a state agency takes effect 20 days after the date on which it is filed with the Secretary of State unless a later date is required by statute or specified in the rule (Government Code, §2001.036). If a rule is adopted without change to the text of the proposed rule, then the *Texas Register* does not republish the rule text here. If a rule is adopted with change to the text of the proposed rule, then the final rule text is included here. The final rule text will appear in the Texas Administrative Code on the effective date.

TITLE 28. INSURANCE

PART 1. TEXAS DEPARTMENT OF INSURANCE

CHAPTER 3. LIFE, ACCIDENT, AND HEALTH INSURANCE AND ANNUITIES

SUBCHAPTER F. RATE REVIEW FOR HEALTH BENEFIT PLANS

28 TAC §3.505

The commissioner of insurance adopts amendments to 28 TAC §3.505, concerning required rate filings. The amendments are adopted with changes to the proposed text published in the November 8, 2024, issue of the *Texas Register* (49 TexReg 8831). The rule will be republished. Section 3.505 was revised in response to public comment.

REASONED JUSTIFICATION. The amendments to 28 TAC §3.505 update the cost-sharing reduction (CSR) adjustment factor and clarify the actuarial value (AV) factors that health benefit plan issuers use in setting premium rates for plans sold to individuals and small groups.

In 2017, the federal government stopped reimbursing issuers for the cost of providing CSRs. Since 2018, issuers have adjusted premiums for Silver plans sold on the exchange to account for those costs. The amendments to §3.505 ensure that premium rates for Silver plans sold to individuals through the health insurance exchange are sufficient to cover the cost of CSRs that issuers are required to provide certain consumers within Silver plan variations under the federal law (42 USC §18071).

Senate Bill 1296, 87th Legislature, 2021, directed the commissioner to review rates and consider, for Silver plans, "whether the rate is appropriate for the plan in relation to the rates charged for qualified health plans offering different levels of coverage, taking into account any funding or lack of funding for cost-sharing reductions and the covered benefits for each level of coverage." In 2022, TDI adopted a CSR adjustment factor of 1.35 within §3.505(f)(6)(B)(iii).

TDI develops the CSR adjustment factor on the basis of (1) data that reflects the number of individuals enrolled in each Silver plan variation, (2) the actuarial value associated with each Silver plan variation, and (3) the induced demand factor (IDF) that TDI assigns to each Silver plan variation. TDI generally assigns IDFs similar to the IDFs set by the Centers for Medicare & Medicaid Services (CMS), except for Platinum-level plans, because TDI actuaries believe the IDF factor of 1.15 is not justified for plans with an AV of 94%. For the purposes of the CSR adjustment factor, the TDI-established IDFs have been:

- 1.03 for plans with an AV of 70% or 73%;

- 1.08 for plans with an AV of 87%;

- 1.09 for plans with an AV of 94%; and

- 1.15 for plans with an AV of 100%.

The methodology for calculating the CSR adjustment factor has been as follows:

(1) Divide the average actuarial value provided by Silver plans on the exchange based on the latest enrollment data by 70%.

(2) Divide the average induced demand factor associated with Silver plans on the exchange based on the latest enrollment data by 1.03.

(3) Multiply the resulting number from paragraph (1) by the resulting number from paragraph (2).

Based on the enrollment data for 2021, TDI calculated a CSR adjustment factor of 1.35. However, the same methodology would result in a CSR adjustment factor of 1.40 based on enrollment reported in 2024.

TDI also amends the current reference to AV in the rule. In response to comment, TDI removed the requirement for issuers to use the federal AV calculator in developing their individual and small group rates, as long as their pricing AV is within the permitted range for each level of coverage. This gives issuers flexibility to use their own pricing tools while ensuring a level playing field.

Descriptions of the section's amendments follow.

Section 3.505. TDI amends the CSR adjustment factor in subsection (f)(6)(B)(iii) to replace the old factor of 1.35 with a new factor of 1.40. As previously described, this new factor is based on the same methodology that TDI has historically used, but it now reflects the changes in enrollment currently seen across the Silver-level-plan variations. TDI also amends the rule text in §3.505(f)(6)(B)(i) that requires issuers to provide the AV for their individual and small group plans. The former rule required the AV to be "calculated consistent with 45 CFR §156.135," which specifies use of the federal AV calculator. In response to a comment, TDI changed this provision as proposed to require the AV used in the pricing of the plan to be consistent with the level of coverage provided by the plan under 45 CFR §156.140, subject to the permitted de minimis variation. As adopted, issuers are not required to use the federal AV calculator in developing their rates, but they are required to use pricing AVs that are within the federally permitted values for each level of coverage. The federal rules require an AV of 58% - 62% for Bronze (or 58% - 65% for Bronze plans that meet certain criteria), 68% - 72% for Silver, 78% - 82% for Gold, and 88% - 92% for Platinum. This will support compliance with federal single risk pool requirements by ensuring that issuers use enrollee health status only when setting their index rate used to price all their plans. Enforcing the

single risk pool standards and preventing issuers from setting rates that reflect plan-to-plan variations in enrollee health status within the pricing AV will support a level playing field. This change will also ensure that an issuer's self-assessment of its plans' AV will match what the issuer represents to consumers about each plan's metal level.

