OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

February 1, 2013

Honorable Gordon D. Fox
Speaker, Rhode Island House of Representatives

Honorable M. Teresa Paiva Weed
President, Rhode Island State Senate

82 Smith Street
Providence, RI 02903

Dear Mr. Speaker and Madame President:

This will serve as a letter of transmittal and summary of recommendations for the reports requested of this Office by the Rhode Island Legislature in 2012 Senate Bill: S 2888 A and House Bill: H 7892 A.

Introduction and background
The report was ordered by the legislature in light of significant policy choices regarding commercial health insurance markets created by the Affordable Care Act (ACA). The report was prepared by Deborah Chollet, PhD of Mathematica Policy Research for the Office of the Health Insurance Commissioner (OHIC), with additional input from the Rhode Island Health Benefits Exchange. Dr. Chollet has done significant work in the area of commercial insurance markets for numerous clients and is familiar with the Rhode Island health insurance market.

Funding for the report and supplemental analyses cited within it was provided under the Affordable Care Act (ACA).

Summary of findings and recommendations
Although the report contains fuller analyses, this letter summarizes findings for each topic requested by the legislature and makes resulting recommendations.

1. **The impact of eliminating gender as a rating factor, limiting variation in community rates based on age, and limiting waiting periods for coverage**

The report finds that the ACA eliminates gender as a rating factor for all policies issued after January 1, 2014 and reduces rating variation from the current state-required 400 percent to 300 percent. The report also finds that RI's current waiting period for coverage in the small group market of 60 days provides greater consumer protections than the ACA-mandated 90 days.

OHIC does not recommend additional statutory action on any of these measures. State action to eliminate gender rating would gain at most six months on federal law, at a time when insurers and regulators are already

endeavoring to implement numerous other measures. Reducing rating variation beyond federal guidelines would further raise rates for younger groups and lower rates for older groups. Finally, there is no compelling reason to relax consumer protections by implementing a longer waiting period; however in preparation for the change in the federal definition of small group for the purposes of health insurance from 50 to 100 employees on January 1, 2016, the legislature should consider extending the 60 day waiting period limit accordingly.

2. **The impact of merging the individual and small group insurance markets on rates and coverage, including a proposed plan for implementation.**

Merging the individual and small group markets would result in common insurers and common products offered to small groups and individuals. It would also require a single rating pool for both markets. The report summarizes actuarial analyses that find that merging the individual and small group markets for underwriting purposes would result in individuals most likely seeing an average rate increase of one percent, while small groups would see their rates reduced by a similar amount. Individual persons and small groups would experience significant premium shifts above and below this average.

While the long term policy benefits of a merged market may be significant, OHIC does not recommend merging the markets for underwriting purposes at this time. Merging markets does not reduce overall costs but merely shifts them further – and creates additional employer uncertainty - at a time when the individual and small group markets will be adjusting to the many requirements of the ACA. Instead, OHIC should be directed to coordinate pricing policies to encourage consistent pricing between markets and insurers, monitor the effects of 2014 changes, model the effects of the mandated 2016 expansion of the definition of small group to include groups of 51 to 100, and re-model merging the individual market as well at that time.

3. **The feasibility of requiring insurance product consistency inside and outside of a state health insurance Exchange, including an assessment of coverage and rate impacts**

The report notes that offering unique products on the Exchange could align with state policy goals regarding the Exchange. The report finds that while it is theoretically ideal to have identical product offerings inside and outside an exchange to reduce opportunities for population segregation and adverse selection, these risks can be greatly reduced in a well-overseen market with consistent product and pricing oversight.

OHIC recommends that unique products be permitted on the Exchange, and a comprehensive and consistent program of product and pricing oversight be put in place by OHIC for products inside and outside the Exchange, with extensive coordination with Exchange staff.

4. **Substantially equivalent utilization coverage limits in lieu of the current dollar coverage limits on some state health insurance mandates**

Health insurers will be submitting their proposed products for 2014 in the individual and small group markets and the rates for these projects in the first two quarters of 2012. The report notes that dollar limitations on insurance benefits are not allowed under the ACA. Dollar limits accompany several insurance benefits mandated by Rhode Island laws, and thus will be pre-empted by federal law. Absent a process for converting these dollar limits in the narrow implementation time frame of the first two quarters of 2013, the mandates will be open ended and create unintended additional expenses. While limitations of scope and duration (e.g. visits or time) are permissible under the ACA, these do not necessarily promote evidence-based or customized care.

OHIC recommends that insurers be directed to propose actuarially equivalent alternatives to the current dollar limits for each benefit in question, consistent with legislative intent and with an additional goal of promoting evidence-based treatment. These proposals would be subject to OHIC review and approval.

Closing
The attached report provides greater detail on each of these areas. I acknowledge the collaboration and insights of the Health Benefits Exchange Director and staff in preparing it.

The Office is available to answer any questions raised by the report, the recommendations in this letter and additional issues regarding implementing the ACA in the commercial insurance market, as requested. Thank you for the opportunity to provide this information.

Sincerely,

Christopher F. Koller
Health Insurance Commissioner

Attachment

Cc: Christine Ferguson, Director, RI Health Benefits Exchange

Affordable Care Act Implementation - Report to the Joint Legislative Committee on Health Care Oversight

December 3, 2012

Deborah Chollet

MATHEMATICA
Policy Research

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Affordable Care Act Implementation - Report to the Joint Legislative Committee on Health Care Oversight

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INTRODUCTION

General Law 40-8.4-14, which established a Permanent joint committee on health care oversight, also directs the Office of the Health Insurance Commissioner (OHIC) and the Executive Office of Health and Human Services to report to the Joint Committee on state implementation on options related to the U.S. Patient Protection and Affordable Care Act of 2010 as amended by the Health Care and Education Reconciliation Act of 2010 (collectively referred to as "the ACA") and any further amendments to or regulations or guidance issued related to the ACA.

This report responds to the four issues in that directive that are within the purview of OHIC. Specifically, these issues are:

- The impact of eliminating gender as a rating factor, limiting variation in community rates based on age, and limiting waiting periods for coverage, as required under the Act
- The impact of merging the individual and small group insurance markets on rates and coverage, including a proposed plan for implementation
- The feasibility of requiring insurance product consistency inside and outside of a state health insurance exchange, including an assessment of coverage and rate impacts
- The substantially equivalent utilization coverage limits that the legislature may substitute for the current dollar coverage limits on numerous state health insurance mandates, to conform with the Act.

1. THE IMPACT OF ELIMINATING GENDER AS A RATING FACTOR, LIMITING VARIATION IN COMMUNITY RATES BASED ON AGE, AND LIMITING WAITING PERIODS FOR COVERAGE

Currently, issuers in Rhode Island may consider age and gender in setting rates in the individual preferred risk pool and in the small group market. In the individual guaranteed issue pool, issuers may consider age but not gender. Both the level and any variation in individual and small group rates by allowed rating factors must be actuarially justified.

OHIC is responsible for enforcement of these regulations. OHIC reviews the actuarial justification for premiums in the individual and small group markets and approves premiums in these markets. At present Blue Cross & Blue Shield of Rhode Island (BCBSRI) is the only issuer in the individual market; however, it is hoped that the Exchange will attract other issuers to offer individual coverage.[1] OHIC also reviews actuarial justification for rates in the large group market and approves large group rates.

The Affordable Care Act (ACA) addresses issuers' rating practices in both the individual and small group markets. The ACA defines small groups as having at least 1 employee[2] and as many as

[1] Proposed increases in Blue Cross & Blue Shield individual rates are subject to a public hearing process as well as OHIC review.

[2] Federal rules clarify that groups eligible to purchase coverage in the Small Business Health Options Program, or SHOP, do not include sole proprietors. Specifically: "The Affordable Care Act and the proposed rule base their definitions of "employer," "employee," "small employer," and "large employer" on the definitions in the Public Health Service Act (PHS Act). Section 2791 of the PHS Act incorporates by reference the definition of employee in section 3(6)

100 employees, but allows states to wait until January 1, 2016 to include groups of 51-100 in the small group market.[3]

Effective in 2014, the ACA will allow issuers to vary rates for individual and small-group coverage only by (1) individual or family enrollment (allowing variation for family composition)[4]; (2) geographic area; and (3) age.[5] The ACA prohibits rating on gender, alone or in combination with other factors, and limits variation in rates by age for adults aged 21 to 64 by as much as 3 to 1.[6]