The amendments are effective June 1, 2025, and TDI will begin enforcing the changes for rates applicable to plans to be issued or renewed effective on or after January 1, 2026.

SUMMARY OF COMMENTS AND AGENCY RESPONSE. TDI provided an opportunity for public comment on the rule proposal for a period that ended on December 9, 2024.

Commenters: TDI received comments from one commenter. The Texas Association of Health Plans commented in support of a portion of the proposal and in opposition to a portion, as discussed in the comments and responses that follow.

Comment. A commenter supports raising the CSR factor from 1.35 to 1.40.

Agency Response. TDI appreciates the support.

Comment. A commenter opposes the proposed required use of the federal AV calculator to develop rates. The commenter states that the federal tool is simply a plan comparison tool for shoppers that was never intended to be used for plan pricing and is not designed and vetted to correctly achieve this need. The commenter adds that the federal AV calculator is not sufficiently accurate and undervalues certain benefits in the context of Bronze plans, and the result will be to limit affordable options for consumers who have incomes just above the threshold to qualify for additional cost-sharing reductions. For instance, the commenter states that popular benefit-rich Bronze plans with zero-dollar deductibles would be eliminated from the market. The commenter proposes two alternatives that TDI could use to create a level playing field. First, the commenter suggests that TDI require that each carrier's standard plan have priced AVs that increase from metal to metal. Second, the commenter suggests that TDI could object and seek appropriate justification for any carrier that exceeds a permissible deviation, such as 5% from the slope of the standard federal AVs.

Agency Response. TDI agrees, in part, with the commenter, and has changed §3.505(f)(6)(B)(i) as proposed. The change removes the proposed requirement to use the federal AV calculator found in 45 CFR §156.135, and instead requires the AV used in the plan's pricing to be within the de minimis ranges permitted for the level of coverage provided by the plan under 45 CFR §156.140. This will allow companies to continue using their own pricing tools and will address concerns about the federal AV calculator's accuracy. However, it will also maintain limits on how much the pricing AV can vary, consistent with federal metal-level requirements. In particular, 42 USC §18022(a) generally requires that plans provide coverage within four basic levels of coverage: Bronze, Silver, Gold, or Platinum. Each plan must provide benefits that are actuarially equivalent to a set percentage of the full AV of the benefits covered under the plan. For instance, Bronze plans must have an AV of 60%, subject to the de minimis variations provided by federal rules.

Based on previous rate filings, TDI believes a majority of plans are already within the federally prescribed de minimis ranges. However, in many other cases, issuers' plans do not offer sufficient benefits (according to their own pricing AV) to justify the metal labels of their plans. For instance, a plan labeled as Silver, which should make the issuer responsible for between 68% and 72% of claims, instead may have a pricing AV below 68%. Because issuers do not disclose the pricing AV, consumers may be misled into thinking they have purchased a Silver-level plan when the issuer is actually paying claims at a Bronze level. In fact, for plan year 2025, about 78% of Gold plans appear, according to the issuers' pricing AVs, to be paying below the Gold range of coverage, with many plans using pricing AVs closer to the Silver range.

TDI's AV requirement, as adopted, requires that an issuer's self-assessment of its plans' AVs match what it is representing to consumers about its metal level. TDI disagrees with the commenter that simply checking for standard plan AVs to increase with each metal level would be an effective compliance method. TDI also disagrees with setting a permissible 5% deviation from the slope of the standard federal AVs. Both of these alternative approaches could result in pricing AVs that are outside the levels of coverage defined in 42 USC §18022(d) and would be misleading to consumers. In 45 CFR §156.135, issuers whose plans are not compatible with the federal AV calculator are given other options for calculating their AV. However, the federal rules do not permit issuers to represent a plan as being a particular metal level when the issuer's calculations say it is not.

STATUTORY AUTHORITY. TDI adopts amendments to §3.505 under Insurance Code §§1698.051(b), 1698.052, 1701.060, and 36.001.

Insurance Code §1698.051(b) 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 Insurance Code 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 requires that the commissioner 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 purposes of Insurance Code 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.

§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 used in the pricing of the plan, which must fall within the de minimis variation permitted for the level of coverage provided by the plan under 45 CFR §156.140, concerning Levels 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 1.40, 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.

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

Filed with the Office of the Secretary of State on April 16, 2025.

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Texas Department of Insurance
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