A. Eliminate gender as rating factor

On average, women insured in the preferred pool currently see significantly higher premiums than men, based on gender. In contrast, individuals in the guaranteed issue pool are not rated on gender (so women see no systematic difference in rates), and differences in rates by gender in the small group market (if any) are small. The analysis prepared for OHIC by the Wakely Consulting Group estimated that, for individuals currently insured in the preferred risk pool, elimination of gender rating will reduce average premiums for women by roughly 12 percent, and increase average premiums for men by roughly the same amount.[7] In the small group market, elimination of gender as a rating factor is expected to have no appreciable impact on average premiums, although some small groups might see higher premiums if they include disproportionately men or lower premiums if they include disproportionately women.[8]

Within six months of the close of the 2013 legislative session, implementation of the ACA will prohibit issuers from rating individual and small group policies issued on gender, achieving the purpose of legislation proposed in Rhode Island in 2012. As indicated above, the ACA requires that groups of 51-100 be included in the small group market by 2016. Thus, the ACA's prohibition on using gender as a rating factor will extend also to mid-sized groups of 51-100 workers as of 2016, if the legislature does not act to include these groups earlier in the small group market.

(continued)

of ERISA. Further, section 2791 provides that an employer is defined by reference to section 3(5) of ERISA. .... Under 29 CFR 2510.3–3, an employee would not include a sole proprietor or the sole proprietor's spouse." See: Federal Register, Vol. 77, No. 59 (March 27, 2012), p. 18399.

[3] See: 42 U.S.C. §1304(b).

[4] Proposed federal rules require that family rates be built up based on the characteristics of each family member. The rules would expressly prohibit family rate tiering (as is currently allowed in Rhode Island) where issuers rate coverage on age. See: Department of Health and Human Services. 45 CFR Parts 144, 147, 150, 154 and 156 [CMS-9972-P] RIN 0938-AR40, pp. 29-30. Available at [http://www.ofr.gov/OFRUpload/OFRData/2012-28428_PI.pdf], accessed November 20, 2012.

[5] The ACA also allows issuers to increase rates for tobacco use (a rating factor currently not allowed in Rhode Island) by as much as 50 percent.

[6] HHS has issued proposed regulations governing these provisions. See: Department of Health and Human Services, op cit.

[7] Wakely Consulting Group. Actuarial Analysis: Impact of the ACA on Small Group and Non-Group Market Premiums in Rhode Island – Provisional Report (December 13, 2011), p. 18.

[8] Wakely Consulting Group. Actuarial Analysis: Impact of the ACA on Small Group and Non-Group Market Premiums in Rhode Island (December 12, 2011), presentation slides p. 6.

B. Limit variation in community rates based on age

While current regulation in Rhode Island does not constrain variation in individual rates on age, it does constrain variation on age in small group rates. In the small group market, rates for the oldest members of the issuer's risk pool (at age 64) cannot exceed 400 percent of the rates charged to the youngest members, inclusive of children. In both markets, OHIC requires actuarial justification for any proposed rate variation.

Currently, BCBSRI varies rates by nearly 3 to 1 on age for adults in the individual guaranteed issue pool, and slightly more for adults in the preferred pool. Age-based rate variation among adults in the small group market (exclusive of children) is also about 3 to 1. Consequently, the ACA requirements constraining rates for adults are expected to cause very little change from current RI state law in either the individual market or small group markets. That is, in effect, the ACA's rate bands for age endorse current issuer practice in Rhode Island.

For policy purposes, the legislature might consider rate bands that are narrower than the 3 to1 rate bands for adults aged 21-64 required by the ACA—although issuers' current rating (already nearly or fully compliant with the ACA's rate bands on age) is actuarially justified. Further compression of rates would reduce premiums charged to the oldest individuals and small groups, and increase premiums paid by young adults and small groups that disproportionately employ young adults. Alternatively, the legislature might allow the provisions of the ACA to take effect and observe the impacts of the new law on Rhode Island's insurance markets before considering rules that would further narrow rate variation by age.

C. Limit waiting periods for coverage

Waiting periods in group health insurance plans delay benefits for individuals eligible for coverage for some period of time after they apply to enroll.[9] During the waiting period, if any, the issued coverage is not effective and the issuer may not charge premiums. In general, issuers use waiting periods to avoid the administrative cost of enrolling and disenrolling employees who might quickly leave employment, and also to deter adverse selection in employer group plans. For small group enrollees, Rhode Island currently prohibits waiting periods longer than 60 days, but Rhode Island does not limit waiting periods for enrollees in large groups. Issuers do not use waiting periods in individual plans.

The ACA prohibits waiting periods longer than 90 days in the small group and large group markets.[10] Thus, current Rhode Island law will constrain waiting periods in small group plans to a period of time (60 days) that is shorter than will be allowed in federal law, when the ACA becomes effective in 2014. Because the ACA redefines small groups (effective not later than 2016) as groups with 1-100 employees, Rhode Island's shorter waiting period ultimately will apply also to mid-sized groups with 51-100 employees.

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[9] See: RI 27-50-3. Definitions. Available at [http://webserver.rilin.state.ri.us/PublicLaws/law12/law12256.htm], accessed November 20, 2012.

[10] See: 42 U.S.C. § 300gg-7.

2. THE IMPACT OF MERGING THE INDIVIDUAL AND SMALL GROUP INSURANCE MARKETS ON RATES AND COVERAGE, INCLUDING A PROPOSED PLAN FOR IMPLEMENTATION

Merging the individual and small group market presents issues that are far more complex than those discussed above. A merged market would not only offer individuals and small groups the same products, but also combine Rhode Island's current individual risk pools with the small group risk pool for the purpose of rating coverage. That is, for the same product, an issuer would charge the same premium to individuals (by family status, geographic location, age, and tobacco use) as to small group employees and their dependents. In effect, merging the markets would add another layer of rate changes in both markets—in addition to the changes that will occur under the ACA due to the elimination of gender rating, the slight adjustment of effective rate bands on age, and any changes in plan design that may be necessary to conform to Rhode Island's benchmark plan. With merged risk pools, the individual and small group markets would cross-subsidize one another to the extent that their medical costs are different, burdening whichever component—either individuals or small groups—that has lower medical costs.

However, merging the markets might achieve some purposes that might be attractive public policy, especially if combined with employee choice among plans in the Small Business Health Options Program (SHOP) Exchange. For example, because the same policies would be available to both individuals and small groups, merging the markets could improve portability between small group and individual coverage. Workers and their dependents would not need to change health plans (and potentially also change their providers) when moving between individual and small group coverage, because the same insurance plans would be available to them in the merged market. In addition, a merged market might reduce "rate shock" when moving from group to individual coverage, although a worker would still pay much more after losing his or her employer's contribution to coverage. The greater portability offered in a merged market might also help reduce administrative costs by avoiding much of the health plan disenrollment and re-enrollment that now routinely occurs with changes in employment. There is no reason to anticipate that merging the markets would have any impact on the cost of health care, which is the largest component of health insurance premiums.

Many of the potential benefits of merging the individual and small group markets might be achieved by *coordinating the markets* rather than *merging the risk pools*. In coordinated markets, small groups and individuals would have the same menu of health insurance products from which to choose, but individual and small group premiums would differ if individual enrollees have, on average within a rate class, different medical costs than small-group enrollees.

Such an effort to coordinate Rhode Island's individual and small group markets is already underway. The SHOP Exchange hopes to allow employees to choose among all of the plans offered (across issuers and plan tiers) regardless of the "benchmark" plan their employer may choose. This effort is consistent with the state's objective of facilitating employee choice, maximizing competition among issuers, and improving portability and value in individual and small group coverage. If successful, it could help the markets move together toward more efficient delivery systems and networks that provide both higher-quality care and lower cost growth.

Earlier this year, OHIC received the results of a study it had commissioned to estimate the impacts of the ACA on the cost of coverage in, respectively, the individual and small group markets (the latter defined as groups of 50 or less) compared with the costs that would occur in a merged market. This study projected the average medical cost of Rhode Islanders who will enter the

individual market in 2014. It concluded that, while average medical risk in the individual market will exceed that in the small group market, merging the markets would change the average premiums paid in either market very little: average individual premiums would increase about 1 percent, while average small group premiums would decline about 1 percent.[11]

This study suggests that merging the markets in Rhode Island would have very different results than those that occurred in Massachusetts when it merged its small group and individual markets. When Massachusetts merged its markets the individual market had a high proportion of members in relatively poor health. Consequently, merging the sicker individual pool with the more balanced small group pool produced significantly lower rates for individuals and higher rates for small groups. In 2008, one year following Massachusetts' market merger, individual's medical costs in post-merger products were 112 percent of premiums, while small group medical costs were 86 percent of premiums—demonstrating that small groups were (as expected) subsidizing individuals in the merged market. Because individuals accounted for relatively few enrollees (17 percent of all enrollees) in post-merger products, the impact on small group premiums, while significant, was relatively small.[12]

With the subsidies that will become available to individuals for private coverage under the ACA, Rhode Island might expect much larger individual enrollment in a merged market than occurred when Massachusetts launched its market reforms.[13] Nevertheless, Rhode Island's structured individual market and carefully monitored rates presents a very different picture than that in Massachusetts before it merged its markets and even today. As a result, individuals and small groups in Rhode Island might experience less rate change than occurred in Massachusetts if the markets were merged.

However, because the ACA will have significant effects, regardless of whether the markets are merged, there is reason to be cautious when considering the prospect of merging Rhode Island's individual and small group markets. Specifically, with implementation of the ACA:

- The individual market will quadruple in size and medical underwriting will be eliminated. The "medium" estimates developed for OHIC indicate that average rates will change relatively little (increasing about 5 percent), although less optimistic assumptions about the morbidity of the uninsured population suggest much greater rate change. In any event, the effects of removing medical underwriting will be to raise rates for healthy individuals and lower rates for individuals with health problems prior to any changes that might result from new Exchange options that could increase competition and improve the efficiency of care.
- In the individual and small group markets, gender rating will be eliminated, increasing rates for men while reducing them for women. The ACA's rate bands might also raise

[11] Wakely Consulting Group. *Op cit.* (December 13, 2012), p. 48.

[12] D. Welch. Premium Levels and Trends in Private Health Insurance Plans (February 2010). Report prepared for the Massachusetts Division of Healthcare Finance and Policy, Executive Office of Health and Human Services. Available at [http://www.mass.gov/chia/docs/r/cost-trends-files/part2-premium-levels-and-trends.pdf], accessed November 29, 2012.

[13] In Massachusetts, the lowest-income adults ineligible for Medicaid were eligible to enroll in Commonwealth Care and therefore were not introduced into the private individual market, as will occur in Rhode Island under the ACA.

rates for small groups with a younger mix of employees, while lowering rates for those with an older mix of employees. The small group market might also see a significant change in enrollment due to the individual mandate, expanded eligibility for Medicaid, employer penalties, and the availability of premium subsidies to many workers who might enroll in individual coverage through the Exchange.

- By 2016, the ACA requires that groups of 51-100 be included in the small group market, with access to the SHOP Exchange. Adding these groups to the small group pool will change average rates and may result in rate changes for the groups of 1-50 that will already be in the small group market as well as for the groups of 51-100 that will enter that market.

In December 2012, Rhode Island's Exchange will have new data from a survey measuring health status and prospective health care costs of the uninsured in Rhode Island. While these new data will help to estimate the changes likely to occur in the individual market in 2014 with greater certainty (and, therefore, the potential impact of a market merger), they are not expected to change the conclusions of the market merger analysis conducted for OHIC last year. In contrast, an analysis of the expansion of the small group market has not yet been conducted. Such an analysis could provide another opportunity to re-assess the effects of merging the individual market and small group market when the size and risk composition of these markets after implementation of the ACA will be better understood, and the effects of ongoing efforts to coordinate the plans offered in the individual and SHOP Exchanges may be apparent.

3. THE FEASIBILITY OF REQUIRING INSURANCE PRODUCT CONSISTENCY INSIDE AND OUTSIDE OF A STATE HEALTH INSURANCE EXCHANGE, INCLUDING AN ASSESSMENT OF COVERAGE AND RATE IMPACTS

Requiring issuers to offer the same products in the Exchange as in the outside market might have at least two positive effects for the Exchange and for the individual market more broadly. First, it would eliminate any potential for issuers to "game" the market, offering products intended to attract better risk selection in the outside market where there will be less information available to consumers to help them compare products. Second, individuals who enroll in the Exchange might have less incentive to leave when their incomes rise (and, therefore, the subsidies available to them in the Exchange fall). Strong and stable enrollment will be essential to financing the Exchange. However, requiring issuers to offer the same products in and outside the Exchange may not be the only way to achieve these results, and may actually deter achieving other desirable results—such as market innovation.

As described earlier, OHIC currently reviews products and rates in both the individual and small group market, and requires actuarial justification of rate differences both within and across products. This regulatory process makes it feasible to have issuers offer different products in and outside the Exchange without concern that issuers might cross-subsidize their products. However, in addition, the Exchange will promote a much greater degree of transparency about the costs, benefits, and quality of health insurance plans than has ever before been available to consumers, helping them to directly compare health plans. As a result, the Exchange could foster innovative new products, accelerating improvements in quality and efficiency, helping to constrain cost growth, and helping the Exchange to attract and retain enrollment. Such products might not be as marketable outside the Exchange, where consumers will have less information to help them compare plans.

In anticipation of the Exchange coming on line, Rhode Island has begun a process of negotiation with issuers, coordinated with regulatory oversight. Specifically, the Exchange has begun negotiating with issuers about plans and rates, and OHIC has begun to review the negotiated plans and rates while also reviewing plans and rates to be offered outside the Exchange.

OHIC's oversight process is intended to protect against risk selection, cost shifting, or infeasible assumptions that would affect the market outside the Exchange. In addition, it ensures the consistency of pricing assumptions and enforces rules regarding covered benefits and actuarial value. Such strong oversight of insurance products and rates makes it feasible for issuers to offer unique and innovative products in the Exchange that could benefit Rhode Island, if they contribute to a dynamic market with greater potential for constraining cost growth. Rhode Island's process of rate review also means that requiring issuers to offer the same products both in and outside the Exchange would have no particular impact that would reduce rates in the Exchange.

4. SUBSTANTIALLY EQUIVALENT UTILIZATION COVERAGE LIMITS IN LIEU OF THE CURRENT DOLLAR COVERAGE LIMITS ON SOME STATE HEALTH INSURANCE MANDATES

The ACA prohibits issuers from setting annual or lifetime limits on the amount that a plan will pay for Essential Health Benefits. This provision means that issuers must revise any dollar-denominated limits that they place on Essential Health Benefits, either eliminating them entirely or substituting limits denominated in terms of the quantity of services that the plan will cover.

In Rhode Island, issuers are required to cover, within a dollar limit, a number of services that might be considered Essential Health Benefits. Such services include:

- Early intervention services for children to age 3, within $5,000 per year (RI Gen. Laws § 27-20-50)
- Hair prostheses for cancer patients, up to $350 per year (RI Gen. Laws § 27-20-54)
- Hearing aids, up to $1,500 every 3 years for children under age 19, and $700 every 3 years for adults aged 19 or older (RI Gen. Laws § 27-20-46)
- Infertility services within a lifetime limit of $100,000 (RI Gen. Laws § 27-20-20)
- Nonprescription enteral formula, up to $2,500 per year (RI Gen. Laws §27-20-56)

If issuers limit other services that fall within the ACA's Essential Health Benefits, they will need to revise these limits also to comply with the ACA. Issuers will not need to revise dollar limits for any service—including any state mandate—that is not included in the Essential Health Benefits in order to comply with the ACA.[14]

[14] Such a mandate includes applied behavioral analysis (ABA) for autism spectrum disorder, within $32,000 per year (RI Gen. Laws § 27-20-11). Because Rhode Island mandates ABA only in large group plans, it is not included in the benchmark plan. Preliminary federal regulations issued November 22, 2012 propose a transitional policy for coverage of habilitative services that would provide states with the opportunity to define Essential Health Benefits if not included in the base-benchmark plan. Specifically, the proposed regulations would allow the state to determine the services included in the habilitative services category in order to define Essential Health Benefits, if the base-benchmark plan does not include coverage of habilitative services. See: Department of Health and Human Services, *op cit.*, pp. 27-28.

A report completed for OHIC in May 2012 offers options for removing dollar limits on Rhode Island's mandated benefits.[15] The report observes that issuers might replace dollar limits on some benefits—such as nonprescription enteral formula— with an individualized treatment plan, potentially improving both the efficiency and quality of care provided to patients. Similarly, the report observed that issuers might substitute preferred products (analogous to a prescription drug formulary) for dollar limits on hearing aids and hair prostheses for cancer patients, and numbers of "attempts" for dollar limits on infertility treatments.

These observations comport with the guidance that OHIC expects to issue to issuers with respect to transitioning from dollar limits to quantity limits on mandated benefits that are Essential Health Benefits. At this time, OHIC intends to articulate a process and general guidance under which each issuer will (in its form filing) propose to remove current dollar limits. For habilitative services, issuers might justify any alternative limits in terms of patient need and/or evidence-based best medical practice using methods such as individualized treatment plans, preferred providers, or preferred product lists to help manage cost. For other mandated benefits, alternative quantitative limits may be acceptable.

[15] K. Wells. Essential Health Benefits: Selecting and Supplementing a Benchmark Plan in Rhode Island. Report prepared for the Office of the Insurance Commissioner (May 2012).

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